ALGOMA PUBLIC HEALTH BOARD MEETING
SEPTEMBER 22nd , 2015 @ 5:00 PM
SAULT STE MARIE ROOM A&B 1ST FLOOR, APH SSM

ADDENDUM

11) Addendum

a) Provincial Public Health Funding
- Letter from the Minister of Health and Long-Term Care to Algoma Public Health Board of Health Chair dated September 4, 2015
- Memo: Update on Public Health Funding Review dated September 4, 2015
- Final Report of the Funding Review Working Group dated December 2013
- Appendix 1 – Funding Review Working Group Field Input Responses

b) Electronic Means of Participation of Local Boards
- Letter to the Ministry of Municipal Affairs and Housing from Wellington-Dufferin-Guelph Public Health dated September 10, 2015.
- Letter to Wellington-Dufferin-Guelph Medical Officer of Health from the Interim Chief Medical Officer of Health dated June 30, 2015
- Resolution from Wellington-Dufferin-Guelph BoH Meeting September 9, 2015

c) Board Development Workshop – October 24, 2015
Hosted by The Children's Rehabilitation Centre Algoma Board of Directors

d) Board of Health Orientation Manual Updates – *For replacement in Orientation Binder*.
- 02-05-065 – Algoma Board of Health Reserve Fund
- Bylaw 95-2 – To Provide for Banking and Finance
- Bylaw 95-3 – To Provide for the Duties of the Auditor of the Board of Health
- Bylaw 2015-1 – To Provide for the Management of Property
- 2015 alPHa Orientation Manual for Board of Health

Ministry of Health and Long-Term Care

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Ontario

iApprove-2015-00949

SEP 0 4 2015

Mr. Lee Mason
Chair, Board of Health
District of Algoma Health Unit
294 Willow Avenue
Sault Ste. Marie ON P6B 0A9

Dear Mr. Mason:

I am pleased to advise you that the Ministry of Health and Long-Term Care will provide the Board of Health for the District of Algoma Health Unit up to $86,923 in additional base funding and up to $44,800 in one-time funding for the 2015-16 funding year to support the provision of mandatory and related public health programs and services in your community.

The Executive Director of the Public Health Division and Assistant Deputy Minister (A) of the Health Promotion Division will write to the District of Algoma Health Unit shortly concerning the terms and conditions governing this funding.

Thank you for your dedication and commitment to Ontario's public health system.

Yours sincerely,

Dr. Eric Hoskins
Minister

c: Michael Mantha, MPP, Algoma-Manitoulin
Hon. David Orazietti, MPP, Sault Ste. Marie
Sandra Laclé, Chief Executive Officer (A), District of Algoma Health Unit
Dr. Penny Sutcliffe, Medical Officer of Health (A), District of Algoma Health Unit

Appendix 1

Funding Review Working Group
Field Input Response

Field input sessions were led by members of the Funding Review Working Group on January 14, 2013 with public health unit Medical Officers of Health and Chief Executive Officers, and again on January 16, 2013 with public health unit Business Administrators.

The purpose of the field input sessions was to seek input on the proposed elements of the public health funding model. The sessions were well attended and a total of 28 public health units and the Council of Ontario Medical Officers of Health provided feedback during the sessions, in writing, or both.

The following represents the response by the Funding Review Working Group to the field input received from Medical Officers of Health, Chief Executive Officers, and Business Administrators. A summary of the input received from the field is first provided (including the number of public health units that provided the comments), followed by a response from the Funding Review Working Group. Much of the language included in this document reflects content included in the Final Report.

1. Service Cost Drivers: Geography

Field Input Summary:

The Adapted Concentric Circle Model is not an appropriate measure of geography for the funding model.

- Further information requested regarding how the largest public health unit office was chosen/measured (2).
- Recommendation that both monetary and distance implications be considered for this indicator (3).
- Assertion that census subdivision (CSD) is too large a measure of geography for a population-weighted approach (1).
- Assertion that this indicator is not resistant to manipulation since office locations and sizes change over time (3).

Funding Review Working Group Response:

A measure of geography is recommended for inclusion in the funding model as geographic characteristics affect costs related to delivering public health programs and services (e.g., transportation costs, travel time).

Consistent with the 1996 and 2001 funding models/reviews, the Adapted Concentric Circle Model was chosen to represent these costs. This model takes the population in a defined area (CSD or dissemination area (DA)) and weights it according to how far it is from the largest office of the public health unit (the site with the greatest number of staff). This definition was chosen as it provided the best data available to represent where the most staff would be travelling from to deliver programs and services. This measure can represent both the direct costs of travel and the costs associated with travel time. The largest public health unit office was identified based on the office for which the greatest number of staff was reported on the 2013 Program-Based Grants Occupancy Report.

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The Funding Review Working Group is recommending that the Ministry use CSD level data when calculating the Adapted Concentric Circle Model after reviewing a comparison analysis of CSD level (larger geographic areas) and DA level (smaller geographic areas) data. The result does not differ substantially between the two (2) levels of data. However, the DA level data is only available based on census population counts whereas the CSD population can be based on either census population counts or population estimates. The population estimates take into account net under-coverage from the post-censal coverage study and therefore provide a more accurate measure of population counts.

Additional modifications to the methodology were considered but not adopted, as they were either unfeasible or did not add to the validity of the measure. For example, an adaptation for road density, to account for the fact that some areas are difficult to travel to, was considered. However, updated road density data is not available. Road density is generally highly correlated with population density and thus may not adequately measure the remoteness of the population. Other Geography indicators considered but not selected included: Population per Km Road, Rural Index of Ontario, Rural and Small Community Measure, and Population Density.

Given the complexities and costs of moving office locations, and the unlikelihood of a public health unit choosing to locate an office further away from the population it serves, the Funding Review Working Group did not believe that this indicator would, in practice, be subject to significant manipulation.

2. Service Cost Drivers: Language

Field Input Summary:

The Language indicator should be measured differently or possibly removed.

- A distinction should be made between French as a first language and other first languages that are not English (2).
- Recommendation that linguistic diversity (communities with different languages) should be taken into consideration (2).
- Assertion that the inclusion of both the Language and Recent Immigrant indicators results in 'double counting' (4).

Funding Review Working Group Response:

Language is being recommended for inclusion in the model as language spoken can impact the costs of service delivery since certain populations may require linguistically and/or culturally adapted services. A measure of the proportion of the population whose Home Language is not English was chosen to represent these costs. This indicator was also recommended in the 1996 and 2001 funding models/reviews. Although this service cost driver is named "Language", it is recognized that there are also costs related to cultural adaption of materials and programs.

Several other ways of measuring language were reviewed, including measures of the Francophone population and the population that speaks neither English nor French. In addition, the impact of the number of different languages was considered. The Funding Review Working Group decided that the population whose Home Language is not English was the most appropriate way to represent the costs of translation and culturally specific programming at public health units.

It is recognized that there are unique obligations regarding the provision of services in French; however, the indicator is intended to reflect the costs for translation and cultural adaptation of materials and programs, which are expected to be similar regardless of language.

The Funding Review Working Group recognizes that there is some double counting (as there will be with many indicators) if both Language and Recent Immigrant indicators are included in the model. However, the former is included as a service cost driver, with the weighting assigned to reflect the costs of translation and culturally specific programming, while the Recent Immigrants indicator was included as a driver of need with weighting assigned to reflect areas of increased need for public health services among immigrant populations. As noted below, the Recent Immigrants indicator has now been replaced with the Ethnic Concentration dimension within the Ontario Marginalization Index (ON-Marg).

3. Drivers of Need: Aboriginal Population

Field Input Summary:

Greater clarity sought regarding whether the Aboriginal indicator reflects on-reserve aboriginal populations, off-reserve aboriginal populations, or both.

- Assertion that the Aboriginal population is under reported (2).
- Assertion that on-reserve services are funded and provided by the Federal Government not public health units and therefore should be given a lower weight or not be included in the funding model (5).
- Assertion that the Aboriginal indicator does not reflect all the issues that this population faces (2).
- Assertion that the inclusion of both the Aboriginal and ON-Marg indicators results in 'double counting' (2).

Funding Review Working Group Response:

A measure of Aboriginal status is being recommended for inclusion in the model to reflect the established disparity in health status between Aboriginal and non-Aboriginal populations. The Aboriginal population refers to those persons who report: identifying with at least one Aboriginal group, that is, North American Indian, Métis or Inuit, and/or being a Treaty Indian or a Registered Indian, as defined by the *Indian Act* of Canada, and/or they were members of an Indian band or First Nation (Statistics Canada, 2006 Census of Population). Aboriginal status includes both on- and off-reserve populations. The known under reporting of Aboriginal populations in the Census supports the importance of using population estimates that adjust for this, for example, in the geography indicator and for the overall funding model. In addition, using the same source of data for all public health units should capture the relative impact of need in public health units related to Aboriginal population.

Aboriginal people experience the lowest health status of any identifiable population in Ontario. Indicators of lower health status include: shorter life expectancy; higher infant mortality; elevated rates of obesity; greater prevalence of chronic diseases (including diabetes and mental health and addictions); higher hospitalization rates, longer length of hospital stays, fewer visits to specialists, and, poor outcomes regarding socio-economic determinants of health (e.g., greater burden of poverty, unemployment, and lower educational attainment).

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Health Canada's First Nations and Inuit Health Branch (FNIHB) has a role with respect to on-reserve public health given the history and mandate of the Branch, funding and governance relationships with First Nations, and the extent of programming and expertise currently deployed for on-reserve First Nations peoples. Notwithstanding FNIHB's responsibility, the province has primary responsibility for the provision of health care services to all residents of Ontario, including First Nations people living on-and-off-reserve. Public health units are defined based on their geographic boundaries; therefore, every part of Ontario is covered by a public health unit and subject to the HPPA, including First Nation communities and reserves. The Ministry's position is that provincial funding for public health units for mandatory and related programs is for the entire population within the public health units - with the actual program and service delivery being determined between the public health units and First Nations communities. Under section 50 of the HPPA, a board of health and a band council may enter into an agreement under which: the board agrees to provide health programs and services to members of the band; the band council agrees to accept the responsibilities of a municipality within the public health unit; and, the band council may appoint a member of the band to sit on the board of health.

The Aboriginal indicator has a moderate correlation with some of the other indicators. This means that needs related to some of the issues faced by this population are addressed by other indicators, not this one. However, as these other indicators alone do not fully reflect the needs of the Aboriginal population, the Aboriginal indicator is also necessary to recognize this residual disadvantage.

4. Drivers of Need: Ontario Marginalization Index

Field Input Summary:

ON-Marg is an inappropriate measure of deprivation for the funding model.

- Concerns expressed regarding 'double counting' with other drivers of need (7).
- Assertion that ON-Marg is an inner city/urban centric measure of deprivation (6).
- Clarification sought regarding which ON-Marg variables and/or dimensions are used and how the ON-Marg score is used in the model calculation (3).
- Assertion that ON-Marg is an inconsistent predictor of actual health outcomes (1).

Funding Review Working Group Response:

In line with the Funding Review Working Group's decision to use an upstream approach for the development of the funding model, several deprivation and marginalization indices were considered for inclusion in the model.

ON-Marg was chosen by the Funding Review Working Group as it demonstrates the difference in marginalization between areas and describes the inequalities in various health and social wellbeing measures. ON-Marg is a census- and geographically-based index that can be used for planning and needs assessment, resource allocation, monitoring of inequities, and research. ON-Marg is an Ontario-specific version of the Canadian Marginalization Index (CAN-Marg, www.canmarg.ca), which has been in use since 2006.

Appendix 1

ON-Marg is multifaceted, allowing researchers and policy and program analysts to explore multiple dimensions of marginalization in urban and rural Ontario. The four (4) dimensions are: Residential Instability, Material Deprivation, Dependency, and Ethnic Concentration.

The index was developed using a theoretical framework based on previous work on deprivation and marginalization. It was then empirically derived using principal components factor analysis on data from across Ontario including all geographic areas. It has been demonstrated to be stable across time periods and across different geographic areas (e.g., cities and rural areas). It has also been demonstrated to be associated with health outcomes including hypertension, depression, youth smoking, alcohol consumption, injuries, body mass index and infant birth weight.

Each of the four (4) ON-Marg dimensions can be used separately or combined into a composite index. Dimensions may be chosen by comparing correlations between each dimension and a given outcome, as a way of testing appropriateness for inclusion. Each dimension may not be related to the chosen outcome in the same direction. The Funding Review Working Group analyzed each dimension's relationship to two (2) Health Status indicators – Preventable Mortality Rate and Potential Years of Life Lost Ratio – to determine how the dimensions should be incorporated in the model.

There was a positive relationship with the Residential Instability dimension. Variables in this dimension include: proportion of the population living alone, proportion of the population who are not youth (age 16+), average number of persons per dwelling, proportion of dwellings that are apartment buildings, proportion of the population who are single/divorced/widowed, proportion of dwellings that are not owned, and proportion of the population who moved during the past 5 years.

There was a positive association with the Material Deprivation dimension. Variables in this dimension include: proportion of the population age 20+ without a high-school diploma, proportion of families who are lone parent families, proportion of the population receiving government transfer payments, proportion of the population aged 15+ who are unemployed, proportion of the population considered low-income, and proportion of households living in dwellings that are in need of major repair.

There was a positive correlation with the Dependency dimension. Variables in the Dependency dimension include: proportion of the population who are aged 65 and older, dependency ratio (total population 15 to 64/total population 0-14 and 65+), and proportion of the population not participating in the labor force (aged 15+).

In contrast to the other dimensions, there was a negative correlation with the Ethnic Concentration dimension. Variables in this dimension include: proportion of the population who are recent immigrants arrived in 5 years prior to census, and proportion of the population who self-identify as a visible minority.

The Ethnic Concentration dimension was originally removed for the purpose of the funding model because it was negatively correlated with other indicators and a Recent Immigrant indicator was already being considered for inclusion in the model. However, a high level of feedback from the field regarding the appropriateness of the Recent Immigrant indicator led to the review and consideration of the meaning of the 'healthy immigrant effect' in identifying drivers of need in a public health context (see following section regarding "Recent Immigrants").

The Funding Review Working Group concluded that the inclusion of an indicator that represents the health needs of immigrants was appropriate for the model. However, in deciding how to best represent the immigrant population in the model, that is, whether to include the Recent Immigrant indicator or the Ethnic Concentration dimension of ON-Marg, the Funding Review Working Group decided that the inclusion of the latter indicator would better facilitate interpretation of the model, as the three (3) remaining components of the ON-Marg were already included. Therefore, the Ethnic Concentration dimension was included in the model and the Recent Immigrant indicator was removed.

The Funding Review Working Group is also recommending that each of the four (4) ON-Marg dimensions be used separately so that each can be individually weighted to reflect its impact as a public health driver of need.

For more information on the ON-Marg go to http://www.crunch.mcmaster.ca/ontario-marginalization-index.

5. Drivers of Need: Recent Immigrants

Field Input Summary:

The Recent Immigrants indicator should be removed from the model given evidence of the 'healthy immigrant' effect (8).

Funding Review Working Group Response:

The Funding Review Working Group reviewed evidence related to the 'healthy immigrant effect' to better understand the Recent Immigrants indicator as a potential driver of need in this public health context.

The review determined that although new immigrant mortality and health care utilization rates are lower for recent immigrants upon arrival, as compared to the Canadian-born comparison population, the health advantages seen in the data diminished with time, with the health status of more established immigrants approaching that of the Canadian-born population. Furthermore, mortality alone is an inadequate measure of the health impact of immigration. Recent immigrants have a many fold excess of numerous infectious diseases (e.g., tuberculosis, enterics) which require intensive follow up by public health. Many immigrant groups have poor oral health, and many have greatly increased risks of diabetes and cardiovascular disease. Refugees tend to have multiple health problems.

The Funding Review Working Group concluded that the inclusion of an indicator that represents the health needs of immigrants was appropriate for the model. However, in deciding how to best represent the immigrant population in the model, that is, whether to include the Recent Immigrant indicator or the Ethnic Concentration dimension of ON-Marg, the Funding Review Working Group decided that the inclusion of the latter indicator would better facilitate interpretation of the model, as the three (3) remaining components of the ON-Marg were already included. Therefore, the Ethnic Concentration dimension was included in the model and the Recent Immigrant indicator was removed (see also previous section regarding ON-Marg).

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6. Excluded Indicators

Field Input Summary:

The field recommended a number of additional indicators for inclusion in the model including health status (11), cost of living (4), environmental health (11), special populations (8), and infrastructure/administration (10).

Funding Review Working Group Response – Health Status:

The Funding Review Working Group considered many health status indicators but originally chose not to recommend them in the model in keeping with the decision to develop a funding model using an upstream approach focusing on socio-economic determinants of health rather than on health outcomes. Health status indicators originally considered by the Funding Review Working Group included: Obesity, Daily Smoking, Physical Inactivity, Self-Rated Health, Low Birth Weight, Potential Years of Life Lost Ratio, and Standardized Mortality Ratio.

Most of the funding for public health is spent on programs only weakly related to mortality, and where better measures of outcome might include disease incidence and prevalence indicators, or data on risk factors. However, there are significant limitations in the range, quality and availability of risk factor and morbidity data. Therefore, although risk factor and morbidity rates most appropriately reflect issues related to the mandate of public health, the Funding Review Working Group does not recommend the inclusion of any health status indicators based on morbidity or risk factor data in the model.

After a high level of input received from the field recommending the inclusion of a health status indicator in the funding model, the Funding Review Working Group re-examined the issue of a health status indicator, and conducted an analysis of the correlations of two (2) mortality-based health status indicators with other indicators in the model. The health status indicators considered were: (1) Preventable Mortality Rate (under age 75) which is defined as premature mortality per number of population from preventable causes that could be potentially avoided through primary prevention efforts; and, (2) Potential Years of Life Lost Ratio (under age 75) which is defined as potential years of life lost per number of population from premature mortality due to a particular cause that could be potentially prevented. Both health status indicators measure the relative impact of preventable diseases and lethal forces on population. This analysis was intended to determine if the need for prevention programs or services that could potentially reduce premature mortality were already represented by other indicators of the funding model.

The Funding Review Working Group recommends the inclusion of the Preventable Mortality Rate in the model to reflect unrecognized aspects (i.e., not included in the other model indicators) of the health profile of public health unit populations and the services they provide. The Preventable Mortality Rate was considered the most appropriate proxy indicator of health status for the purposes of the funding model.

Funding Review Working Group Response – Cost of Living:

The Funding Review Working Group considered many Cost of Living indicators for inclusion in the funding model. However, due to data quality issues (cost of living, average dwelling cost, income per health occupation), inconsistent availability (consumer price index), little

demonstrated variation between highest and lowest public health unit values (nutritious food basket), or inclusion in ON-Marg (unemployment), none were included in the model.

Funding Review Working Group Response – Environmental Health:

Environmental health indicators were not originally considered for inclusion in the model. In response to feedback received from the field, an analysis of the number of food premises, pools, and personal service settings per population was reviewed by the group. The analysis suggested a fairly even distribution of these premises per population across the province in most cases. Given the even distribution, the Funding Review Working Group determined that the exclusion of environmental health indicators was appropriate, as it would not add significant differentiation beyond the population distribution.

Funding Review Working Group Response – Special Populations**:**

The Funding Review Working Group extensively reviewed the possibility for the inclusion of special populations (e.g., corrections, students, seasonal, migrant workers, homeless, commuters, etc.) not captured by the Statistics Canada Population Estimates. However, what few data were available on these populations were not captured consistently across all public health units. Therefore, there are no adjustments included in the model to account for these factors. Correctional facility populations are included in the Statistics Canada census if they have resided in the facility for longer than 6 months. Students who return home to live with their parents during the summer are enumerated at their parents' place of residence.

Funding Review Working Group Response – Infrastructure:

The Funding Review Working Group also extensively considered the inclusion of infrastructure/administration as a separate component in the funding model. Infrastructure/administration costs were defined as those costs associated with the organizational functions of each public health unit. Organizational infrastructure costs, while necessary, are generally not viewed as contributing directly to service delivery. It is not uncommon for funding models to include a separate infrastructure/administration component as the perception is that it provides some assurance of stability for the organization.

Upon further examination, it was determined that the key factor affecting infrastructure/administration was geography, which is recommended in the final model as a service cost driver indicator. Other costs, such as those associated with board of health governance, were found to be relatively consistent across public health units. Based on this, the Funding Review Working Group determined that infrastructure/administration would not be recommended as a separate model component.

7. Model Construction: Weighting

Field Input Summary:

The field felt that the indicator weightings did not represent the work of public health units.

- There were conflicting assertions that the same indicators were weighted either too heavily or not heavily enough (14).
- Questions were raised regarding what evidence was used to support the weighting of the indicators (4).

Funding Review Working Group Response:

The funding model was developed by the Funding Review Working Group as an Ontario model balancing the needs of all 36 public health units, and this is reflected in the weighting of the indicators. However, the funding model recommended is sufficiently flexible to allow the Ministry to develop implementation strategies that reflect other factors that contribute to the unique funding needs of each public health unit in Ontario.

Very little research was available on funding model development for the public health sector. As such, Funding Review Working Group members relied on their public health expertise and judgment when considering recommendations for the weighting of each indicator. Through a scenario analysis tool, which included the interaction between weight and scale, a variety of weighting scenarios were considered by the Funding Review Working Group.

It is important to note that the indicator weights in the funding model do not translate or equate to a percentage of total public health unit funding. Rather, they are used to determine an equity adjustment factor score for each public health unit that is applied to its population.

8. Model Construction: Population

Field Input Summary:

The field had a number of questions regarding which population data would be used and how it would be used in the model (7). Concerns were also expressed regarding changes to the census process with the move to the National Household Survey.

Funding Review Working Group Response:

The Funding Review Working Group is recommending that the most recent Statistics Canada Population Estimates be used for the purposes of the funding model for both mandatory programs and unorganized territories funding. Population statistics will be updated annually in order to acknowledge the high growth experienced in certain regions.

Statistics Canada Estimates were deemed to provide the most accurate Aboriginal population numbers as Statistics Canada Post-Censal Estimates include adjustments for incompletely enumerated First Nation Reserves.

It is also recommended that the population data used for the unorganized territories funding model calculations only reflect Statistics Canada Population Estimates for unorganized territories. Any reserves/settlements contained within the boundaries of the unorganized territory will be included in this population count.

Ministry of Finance population statistics projections were considered for inclusion in the model, however, it was determined that, due to several issues that would require adjustment to the data (e.g., geographic boundary differences), Statistics Canada's most recent population estimates should be used.

In 2011, the federal government announced that the long-form census questionnaire would no longer be mandatory and introduced the voluntary National Household Survey. Critics of the change have expressed concerns that the data collected is less accurate and results skewed as some population groups may be less likely to respond than others (particularly low-income

populations and those whose home language is neither official language). The Funding Review Working Group has recommended in its report that the Ministry consider how changes to the Census data collection process will affect the funding model put forward in this report and pursue the most appropriate and accurate data sources, if/as they become available, in its implementation.

9. Model Implementation

Field Input Summary:

The field expressed a number of concerns regarding the implementation of the model.

- Questions were raised regarding the funding impact on each public health unit (14).
- Concerns expressed regarding the impact changes to provincial funding will have on service provision and municipal funding (14).
- Concerns expressed regarding the perceived shift from the model applied to only incremental, versus base funding, as outlined in the original Funding Review Working Group Terms of Reference (4).
- Concerns expressed regarding the timing for implementation (14).
- Assertion that smaller/less populated public health units will be impacted negatively by the model, while other large public health units with larger populations will benefit (2).
- Recommendation that amalgamation be considered as part of the implementation process (3).

Funding Review Working Group Response:

Throughout the development of the funding model, the Funding Review Working Group was cognizant of the fact that the funding model's implementation would ultimately be a government policy decision dependent on available funding and approvals. The Funding Review Working Group understood that the model must be cost neutral and/or within the Ministry's approved funding allocation.

The Funding Review Working Group has recommended that the Province use the following implementation principles when developing its method for implementing the above recommended funding model:

- The timing to reach equity/model-based share must be balanced with maintaining system stability but should not further exacerbate current funding disparities.

- The Ministry should use incremental funding to the greatest extent possible in the application of the new funding model in order to minimize the disruption to existing service provision.

- Public health units should be provided with sufficient notice regarding the implementation of the funding model for planning purposes. A transition period (e.g., at least 3 years) is necessary to implement changes to funding. The Ministry should work with boards of health and public health units to mitigate the impact on service provision during the transition period.

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- The impact of funding changes should be monitored by the Ministry to ensure that service provision is not being unduly impacted.

- The impact of funding changes should be taken into consideration in the setting of targets for Public Health Accountability Agreement indicators.

- The model is not intended to affect the municipal cost-share formula (75% provincial/25% municipal) although there may be impacts on municipal funding contributions resulting from the implementation of the model.

- The impact of funding changes to the municipal cost-share formula (i.e., decreases or increases in provincial funding affecting municipal contribution levels) should be taken into consideration when determining an implementation method.

- The most current data should be used for the public health funding model.

PUBLIC HEALTH FUNDING MODEL FOR MANDATORY PROGRAMS

The Final Report of the Funding Review Working Group

December 2013

Letter of Transmittal

December 2013

Dr. Arlene King
Chief Medical Officer of Health, Public Health Division

Roselle Martino
Executive Director, Public Health Division and
Office of the Chief Medical Officer of Health

Kate Manson-Smith
Assistant Deputy Minister, Health Promotion Division

Dear Dr. King, Ms. Martino, and Ms. Manson-Smith:

On behalf of the Funding Review Working Group, we are pleased to present you with our final report *Public Health Funding Model for Mandatory Programs: The Final Report of the Funding Review Working Group*. This report provides advice and recommendations on a model for the allocation of provincial funding to public health units for the delivery of mandatory public health programs and services in both organized and unorganized areas.

The recommendations in this report support the creation of a public health funding model with an "upstream" approach incorporating socio-economic determinants of health. This funding model was developed with the intention of identifying an appropriate funding share for each public health unit that reflects its needs in relation to all other public health units. The report also provides advice to the Ministry on implementation principles.

The Funding Review Working Group would like to thank the Ministry of Health and Long-Term Care for its dedication to the development of a fair, transparent, and consistent method of funding for public health units. We would also like to thank former members of the Funding Review Working Group who contributed to the findings and recommendations of this report and our sector colleagues for their invaluable input to the development of this funding model. Dedicated staff from the Public Health Division, Health Promotion Division, and Health System Information and Investment Division also provided adept and diligent secretariat support.

This funding model represents not only an opportunity to improve upon the accountability and transparency of provincial funding of public health services but, more importantly, marks an opportunity for the Province of Ontario to implement an equitable way of funding public health services.

Sincerely,

Original Signed By

Dr. David L. Mowat
Chair, Funding Review Working Group

c: Members, Funding Review Working Group
Sylvia Shedden, Director, Public Health Standards, Practice & Accountability Branch
Laura Pisko, Director, Health Promotion Implementation Branch
Brent Feeney, Manager, Public Health Standards, Practice & Accountability Branch

Members of the Funding Review Working Group

Dr. David L. Mowat *(Chair)*
Medical Officer of Health, Peel Public Health

Jackie Boufford
Director, Administration, Durham Region Health Department

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Medical Officer of Health, Eastern Ontario Health Unit

Cynthia St. John
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Director, Planning & Policy, Toronto Public Health

Don West
Chief Administrative Officer, Porcupine Health Unit

Past Members of the Funding Review Working Group:

Vance Blackmore ***(April 2010 – January 2011)***
Former Member, Board of Health Section, Association of Local Public Health Agencies

Dale Jackson ***(April 2010 – June 2011)***
Former Director of Administration, Hastings & Prince Edward Counties Health Unit

Dr. Christopher Mackie ***(April 2010 – June 2011)***
Former Associate Medical Officer of Health, City of Hamilton, Public Health Services

Dr. Allan Northan ***(April 2010 – July 2011)***
Former Medical Officer of Health, District of Algoma Health Unit

Secretariat Staff:

Public Health Standards, Practice & Accountability Branch, Public Health Division

Health Promotion Implementation Branch, Health Promotion Division

Health System Funding Policy Branch, Health System Information Management and Investment Division

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Executive Summary

Why is a funding review necessary?

Over the past few years, the Ministry of Health and Long-Term Care (the "Ministry") has been faced with increased scrutiny and accountability requirements for the provision of transfer payments to health sector organizations, such as public health units.

Public health is one of the few areas where provincial funding is not governed by a formula for its distribution. As a result, the Ministry cannot explain or justify the variation in per capita funding levels among public health units. Public health funding also does not currently align with the underlying principles of Health System Funding Reform. In addition, a number of reports and stakeholders have recommended that the Ministry allocate provincial funding for public health units more equitably, using indicators that reflect service costs and the relative health needs of communities.

It was within this context that the Ministry initiated a process to review the provincial funding provided to public health units for mandatory programs in both organized and unorganized areas. The Funding Review Working Group, made up of public health sector representatives, was established in 2010 with a mandate to investigate the current status of public health funding, provide advice to the Ministry on a future public health funding model, and advise the Ministry on principles for implementing the funding model.

What guided the Funding Review Working Group's deliberations?

A great deal of research, analysis, and thoughtful discussion has taken place over almost three (3) years to develop the funding model recommended in this report. Representatives from across the public health sector, including boards of health, public health units, the Association of Local Public Health Agencies (alPHa), and the Association of Municipalities of Ontario (AMO), have worked to develop a model we believe best represents the costs of the provision of mandatory program services in public health units using the best available data.

Over the past few years, the Funding Review Working Group has reviewed and analyzed current and historical funding levels, sources of funding, expenses, and cost pressures of public health units; examined prior reviews/reports and information from other jurisdictions; established sub-committees to conduct research and make recommendations on key issues/areas; established characteristics and criteria for the funding model; reviewed potential components and indicators for inclusion in a funding model and developed the respective scaling and weighting of the various components; and, formulated implementation principles. Over the course of our deliberations, input was sought from the field on the proposed elements of the public health funding model.

Public Health Funding Model Recommendations

The Funding Review Working Group considered three (3) potential components for the public health funding model: population, infrastructure/administration, and an equity-adjusted population model.

Population was considered by the Funding Review Working Group, where funding would be allocated to each public health unit in proportion to its population. While public health units with a higher population likely require more funding, this approach alone would not reflect the drivers of need and/or service cost drivers that differ from public health unit to public health unit. For these reasons population was not recommended as a separate model component.

Costs associated with **infrastructure/administration** were also considered by the working group for which funding would be allocated to each public health unit based, in part, on these costs. Upon further examination, it was determined that the key factor affecting infrastructure/administration was geography, which is recommended in the final model as a service cost driver indicator. Other costs, such as those associated with board of health governance, were found to be relatively consistent across public health units. Based on this, the Funding Review Working Group determined that infrastructure/administration would not be recommended as a separate model component.

The Funding Review Working Group is recommending that **an equity-adjusted population model** be used that takes into account population as well as equity measures. Six (6) groups of equity factors and associated indicators were considered for inclusion:

1. Health Risks (e.g., Daily Smoking, Obesity, Physical Inactivity)
2. Health Outcomes (e.g., Low Birth Rate, Preventable Mortality Rate)
3. Service Cost Drivers (e.g., Cost of Living, Geography, Language)
4. Drivers of Need (e.g., Aboriginal, Recent Immigrants, Visible Minorities)
5. Socio-Economic Characteristics (e.g., Deprivation Indices, Education)
6. Replacement Services (e.g., Pharmacies, Physicians)

The Funding Review Working Group also reviewed each of the potential indicators against characteristics and criteria established at the outset of the review. Indicators must be resistant to manipulation, reliable, independent, based on available data, easily explained, and unlikely to change over time. In many cases, data were not available at the public health unit level, resulting in the exclusion of those indicators or the use of proxy indicators.

The public health funding model recommended in this report uses an “upstream” approach focusing on socio-economic determinants of health. The resulting model has two (2) groups of equity factors (and associated indicators) as follows:

1. **Service Cost Drivers** that reflect the variable cost of delivering public health services. **Geography** and **Language** are being recommended to reflect service cost drivers.
2. **Drivers of Need** that address demand and reflect the utilization of public health services. **Aboriginal, Ontario Marginalization Index (ON-Marg)**, and **Preventable Mortality Rate** are being recommended to reflect drivers of need. It is important to note that ON-Marg contains four (4)

dimensions (i.e. Residential Instability, Material Deprivation, Dependency, and Ethnic Concentration), which are used in the model to reflect the socio-economic determinants of health.

The intention of this funding model is to identify an appropriate funding share for each public health unit that reflects its needs in relation to all other public health units. The model can work with any size of funding allocation.

In calculating the share for each public health unit, the actual values for each indicator have been rescaled to a common range to allow them to be combined. Percentage weights are then assigned to each of the indicators based on relative valuing. If a certain indicator is felt to account for a higher degree of need/cost, it is assigned a higher weight.

For the **mandatory programs funding model**, the Funding Review Working Group is recommending that Service Cost Drivers reflect 35% of the overall weight and Drivers of Need reflect 65% of the overall weight of the model. The Funding Review Working Group is also recommending that these two (2) Drivers be broken down as follows:

- Service Cost Drivers (35%): Geography at 25% and Language at 10%.
- Drivers of Need (65%): Aboriginal at 12.5%, ON-Marg at 42.5%, and Preventable Mortality Rate at 10%.

An adjustment to the weighting was required for the unorganized territories funding model to adequately reflect the demands and cost of service delivery in remote areas. The Funding Review Working Group, based on advice from the Unorganized Territories Sub-Committee, is recommending that the two (2) Drivers be broken down as follows:

- Service Cost Drivers (45%): Geography at 35% and Language at 10%.
- Drivers of Need (55%): Aboriginal at 20%, ON-Marg at 25%, and Preventable Mortality Rate at 10%.

The indicators are combined to create a unique Equity Adjustment Factor (EAF) for each public health unit. Each public health unit's population is then multiplied by its calculated EAF to arrive at its equity-adjusted population.

To determine the proportional share for each public health unit, its equity-adjusted population is divided by the sum of the equity-adjusted population for all public health units.

The Funding Review Working Group is recommending that the most recent Statistics Canada Population Estimates be used for the purposes of the funding model. It is also recommended that population statistics be updated annually in order to acknowledge the high growth experienced in certain public health unit regions.

The Funding Review Working Group recognizes that the implementation method to be chosen for the funding model is a government policy decision and will be dependent on available funding. To guide the

Ministry in its decisions on implementation, the Funding Review Working Group is proposing the following principles for the Ministry's consideration:

- The timing to reach equity/model-based share must be balanced with maintaining system stability but should not further exacerbate current funding disparities.
- The Ministry should use incremental funding to the greatest extent possible in the application of the new funding model in order to minimize the disruption to existing service provision.
- Public health units should be provided with sufficient notice regarding the implementation of the funding model for planning purposes. A transition period (e.g., at least 3 years) is necessary to implement changes to funding. The Ministry should work with boards of health and public health units to mitigate the impact on service provision during the transition period.
- The impact of funding changes should be monitored by the Ministry to ensure that service provision is not being unduly impacted.
- The impact of funding changes should be taken into consideration in the setting of targets for Public Health Accountability Agreement indicators.
- The model is not intended to affect the municipal cost-share formula (75% provincial/25% municipal) although there may be impacts on municipal funding contributions resulting from the implementation of the model.
- The impact of funding changes to the municipal cost-share formula (i.e., decreases or increases in provincial funding affecting municipal contribution levels) should be taken into consideration when determining an implementation method.
- The most current data should be used for the public health funding model.

The funding model was developed by the Funding Review Working Group as an Ontario model balancing the needs of all 36 public health units. However, the funding model recommended in this report is sufficiently flexible to allow the Ministry to develop implementation strategies that reflect other factors that contribute to the unique funding needs of each public health unit in Ontario.

Developing a funding model for public health services proved to be an exercise in uncharted waters with members having to rely on their professional judgment and experience in the field of public health. It was exciting and interesting work aimed at supporting the strategic vision of strengthening public health in Ontario in the coming years.

1.0 Public Health Funding in Ontario

1.1 Introduction

In Ontario, public health programs and services are delivered by 36 public health units which are established under the *Health Protection and Promotion Act* (HPPA) and aligned with municipal boundaries. Each public health unit is governed by a board of health, whose duty it is to provide or ensure the provision of public health programs and services as required by the HPPA, Ontario Public Health Standards (OPHS), and Ontario Public Health Organizational Standards (Organizational Standards). Part of this responsibility includes the establishment of the operating budget for the public health unit.

Under section 72 of the HPPA, obligated municipalities (single and upper-tier) are required to pay the expenses of boards of health and medical officers of health. The legislative authority for provincial funding to public health units can be found in section 76 of the HPPA, which specifically states that the Minister may make grants for the purposes of the HPPA on such conditions as he or she considers appropriate. This funding is discretionary.

The Ministry currently provides ongoing funding to public health units for the provision of mandatory programs in both organized and unorganized (without municipal organization) areas. Mandatory programs refer to the public health programs and services that public health units must provide to their local communities in accordance with the HPPA, OPHS, and Organizational Standards. Mandatory programs are currently funded at 75% of the Ministry approved allocation in organized areas and 100% in unorganized areas.

When funds are available, the Ministry approves an annual increase over the prior year's base budget for mandatory programs. Over the past 10 years, the increase has ranged between 1.5% to 9.5% for mandatory programs in organized areas and 2% to 15% for mandatory programs in unorganized areas. Over and above the funding for mandatory programs, the Ministry also provides funding to public health units for a number of related programs and initiatives.

Ministry funding to public health units for mandatory and related programs is typically based on a calendar year. Funding decisions are made upon Ministry review of budget submissions from public health units and Minister's approval. If a public health unit's total approved budget exceeds the Ministry's approved funding, then obligated municipalities are solely responsible for those excess costs (as per section 72 of the HPPA).

Funding for mandatory programs is currently governed by the Public Health Accountability Agreement ("Accountability Agreement"), which sets out the obligations of the Ministry and public health units. The Accountability Agreement incorporates financial and performance indicators, and continuous quality improvement tools. Indicators are program-based and focus on board of health outcomes and performance based on identified targets. Targets are negotiated between individual public health units and the Ministry. Performance expectations and financial data are refreshed annually and additional measures may be incorporated in agreements to address issues specific to certain public health units.

1.2 Historical Funding for Mandatory Programs

Over the course of the last century, public health in Ontario has progressed from a very large number of small municipal health departments to the current number of thirty-six (36) public health units. As amalgamations occurred, largely with the encouragement of the Province, existing budgets, which were based upon the ability and willingness of municipalities to pay, were combined. Over time, provincial priorities for program expansion were implemented, sometimes with 100% provincial funding. In the late 1980s, after the introduction of mandatory programs, public health units could apply for additional funding in order to meet the requirements; however, this was at the discretion of boards of health.

Across-the-board increases in provincial funding have served to perpetuate historical anomalies in funding. In addition, the need to secure approval from both municipal and provincial sources has hampered efforts of some public health units to catch up. If a board of health budgets for less than the increase offered, then the provincial funding is reduced accordingly (i.e. the budget is always the lesser of what the province is able to fund or the board of health is prepared to request). Should the board of health wish to recoup funding that had been available in earlier years in a future funding year, the matching provincial funding may not be available.

Perhaps the most important factor affecting per capita funding is differential growth. The population of some public health units has grown at a rate many times faster than others. Over time, across-the-board increases have resulted in large disparities in funding on a per capita basis. Provincial across-the-board allocations for new related initiatives (e.g., Chief Nursing Officer Initiative, Public Health Nurses Initiative, etc) continue to occur.

For the period up to 1997, the Ministry provided grants at 75% of the approved public health unit budgets with the exception of the municipalities in Metropolitan Toronto (Toronto, East York, North York, York, Scarborough and Etobicoke), which received grants at 40% of their approved budgets. Up to 1995, provincial funding was provided at the cost-shared amount based upon the funding available from the province.

In 1996, public health units and the Ministry were facing cuts to provincial transfer payments which necessitated a review of the current funding patterns. At that time, there was agreement between the Ministry and external stakeholders that the impending cuts should not be applied equally (i.e. across-the-board percentage reduction) to all public health units. A stakeholder committee, the Equitable Funding for Public Health Working Group, was established to review factors to rationalize public health funding and propose acceptable modifiers that could be included in the funding model (such as indicators of health needs and service costs). The working group recommended four (4) indicators for use in the model: standardized potential years of life lost ratio, incidence of low income, home language not English, and geographic dispersion. An EAF, which summarized each public health unit's relative position in the provincial distribution, was calculated as a product of the modifiers. There was no attempt to assign relative weights to the modifiers.

The recommended funding model was implemented by the Ministry in 1996 and 1997 and resulted in a reduction of cost-shared mandatory programs totaling $8.3 million in 1996 and $3.7 million in 1997.

Funding reductions were made in such a way that there was a 2.6-fold difference in per capita funding between the public health unit with the highest per capita funding and the public health unit with the lowest per capita funding.

In 1998, a review of public health funding was part of the Local Services Realignment (LSR) process that involved numerous changes in provincial/municipal transfers. The transfers between the Province and municipalities were very broad in scope and included airports, roads, bridges, gross receipt taxes, social services, education, public health, etc. For one year (1998), as a result of LSR, the Ministry provided no grants to public health units for mandatory programs in municipally incorporated areas.

Between 1999 and 2004 the Ministry provided 50% of board of health approved public health unit costs for the provision of mandatory programs. During this time, the Ministry placed no caps on public health unit budget requests, i.e. the Ministry funded 50% of what was requested by any public health unit.

In 2001, the Funding Allocation Formula Working Group, a stakeholder committee, was established to determine a methodology for allocating provincial grants to public health units for the delivery of mandatory programs. Despite changes made as a result of the 1996 funding review, there still existed a 3.0-fold difference in per capita funding between the highest and lowest funded public health units, which could not be explained or justified.

The Funding Allocation Formula Working Group recommended five (5) modifiers for inclusion in the funding model, including: low income, low education (less than grade 9), standardized potential years of life lost ratio, geographic dispersion, and home language (not English). The working group recommended that 5% of the total funding available be allocated for core funding (i.e. administration and overhead costs), two-thirds of the funding available after the core amount was removed be allocated on a per capita basis using permanent resident populations, and one-third of the funding available after the core amount was removed be allocated based on a needs-adjusted per capita allocation. The 2001 funding model developed by the working group was not implemented as consensus was not reached by the working group on many issues (e.g., the inclusion of modifiers such as the absence of general practitioners and transitory populations).

In the 2004 Ontario Budget (and committed to in *Operation Health Protection – An Action Plan to Prevent Threats to our Health and to Promote a Healthy Ontario*), the Ministry announced that it would increase its share of mandatory programs funding from 50% in 2004 to 75% by 2007 to strengthen the resource base of public health. Subsequently, the provincial share for mandatory programs was increased from 50% in 2004 to: 55% in 2005, 65% in 2006, and 75% in 2007.

In 2005, no caps were placed on public health unit budget requests by the Ministry (i.e. the Ministry funded 55% of what was requested by public health units). In 2005, provincial funding for public health units increased by 9.5% over the prior year's Ministry approved allocation.

Due to the provincial need for constraint, in both 2006 and 2007 the Ministry allocated 5% growth above the prior year's Ministry approved allocation to each public health unit, or less if requested, for

the provision of mandatory programs. In 2007, public health units started to report that obligated municipalities were contributing more than 25% of the mandatory programs funding.

In an effort to be more responsive to local needs, elements of the prior funding reviews were implemented in 2008 and 2009 through incremental funding. In both years, the 5% growth in mandatory programs was apportioned based on a 3% across-the-board increase to all public health units for common cost drivers, 1% based on population growth, and 1% based on low income populations. Stabilization funding was provided in the 2008 transition year to ensure that no public health unit received less than a 5% increase.

In 2010, as part of a government-wide commitment to reduce expenditures, the growth funding for mandatory programs was reduced. In 2010 and 2011, the Ministry allocated a 3% across-the-board increase to all public health units, or less if requested, over the prior year's Ministry approved allocation. In 2012 and 2013, the Ministry allocated a 2% across-the-board increase to all public health units, or less if requested.

The 2013 per capita funding for mandatory programs ranged from $29.83 to $83.97 – a 2.8 fold difference. In addition, approximately 50% of public health units are now reporting that obligated municipalities are contributing more than 25% of the mandatory programs funding.

Appendix 1 provides a graph of provincial funding to public health units for mandatory programs from 1995 to 2013.

Appendix 2 provides the 2013 per capita funding for public health units for mandatory programs.

1.3 Historical Funding for Unorganized Territories

Until the late 1970s, the Northern Ontario Public Health Services (provincially funded at 100%) provided public health services to individuals in unorganized northern territories. In 1983, section 6 of Ontario Regulation 382/84 under the HPPA made provision for the Minister to provide grants (100% of board of health approved costs) to a public health unit that has an unorganized territory within its area. About that time, the Ministry began transferring responsibility for these services to public health units (District of Algoma, Muskoka-Parry Sound, North Bay District, Northwestern, Porcupine, Renfrew County & District, Sudbury & District, Thunder Bay, and Timiskaming).

Initial base budgets for unorganized territories were negotiated public health unit by public health unit and the methodology for calculating the grant varied. This ad hoc approach to calculating grants resulted in wide variances in funding among public health units delivering services to unorganized territories. Once a base amount was established for each public health unit, funding was increased by inflationary adjustments until 1991 when the provincial base funding totalled $2.9 million. In 1991/92, funding for unorganized territories was essentially flat-lined for most public health units.

In 2001, a stakeholder committee, the Funding Allocation Formula Working Group, was established to determine a methodology for allocating provincial grants to public health units for the delivery of

mandatory programs in both organized and unorganized areas. Several broad based funding models for unorganized territories were proposed, including:

1. Increase unorganized territories funding levels by the same percentage amount that organized area budgets had increased from 1991 to 2001.
2. Set the per capita grant for unorganized territories equal to the per-capita rate for organized areas.
3. Set the unorganized territories grant as per the per-capita rate of the organized area plus 20%.
4. Poll representatives from each of the public health units and ask them what they required to adequately provide services to their unorganized territory.

While options were developed and recommendations were proposed, none were implemented.

By 2003, total funding had increased to $3.3 million, a cumulative increase of 11% or approximately 1% per year. In 2004, the Ministry recognized the need for additional funding for unorganized territories and from 2004 to 2007 provided an annual increase of 5% for these services.

While funding for unorganized territories increased by 5% annually between 2004 and 2007, some northern public health units continued to maintain that the amount of provincial funding provided for unorganized territories did not cover the true cost of the programs delivered in those territories. In an effort to address this concern, in 2008, the eight (8) public health units receiving funding for unorganized territories were asked to identify as part of their annual budget submission actual staffing costs and other expenditures relating to providing services in unorganized territories. In total, these 8 public health units requested a total of $7.9 million, an increase of 99% over the 2007 Ministry approved allocation.

It was difficult for the Ministry to make comparisons or conduct a detailed analysis as data and methodologies used to calculate the amount needed for service provision in unorganized territories varied with each public health unit. As a funding approach could not be developed from the data, the Ministry committed to conducting a review of the funding provided for unorganized territories.

In the interim, a 15% across-the-board increase was allocated in 2008 in an effort to recognize the increased costs associated with the delivery of services in remote areas. In each of 2009, 2010, and 2011, funding for unorganized territories increased by 5%, exceeding the increase provided for mandatory programs in 2010 and 2011. In 2012 and 2013, funding for unorganized territories increased by 2% consistent with the growth approved for mandatory programs.

Appendix 3 provides a table of provincial funding to public health units for unorganized territories from 1991 to 2013.

2.0 Public Health Funding Review

2.1 Need For a Funding Review

A number of recommendations, reports and other factors have informed the Ministry's decision to initiate a review of the way provincial funding is provided to public health units.

Over the past few years, the Ministry has faced increased scrutiny and accountability requirements in the provision of transfer payments to health sector organizations such as public health units. Most recently the government introduced Ontario's Action Plan for Health Care, which includes a vision to make Ontario the healthiest place in North America to grow up and grow old. The Ministry aims to accomplish this by getting better value for its health care dollars.

Health System Funding Reform is moving Ontario's health care system away from a global funding system towards what is known as Patient-Based Funding. Under this reform, health care organizations are compensated based on how many patients they look after, the services they deliver, the evidence-based quality of those services, and the specific needs of the broader population they serve. Several other Ministries have used funding formulas for some time (e.g., Education), or have recently introduced them (e.g., child care, children's mental health). Patient-based funding is inappropriate for a public health system focused primarily on population health. However, there is an opportunity to align provincial public health funding with the principles that underline this reform, particularly the alignment of funding to reflect the needs of the population of each public health unit.

Public health is one of the few areas where the distribution of provincial funding is not governed by a formula. As a result, the Ministry cannot explain or justify the variation in per capita funding levels between public health units. The Ministry also often receives letters from boards of health, public health units, and other stakeholders (e.g., municipalities) requesting changes to the funding methodology and increased allocations for mandatory programs.

In January 2005, the Ministry announced the creation of the Local Public Health Capacity Review Committee to oversee a review of local public health capacity and to provide guidance and advice to the Ontario Government with respect to the optimal configuration of the delivery of public health programs and services by local public health units. The Final Report of the Capacity Review Committee was transmitted to the Ministry in May 2006 and contained several recommendations for substantial transformation of the current system, including funding. The Capacity Review Committee recommended that the Ministry establish a collaborative process with municipalities, boards of health, public health professionals and academic partners to continue to refine the budgetary allocation mechanism, to achieve greater equity in public health system funding over time.

In addition, two (2) Provincial Auditor Reports (1997 and 2003) recommended that public health funding be allocated more equitably and that the Ministry should use indicators reflecting service costs and relative health needs of communities. In 1997, the Office of the Provincial Auditor of Ontario noted that "in many cases the variations (in funding) appear to be based solely on historical patterns" and recommended that, "to ensure that funding for all mandatory public health programs is allocated

equitably, the Ministry should expand the use of indicators of service costs and of the relative health needs of communities." In 2003, the Office of the Provincial Auditor of Ontario expanded on its 1997 Report stating that "to help meet its objective for Public Health Activity, the Ministry should ensure that individuals with similar needs and risks receive a similar level of service regardless of where in the province they live."

Two previous funding reviews have been conducted since the mid-nineties. These reviews met with limited success in achieving a more equitable approach to public health funding.

The finite resources available from provincial sources should be allocated among the public health units so as to produce the maximum benefit for Ontarians. The most practical approximation of this would be an allocation based upon relative need so that all residents of Ontario with similar needs receive the same level of services. Lastly, there is an imperative to be able to explain to the Legislature and to the public the basis upon which public funds are distributed.

2.2 Approach and Objectives

In 2009/10, the Ministry initiated a process to review provincial funding provided to public health units in an effort to ensure a fair, transparent, and consistent method of funding. The funding review is examining the funding for the delivery of **mandatory programs** in organized and unorganized areas. Funding for other related programs and services, such as the Healthy Smiles Ontario Program, Infectious Diseases Control Initiative, and other nursing initiatives were not included as part of the review as they were already based on explicit funding criteria and/or formulas.

The objectives of the review are to develop a needs-based approach to public health funding, improve funding responsiveness to service needs through the inclusion of equity and population adjustment factors, and reduce funding inequities among public health units over time. The review is not intended to affect the current provincial/municipal cost-sharing formula of 75%/25%, and concerns provincial funding only.

In April 2010, the Funding Review Working Group was struck with a mandate to investigate the current status of public health funding, provide advice to the Ministry on a future public health funding model, and advise the Ministry on implementation principles. Specifically, the Funding Review Working Group was responsible for:

- Reviewing and determining the factors to be used in developing the funding model.
- Providing advice and recommending a model for the allocation of provincial transfer payments to public health units for the provision of mandatory programs in both organized and unorganized territories.
- Providing input into the method of conducting field consultation and determining which model(s) to present for consultation.
- Reviewing the comments of stakeholders following the consultation process.

- Reviewing the draft report.
- Providing advice with respect to the evaluation process of any implemented funding model.

Membership consisted of representatives from boards of health, public health unit staff (medical officers of health, associate medical officers of health, executive directors, business administrators and program staff), alPHa, and AMO.

2.3 Funding Assumptions Underlying the Review

The public health funding review took place during a fiscally challenging time. When the Funding Review Working Group was established, its Terms of Reference recognized that no new significant funding would be available to implement a new funding model, and that any funding adjustments would be implemented on an incremental basis, using any future increases to the overall provincial funding envelope.

Since this time, overall growth for mandatory programs was reduced from 5% in 2009 to 2% in 2013. Accordingly, the Funding Review Working Group was informed by the Ministry that application of a new funding model using only incremental funding may no longer be possible given the current fiscal environment. Regardless, the Funding Review Working Group believed it was important to finalize the work of the funding review in an effort to address funding inequities and to align public health funding with the Health System Funding Reform.

Appendix 4 provides the original Terms of Reference for the Funding Review Working Group. It is important to note that the Terms of Reference were not updated throughout the process of developing the model; however, revisions to the timelines and changes to membership were discussed with the Funding Review Working Group throughout the process.

3.0 Public Health Funding Model

3.1 Development of the Model

A great deal of research, analysis, and thoughtful discussion took place over almost three (3) years to develop the funding model recommended in this report.

Since April 2010, the Funding Review Working Group has held 14 meetings, the majority of which took place in person. Members agreed that decisions would be made by consensus with any disagreements noted in the minutes and Final Report. Members were advised by the Ministry that deliberations and discussions of the Funding Review Working Group were confidential - confidentiality agreements were signed by each of the members. For this reason, no substitutes were allowed in situations where members were unavailable to attend a meeting. It was noted that the timelines at the outset of the working group were aggressive and might change as the process continued (this was ultimately the case).

The Funding Review Working Group reviewed and analyzed historical and current funding levels, sources of funding, current expenses, and cost pressures of public health units. This review found that during the past 15 years, each board of health made decisions and choices based upon its local environment; these choices affected public health unit budgets and public health services delivered in the community, thereby contributing to the disparities in funding. There were many variables affecting local decisions including: increased service demands due to population growth and/or health status; a shortage of health care professionals (e.g., physicians, nurses, etc.); municipal government support and priorities; public health unit capacity; and/or other socio-economic and environmental factors.

To assist with the public health allocation model development, the Funding Review Working Group reviewed the findings of the prior funding reviews conducted since the mid-nineties. The 1996 and 2001 funding reviews looked at a two (2) and three (3) component funding formula respectively. Base funding to support public health unit infrastructure/administration was included in the 2001 review; both reviews included an adjustment for service cost variables (e.g., geographic dispersion to reflect costs of travel/multiple offices, home language to reflect costs of serving multicultural populations) and equity factors such as socio-economic determinants of health (e.g., education, low income), population health status (e.g., premature deaths), and health behaviors (e.g., smoking, physical inactivity, obesity, heavy drinking).

A review of academic literature and an inter-jurisdictional survey of public health allocation methods and methodologies were also conducted. In 2009, a comprehensive literature review revealed very little on funding approaches related specifically to public health. Instead, research findings related primarily to general allocation methods and methodologies. The only literature deemed relevant to public health funding model development was a paper published by the Department of Health, United Kingdom, Resource Allocation: Weighted Capitation Formula. Three (3) provinces (Alberta, Manitoba, and Nova Scotia) provided information about their public health funding methodologies and processes.

Key findings were the presence of largely regionalized approaches, in which the government allocated funds to local authorities. Only a few allocation models dealt exclusively with public health funding. In addition, several jurisdictions made adjustments for social equity factors (e.g., socio-economic status).

Two sub-committees, accountable to the Funding Review Working Group, were established over the course of the review; an Unorganized Territories Sub-Committee and an Infrastructure Sub-Committee.

The Unorganized Territories Sub-Committee was convened to make recommendations to the Funding Review Working Group regarding the potential adaptation of the funding model for the funding of unorganized areas. This sub-committee was composed of representatives from the eight (8) public health units that deliver public health programs and services for unorganized territories.

The Infrastructure Sub-Committee was convened to make recommendations to the Funding Review Working Group respecting public health infrastructure costs and their potential inclusion in the funding model. This sub-committee examined other funding models; reviewed and analyzed infrastructure costs of public health units, including variable and non-variable costs; and, discussed options related to incorporating infrastructure costs as a separate component.

Appendix 5 provides the membership of both sub-committees.

Field input sessions were led by members of the Funding Review Working Group on January 14, 2013 with public health unit Medical Officers of Health and Chief Executive Officers, and again on January 16, 2013 with public health unit business administrators. The purpose of the field input sessions was to seek input on the proposed elements of the public health funding model. The sessions were well attended and a total of 28 public health units and the Council of Ontario Medical Officers of Health provided feedback during the sessions, in writing, or both.

3.2 Characteristics and Criteria

After reviewing the objectives of the current and prior funding reviews, the Funding Review Working Group agreed that the funding model must be based on the following characteristics:

- **Equitable**: Funding model must increase equity in funding among public health units over time.
- **Transparent**: Model must be simple to administer and communicate to the field.
- **Stable**: Model must allow for multi-year planning.
- **Needs-Based**: Model must reflect needs based on provider and community characteristics.
- **Evidence-Based**: Model must be based on measurable demand for and the cost of providing public health services.

Based on these characteristics, the Funding Review Working Group determined that the funding model indicators must also meet certain criteria to be included in the model. The indicators should be:

- Resistant to manipulation (to avoid “gaming” by interested parties);

- Reliable (reproducible over time);
- Largely independent of each other to avoid double counting unless there is a specific rationale to do so;
- Based on available data with proxy validity when direct measurement of a variable is not possible;
- Easily explained; and,
- Unlikely to change over time. (i.e., consistently measured with any change reflective of changes in measured variable only).

3.3 Structure of the Model

The Funding Review Working Group considered the means by which changes to the funding of public health units might be affected. One option, for example, used by Nova Scotia, would be to develop a formula which would be applied to the amount of additional funding only, to guide its distribution. Although this may work well when there is a specific amount of additional funding immediately available, it would be difficult to maintain this system over time. It also does little to address the equity of base funding, and thus lacks transparency. The Funding Review Working Group rejected this approach in favour of one which applies a formula or "model" (based upon relative need) for each public health unit within the mandatory programs provincial funding envelope/budget. The result is expressed as a "share" (percentage) of the funding for each public health unit.

The intent is for funding to be adjusted over time (see section 4.0 Implementation) so as to move all public health units towards their model share. The model share may be easily converted to the amount of the public health unit grant by multiplying the proportion of the share by the total provincial funding for mandatory programs.

3.4 Components of the Model

The Funding Review Working Group is recommending an equity-adjusted population model, meaning that funding is based on population size adjusted for equity factors.

The Funding Review Working Group investigated three (3) possible components to be included in the funding model as described below: population, infrastructure/administration, and equity.

3.4.1 Population

The Funding Review Working Group considered the inclusion of population as a separate component in the funding model. A population component would allocate funding to each public health unit in direct proportion to its population size. Following much discussion, it was determined that population would not be included as a stand-alone component in the funding model.

The Working Group determined that the optimal approach is to use population as the basis for the model, but only after the population number has been modified by the application of "equity-adjustment factors" to produce an "equity-adjusted population".

3.4.2 Infrastructure/Administration

The Funding Review Working Group also extensively considered the inclusion of infrastructure/administration as a separate component in the funding model. Infrastructure/administration costs were defined as those costs associated with the organizational functions of each public health unit. Organizational infrastructure costs, while necessary, are generally not viewed as contributing directly to service delivery. It is not uncommon for funding models to include a separate infrastructure/administration component as the perception is that it provides some assurance of stability for the organization.

Funding Review Working Group members were unable to come to a consensus on the inclusion of infrastructure/administration costs as a separate component in the funding model. Accordingly, an Infrastructure Sub-Committee was established to develop recommendations to the Funding Review Working Group respecting infrastructure/administration costs.

The Infrastructure Sub-Committee met on December 8, 2010 to consider whether or not infrastructure/administration costs should be included as a separate component in the funding model and make recommendations to the Funding Review Working Group regarding the inclusion of infrastructure/administration in the funding model. The Sub-Committee examined other funding models, reviewed and analyzed infrastructure/administration costs of public health units, including variable and non-variable costs, reviewed the factors that affect infrastructure/administration costs, and discussed the reasons for incorporating infrastructure/administration costs as a separate component.

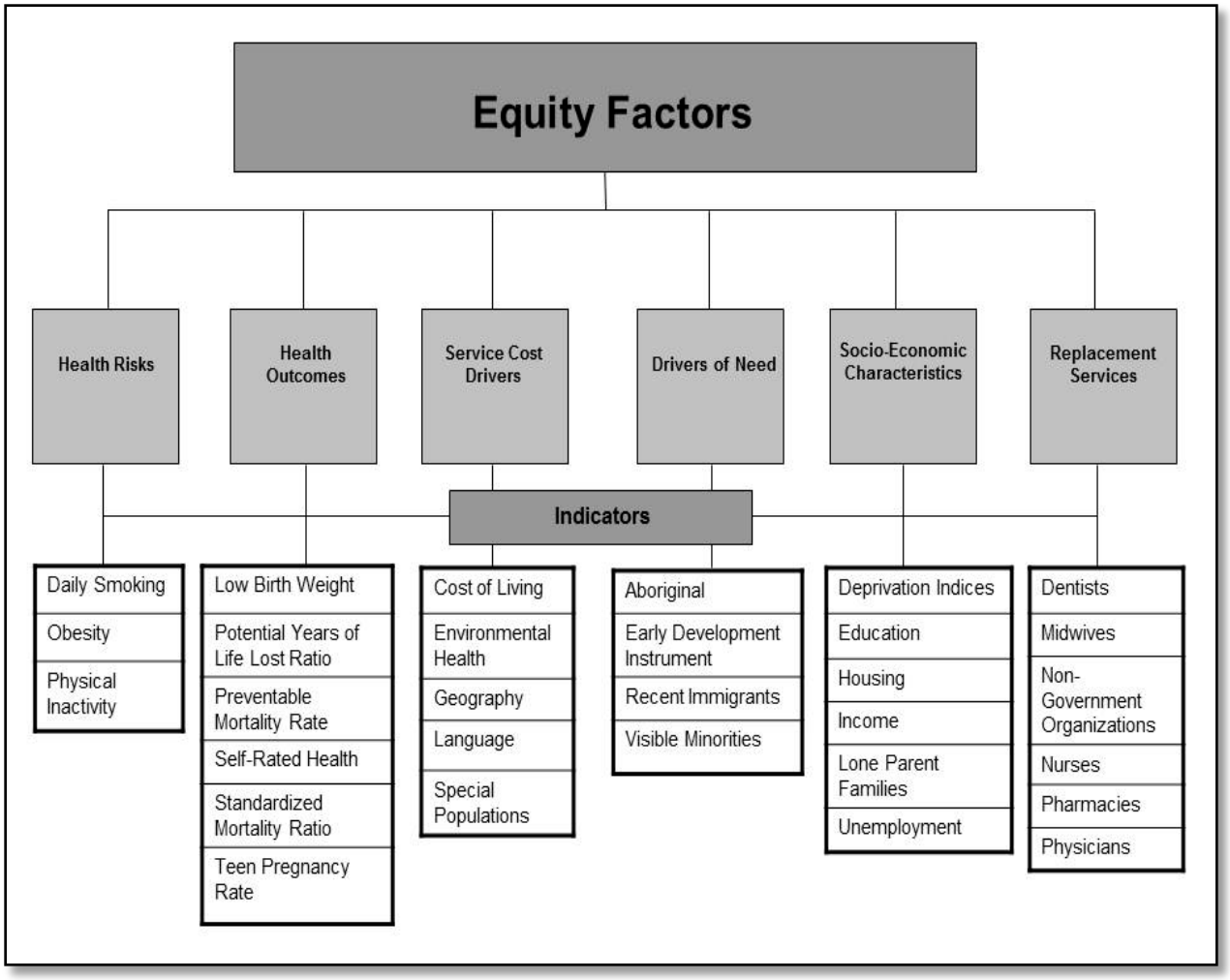
The review noted that, at a provincial level, the average per cent of funding spent by all public health units on infrastructure/administration costs between 2007 and 2009 was consistent at approximately 21%. When the information was viewed on a public health unit by public health unit basis, the percentage of total expenditures spent on infrastructure/administration costs had a significant but fairly consistent range in each of the three (3) years; 11.3% to 29.9% in 2007; 11.8% to 30.4% in 2008; and 11.7% to 33.4% in 2009. The proportion and the dollar per capita spent on infrastructure/administration costs generally tended to decrease as the population increased up to 1 million. The 23 public health units with smaller populations (less than 200,000) spent a higher percentage on infrastructure/administration costs than their larger counterparts.

Upon further examination, it was determined that the key factor affecting infrastructure/administration was geography which is included in the funding model as a service cost driver. Other costs, such as those associated with board of health governance costs, were found to be relatively consistent across all public health units. Based on this, it was determined that infrastructure/administration would not be included as a separate model component.

3.5 Equity Factors Considered

The Funding Review Working Group considered six (6) groups of equity factors and associated indicators as shown below.

Equity Factors Considered



The Funding Review Working Group reviewed each of the above potential indicators against the characteristics and criteria that had been established for the public health funding model (see Section 3.2). In many cases, data was not available at the public health unit level (e.g., Cost of Living) and therefore could not be included or a proxy indicator was selected in its place.

Appendix 6 provides a list of indicators considered but not included, their descriptions, and the rationale for non-inclusion.

3.6 Recommended Model

The Funding Review Working Group determined that an "upstream" approach focusing on socio-economic determinants of health, rather than the "downstream" health outcomes (e.g., low birth weight), would be used in the development of the funding model. Disease incidence and prevalence indicators, which are available, are limited in range and quality; data on risk factors rely very heavily on self-reported population surveys. The problem of mortality data, which are available and of reasonable quality, lies in their relevance. The reduction of mortality is not the best measure of the impact of public

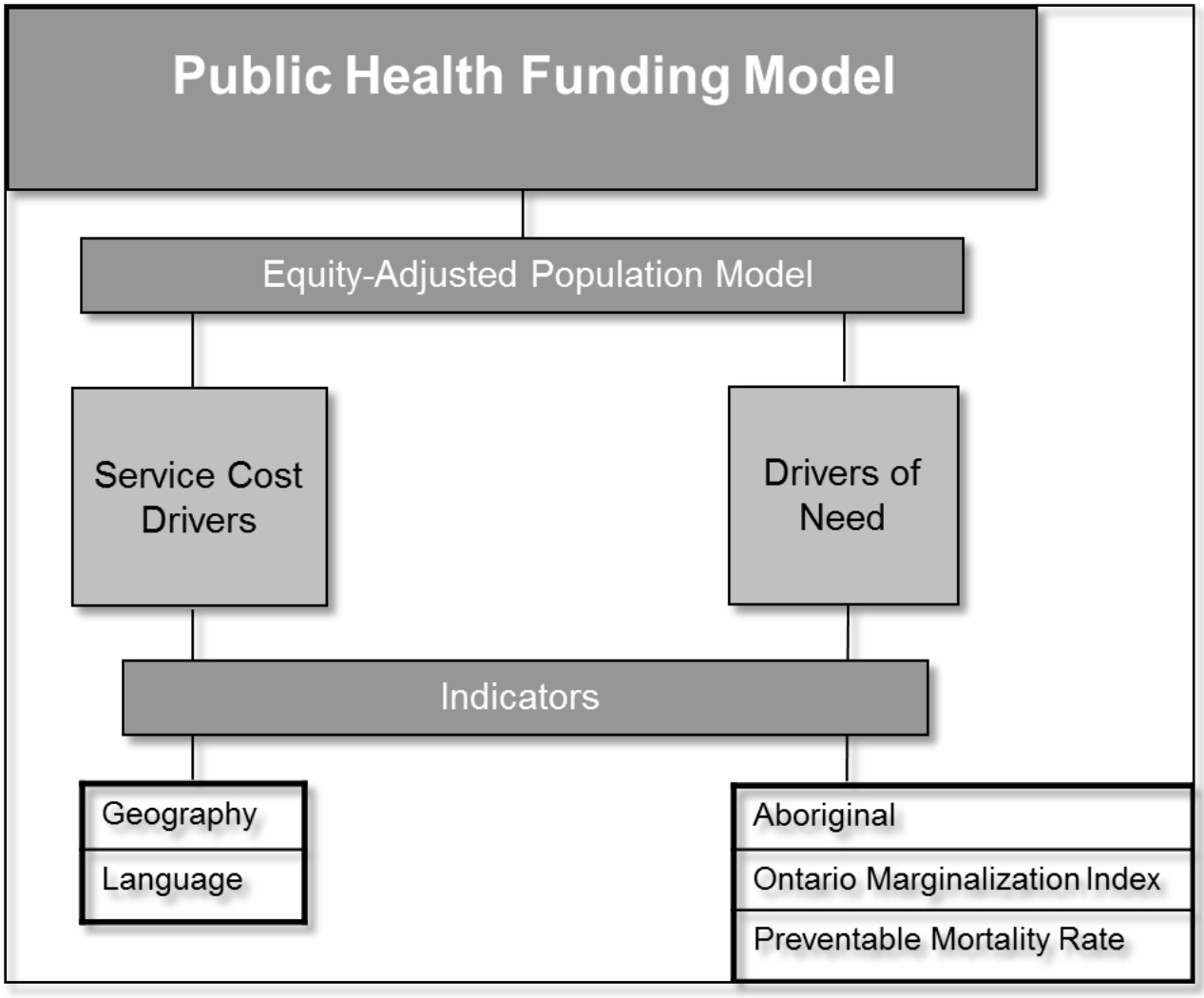
health programs. Most of the funding for public health is spent on programs (e.g., family health, environmental health, oral health, communicable disease control) which are only weakly related to mortality. Nevertheless, in order to provide a balanced model, a health status indicator (preventable mortality rate) was incorporated in the model.

The resulting model has two (2) groups of equity factors (and associated indicators) as follows:

1. **Service Cost Drivers** that reflect the variable cost of delivering public health services. **Geography** and **Language** are recommended to reflect service cost drivers.

2. **Drivers of Need** that address demand and reflect the utilization of public health services. **Aboriginal, ON-Marg**, and P**reventable Mortality Rate** are recommended to reflect drivers of need. It is important to note that ON-Marg contains four (4) dimensions (i.e. Residential Instability, Material Deprivation, Dependency, and Ethnic Concentration), which are used in the model to reflect the socio-economic determinants of health.

Public Health Funding Model



It is also recommended that the funding model be adopted for unorganized territories. The funding model components and indicators address the significant factors affecting demand/utilization and service delivery in the north and key issues identified for unorganized territories funding.

3.6.1 Service Cost Drivers: Geography

A measure of geography is recommended for inclusion in the funding model as geographic characteristics affect costs related to delivering public health programs and services (e.g., transportation costs, travel time).

Consistent with the 1996 and 2001 funding models/reviews, the **Adapted Concentric Circle Model** was chosen to represent these costs. This model takes the population in a defined area (census subdivision (CSD) or dissemination area (DA)) and weights it according to how far it is from the largest office of the public health unit (the site with the greatest number of staff). This definition was chosen as it provided

the best data available to represent where the most staff would be travelling from to deliver programs and services.

Appendix 7 provides the largest office for each public health unit.

A high value would indicate that a public health unit has a substantial proportion of its population living far away from the largest public health unit office. This would represent additional cost pressures associated with providing services due to travel time and transportation costs.

The distance between a public health unit's largest office and the population served is determined using census boundaries and Geographic Information System (GIS) software. It is calculated as the straight-line distance between the largest public health unit office and the centroid of the CSD or DA. Then the population in the CSD or DA is weighted according to how far it is from the head office according to following scheme:

CSD or DA distance (KM) from largest public health unit office	Weight
0-29	1
30-59	1.2
60-89	1.4
…	…
360-389	3.4
>=390	3.6

The weighted CSD or DA population is calculated as the distance weight multiplied by the population of the CSD or DA. The weighted population of the public health unit is the sum of the weighted populations of all its CSDs or DAs. The geography score of each public health unit is calculated by dividing its weighted population by its population.

The Funding Review Working Group is recommending that the Ministry use CSD level data when calculating the Adapted Concentric Circle Model after reviewing a comparison analysis of CSD level (larger geographic areas) and DA level (smaller geographic areas) data. The result does not differ substantially between the two (2) levels of data. However, the DA level data is only available based on census population counts whereas the CSD population can be based on either census population counts or population estimates. The population estimates take into account net under-coverage from the post-censal coverage study and therefore provide a more accurate measure of population counts. **Appendix 8** provides a comparison of CSD to DA scores.

Adapted Concentric Circle Model (Geography) scores ranged from a low of 1.00 to a high of 2.01 across public health units with an average (mean) score of 1.12. **Appendix 9** provides a table of Adapted Concentric Circle Model (Geography) scores by public health unit.

Additional modifications to the methodology were considered but not adopted, as they were either unfeasible or did not add to the validity of the measure. For example, an adaptation for road density, to account for the fact that some areas are difficult to travel to, was considered. However, updated road

density data is not available. Road density is generally highly correlated with population density and thus may not adequately measure the remoteness of the population. Other Geography indicators considered but not selected included: Population per Km Road, Rural Index of Ontario, Rural and Small Community Measure, and Population Density. See **Appendix 6** for a list of indicators considered but not included, their descriptions, and the rationales for non-inclusion.

3.6.2 Service Cost Drivers: Language

Language is being recommended for inclusion in the model as language spoken can impact the costs of service delivery since certain populations may require linguistically and/or culturally adapted services. A measure of the proportion of the population whose Home Language is not English was chosen to represent these costs. This indicator was also recommended in the 1996 and 2001 funding models/reviews. Although this service cost driver is named "Language", it is recognized that there are also costs related to cultural adaptation of materials and programs.

The proportion of population whose Home Language was not English ranged from a low of 1.4% to a high of 38.9% across public health units, with an average (mean) proportion of 10.6%. **Appendix 10** provides a table of Home Language not English values for each public health unit.

Several other ways of measuring language were reviewed, including measures of the Francophone population and the population that speaks neither English nor French. In addition, the impact of the number of different languages was considered. The Funding Review Working Group decided that the population whose Home Language is not English was the most appropriate way to represent the costs of translation and culturally specific programming at public health units.

It is recognized that there are unique obligations regarding the provision of services in French; however, the indicator is intended to reflect the costs for translation and cultural adaptation of materials and programs, which are expected to be similar regardless of language.

3.6.3 Drivers of Need: Aboriginal

A measure of Aboriginal status is being recommended for inclusion in the model to reflect the established disparity in health status between Aboriginal and non-Aboriginal populations. The Aboriginal population refers to those persons who report: identifying with at least one Aboriginal group, that is, North American Indian, Métis or Inuit, and/or being a Treaty Indian or a Registered Indian, as defined by the *Indian Act* of Canada, and/or they were members of an Indian band or First Nation (Statistics Canada, 2006 Census of Population). The known under reporting of Aboriginal populations in the Census supports the importance of using population estimates that adjust for this, for example, in the geography indicator and for the overall funding model. In addition, using the same source of data for all public health units should capture the relative impact of need in public health units related to Aboriginal population.

Aboriginal people experience the lowest health status of any identifiable population in Ontario. Indicators of lower health status include: shorter life expectancy; higher infant mortality; elevated rates of obesity; greater prevalence of chronic diseases (including diabetes and mental health and addictions); higher hospitalization rates, longer length of hospital stays, fewer visits to specialists, and, poor

outcomes regarding socio-economic determinants of health (e.g., greater burden of poverty, unemployment, and lower educational attainment). The average income for First Nations people in Ontario is $24,000, compared to $38,000 for non-aboriginal people (Statistics Canada, 2006 Census).

In the 2006 Canada Census, 242,495 people self-identified as Aboriginal persons in Ontario (2% of the province's total population). The majority of Ontario's Aboriginal population (estimates range from 62% to 78%) live in urban/rural areas; 72% of Métis and 57% of First Nations people are urban, primarily city dwellers. Aboriginal urban dwellers have higher labour force participation, employment rates, higher education levels and higher incomes than those Aboriginal people living on-reserve, but all rates are significantly lower than the urban non-Aboriginal population. Approximately 1 in 10 Aboriginal people (26,575) in Ontario live in the Toronto Census Metropolitan Area (CMA), representing 0.5% of the total population of the CMA. In Northern Ontario, Aboriginal people comprise about 10% of the total population.

The proportion of Aboriginal population per public health unit ranges from a low of 0.4% to a high of 32.0% with an average (mean) proportion of 4.1%. **Appendix 11** provides a table of the Aboriginal population percentage by public health unit.

Health Canada's First Nations and Inuit Health Branch (FNIHB) has a role with respect to on-reserve public health given the history and mandate of the Branch, funding and governance relationships with First Nations, and the extent of programming and expertise currently deployed for on-reserve First Nations peoples. Notwithstanding FNIHB's responsibility, the province has primary responsibility for the provision of health care services to all residents of Ontario, including First Nations people living on-and-off-reserve. Public health units are defined based on their geographic boundaries; therefore, every part of Ontario is covered by a public health unit and subject to the HPPA, including First Nation communities and reserves. The Ministry's position is that provincial funding for public health units for mandatory and related programs is for the entire population within the public health units - with the actual program and service delivery being determined between the public health units and First Nations communities. Under section 50 of the HPPA, a board of health and a band council may enter into an agreement under which: the board agrees to provide health programs and services to members of the band; the band council agrees to accept the responsibilities of a municipality within the public health unit; and, the band council may appoint a member of the band to sit on the board of health.

The Aboriginal indicator has a moderate correlation with some of the other indicators. This means that needs related to some of the issues faced by this population are addressed by other indicators, not this one. However, as these other indicators alone do not fully reflect the needs of the Aboriginal population, the Aboriginal indicator is also necessary to recognize this residual disadvantage.

3.6.4 Drivers of Need: Ontario Marginalization Index

In line with the Funding Review Working Group's decision to use an upstream approach for the development of the funding model, several deprivation and marginalization indices were considered for inclusion in the model. Relative deprivation is a comparative measure, referring to a state of disadvantage experienced by communities relative to the surrounding population. These indices are

typically divided into two (2) primary constructs – social position (e.g., marital status, family structure, number of individuals living alone, etc.) and material access (e.g., income, education, employment, etc.). **Appendix 12** provides a comparison of deprivation/marginalization indices considered.

The Funding Review Working Group was able to locate only one example of the use of deprivation indices for resource allocation purposes (Department of Health, United Kingdom, Resource Allocation: Weighted Capitation Formula). Deprivation indices have primarily been used to assess disparities between communities/populations. However, the Funding Review Working Group felt that the use of a deprivation index was an important component of an upstream-based funding model to represent costs associated with the prevention services provided by public health units to improve future health outcomes of public health unit populations.

ON-Marg was chosen by the Funding Review Working Group as it demonstrates the difference in marginalization between areas and describes the inequalities in various health and social wellbeing measures. ON-Marg is a census- and geographically-based index that can be used for planning and needs assessment, resource allocation, monitoring of inequities, and research. ON-Marg is an Ontario-specific version of the Canadian Marginalization Index (CAN-Marg, www.canmarg.ca), which has been in use since 2006.

ON-Marg is multifaceted, allowing researchers and policy and program analysts to explore multiple dimensions of marginalization in urban and rural Ontario. The four (4) dimensions are: Residential Instability, Material Deprivation, Dependency, and Ethnic Concentration.

On-Marg Deprivation Dimensions
(Ontario Marginalization Index: User Guide Version 1.0)

	Dimensions			
	Residential Instability	**Material Deprivation**	**Dependency**	**Ethnic Concentration**
	- Proportion of the population living alone - Proportion of the population who are not youth (age 16+) - Average number of persons per dwelling - Proportion of dwellings that are apartment buildings - Proportion of the population who are single / divorced / widowed - Proportion of dwellings that are not owned - Proportion of the population who moved during the past 5 years	- Proportion of the population aged 20+ without a high-school diploma - Proportion of families who are lone parent families - Proportion of the population receiving government transfer payments - Proportion of the population aged 15+ who are unemployed - Proportion of the population considered low-income - Proportion of households living in dwellings that are in need of major repair	- Proportion of the population who are aged 65 and older - Dependency ratio (total population 15 to 64/total population 0-14 and 65+) - Proportion of the population not participating in labour force (aged 15+)	- Proportion of the population who are recent immigrants (arrived in the 5 years prior to census) - Proportion of the population who self-identify as a visible minority

The index was developed using a theoretical framework based on previous work on deprivation and marginalization. It was then empirically derived using principal components factor analysis on data from across Ontario including all geographic areas. It has been demonstrated to be stable across time periods and across different geographic areas (e.g., cities and rural areas). It has also been demonstrated to be associated with health outcomes including hypertension, depression, youth smoking, alcohol consumption, injuries, body mass index and infant birth weight.

3.6.4.1 ON-Marg Dimensions

Each of the four (4) ON-Marg dimensions can be used separately or combined into a composite index. Dimensions may be chosen by comparing correlations between each dimension and a given outcome, as a way of testing appropriateness for inclusion. Each dimension may not be related to the chosen outcome in the same direction. The Funding Review Working Group analyzed each dimension's relationship to two (2) Health Status indicators to support the choice of dimensions to be incorporated in the model. Two (2) measures of mortality, Preventable Mortality Rate and Potential Years of Life Lost Ratio, were used in the analysis. Although it is recognized that mortality rates are not an ideal measure of outcome for public health programs, the data for these indicators are available and of reasonable quality. These two (2) measures are also focused on the causes of death that are most likely to be influenced through public health activities.

There was a positive relationship with the **Residential Instability** dimension. Variables in the Residential Instability dimension include: proportion of the population living alone, proportion of the population who are not youth (age 16+), average number of persons per dwelling, proportion of dwellings that are apartment buildings, proportion of the population who are single/divorced/widowed, proportion of dwellings that are not owned, and proportion of the population who moved during the past 5 years.

There was a positive association with the **Material Deprivation** dimension. Variables in the Material Deprivation dimension include: proportion of the population age 20+ without a high-school diploma, proportion of families who are lone parent families, proportion of the population receiving government transfer payments, proportion of the population aged 15+ who are unemployed, proportion of the population considered low-income, and proportion of households living in dwellings that are in need of major repair.

There was a positive correlation with the **Dependency** dimension. Variables in the Dependency dimension include: proportion of the population who are aged 65 and older, dependency ratio (total population 15 to 64/total population 0-14 and 65+), and proportion of the population not participating in the labor force (aged 15+).

In contrast to the other dimensions, there was a negative correlation with the **Ethnic Concentration** dimension. Variables in the Ethnic Concentration dimension include: proportion of the population who are recent immigrants arrived in 5 years prior to census, and proportion of the population who self-identify as a visible minority.

The Ethnic Concentration dimension is likely correlated negatively with the mortality-based Health Status indicators used for the correlation analysis due to the 'healthy immigrant effect'. Mortality and health care utilization rates have been observed to be lower for recent immigrants as compared to Canadian-born comparison populations. However, the health advantages seen in the data diminish with time, with mortality rates among more established immigrants approaching those of the Canadian-born population. Furthermore, mortality alone is an inadequate measure of the health status and public health needs of immigrant populations, particularly with respect to a number of important conditions that may require substantial public health resources but are generally not reflected in mortality rates in Ontario. Recent immigrants have a manyfold excess of numerous infectious diseases (e.g., tuberculosis, enterics) which require intensive follow up by public health. Many immigrant groups have poor oral health and/or greatly increased risks of chronic conditions such as diabetes and cardiovascular disease. Refugee populations in particular tend to have multiple health problems and worse health status than other immigrant populations. **Appendix 13** provides a list of references regarding the healthy immigrant effect.

The Funding Review Working Group is recommending the inclusion of an indicator that represents the health needs of immigrants, and that each of the four (4) dimensions of ON-Marg be included in the model. The Funding Review Working Group is also recommending that each of the four (4) dimensions be used separately so that each can be individually weighted to reflect its impact as a public health driver of need.

3.6.4.2 ON-Marg Construction

Each ON-Marg dimension is provided in two (2) forms at the DA level (i.e., factor scores and quintiles). Factor scores are developed from the principal component analysis and represent a standardized scale with a mean of 0 and a standard deviation of 1. Quintiles are created by sorting the factor scores into five (5) groups, ranked from 1 (least marginalized) to 5 (most marginalized). Each group contains one-

fifth of the geographic units. For instance, an area with a value of 5 means it is in the most marginalized 20 percent of areas in the province.

In constructing scores of a public health unit for each ON-Marg dimension, quintile scales (1 – 5) of the dimensions were multiplied by the DA level population to obtain the weighted population. The weighted population of a public health unit was the sum of the weighted population of its all DA levels. The score of the public health unit for each dimension was calculated by dividing its weighted population by its population.

The score for Residential Instability ranged from a low of 1.80 to a high of 3.65 across public health units with an average (mean) score of 2.77. The score for Material Deprivation ranged from a low of 1.67 to a high of 3.91 across public health units with an average (mean) score of 2.89. The score for Dependency ranged from a low of 2.02 to a high of 4.31 across public health units with an average (mean) score of 3.23. The score for Ethnic Concentration ranged from a low of 1.54 to a high of 4.63 across public health units with an average (mean) score of 2.63. **Appendix 14** provides a table of scores for each ON-Marg dimension by public health unit.

3.6.5 Drivers of Need: Preventable Mortality Rate

The Funding Review Working Group considered many health status indicators for inclusion in the model. In keeping with the decision to develop a funding model using an upstream approach focusing on socio-economic determinants of health rather than on health outcomes, the majority of indicators recommended for the model are drivers of need. However, it was also recognized that certain aspects of need not fully captured by these other indicators could be incorporated by including a health status indicator. Health status indicators considered by the Funding Review Working Group include: Obesity, Daily Smoking, Physical Inactivity, Self-Rated Health, Low Birth Weight, Potential Years of Life Lost Ratio, Standardized Mortality Ratio, and Preventable Mortality Rate.

Most of the funding for public health is spent on programs only weakly related to mortality, and where better measures of outcome might include disease incidence and prevalence indicators, or data on risk factors. However, there are significant limitations in the range, quality and availability of risk factor and morbidity data. Therefore, although risk factor and morbidity rates most appropriately reflect issues related to the mandate of public health, the Funding Review Working Group does not recommend the inclusion of any health status indicators based on morbidity or risk factor data in the model.

The Funding Review Working Group conducted an analysis of the correlations of two (2) mortality-based health status indicators with the other indicators recommended for the model. This analysis was intended to determine if the need for prevention programs or services that could potentially reduce premature mortality were already represented by other indicators of the funding model. A high correlation would indicate that health status was already represented in the model. Conversely, a low correlation would indicate that health status was not already represented in the model by one of the other indicators.

The health status indicators analyzed were: (1) Preventable Mortality Rate (under age 75) which is defined as premature mortality per number of population from preventable causes that could be

potentially avoided through primary prevention efforts; and, (2) Potential Years of Life Lost Ratio (under age 75) which is defined as potential years of life lost per number of population from premature mortality due to a particular cause that could be potentially prevented. Both health status indicators measure the relative impact of preventable diseases and lethal forces on population.

There was a very high correlation between the two (2) health status indicators which indicated that they represented similar aspects of health. Both indicators were moderately positively correlated with Geography which indicated that the higher the proportion of a population living at a distance from the main public health unit office in their area the greater the likelihood that they would have a lower health status. The Preventable Mortality Rate was moderately positively correlated with the Aboriginal indicator while the Potential Years of Life Lost Ratio had a high positive correlation with the Aboriginal indicator. This reflects the fact that the Aboriginal population experiences more potential years of life lost and lower health status than the non-Aboriginal population.

The Preventable Mortality Rate and the Potential Years of Life Lost Ratio were the same indicators used in considering the four (4) dimensions of ON-Marg for inclusion in the model. Both were moderately positively correlated with the Deprivation dimension of ON-Marg which indicated that a higher degree of material deprivation is likely related to lower health status. Both were moderately positively correlated with the Dependency dimension, reflecting that higher dependency is a relative factor that contributes to lower health status. Finally, both were moderately negatively correlated with Ethnic Concentration which indicated that higher ethnically concentrated populations tend to have lower mortality rates.

Appendix 15 provides a table of funding model indicator to health status indicator correlations.

The Funding Review Working Group recommends the inclusion of the Preventable Mortality Rate in the model to reflect unrecognized aspects (i.e., not included in the other model indicators) of the health profile of public health unit populations and the services they provide. The Preventable Mortality Rate was considered the most appropriate proxy indicator of health status for the purposes of the funding model.

The Preventable Mortality Rate (per 100,000 population) ranged from a low of 62.9 to a high of 192.1 across public health units with an average (mean) rate of 125.7. **Appendix 16** provides a table of Preventable Mortality Rates by public health unit.

3.7 Model Construction

The public health funding model was constructed with the intention of identifying an appropriate funding share for each public health unit that reflects its needs in relation to all other public health units.

There are a number of steps that were undertaken to calculate each public health unit's equity-adjusted funding share.

3.7.1 Scaling

The actual values of each indicator need to be scaled to a common range in order to allow them to be combined. After consideration of options of a scale of 1-2, 1-4, and 1-8, the Funding Review Working Group recommends a scale of 1-8, meaning that the lowest possible value for each indicator will be one (1), and the highest possible value will be eight (8). This approach was felt to provide the best recognition of the base needs for a public health unit and reflection of the difference in resource intensity between the public health units with the lowest and highest need.

The first step in this scaling is to establish theoretical maximums of indicator values. These theoretical maximums are considered as the "highest achievable" values, and are assigned a value of eight (8). The theoretical maximums are determined by "stretching" the highest current value of each indicator by 15% to recognize that there will be changes to the highest values over time and thus allows for increases in them while providing consistency and stability to the calculations over time by avoiding the need to change the highest values annually.

The next step is to transform the raw indicator values to the 1-8 scale. This is done by determining the exponent required to transform the theoretical maximum to a value of 8. The raw value of the indicator for each public health unit is then exponentiated with the indicator exponent to provide an indicator value between 1 and 8.

Example:

1. The raw value range of Language is from 1% to 38%. The theoretical maximum is 44% (38%*1.15).
2. The exponent required to transform 44% to a scaling unit of 8 is 5.63, i.e. [(1+44%)^5.63=8].
3. The scaled value of Language for each public health unit is therefore calculated using the formula (1+xi)^5.63, where xi is the raw value of Language (%) of the public health unit (i).

3.7.2 Weighting

Percentage weights are then assigned to each indicator based on relative valuing. If a certain indicator is felt to account for a higher degree of need/cost, it is assigned a higher weight.

Very little research was available on funding model development for the public health sector. As such, Funding Review Working Group members relied on their public health expertise and judgment when considering recommendations for the weighting of each indicator. Through a scenario analysis tool, which included the interaction between weight and scale, a variety of weighting scenarios were considered by the Funding Review Working Group.

The Funding Review Working Group recommends the following weights for the funding model for mandatory programs.

Mandatory Programs Indicators Weighting	
Service Cost Drivers (35%)	Weight
Geography	25%
Language	10%
Drivers of Need (65%)	Weight
Aboriginal	12.5%
ON-Marg Dependency	10%
ON-Marg Ethnic Concentration	10%
ON-Marg Material Deprivation	15%
ON-Marg Residential Instability	7.5%
Preventable Mortality	10%
Total	**100%**

The Funding Review Working Group recommends the following weights, based on recommendations from the Unorganized Territories Sub-Committee recommendations, for the unorganized territories funding model so that it reflects the differences in demands and cost of service delivery in remote areas.

Unorganized Territories Indicators Weighting	
Service Cost Drivers (45%)	Weight
Geography	35%
Language	10%
Drivers of Need (55%)	Weight
Aboriginal	20%
ON-Marg Dependency	5%
ON-Marg Ethnic Concentration	5%
ON-Marg Material Deprivation	10%
ON-Marg Residential Instability	5%
Preventable Mortality	10%
Total	**100%**

It is important to note that the indicator weights in the funding model do not translate or equate to a percentage of total public health unit funding (e.g., a relative weighting of 10% for Language ≠ 10% of public health mandatory program funding to be allocated based on the value of this indicator). Rather, the weighting of an indicator is only used to determine the EAF.

3.7.3 Calculating the EAF (Equity Adjustment Factor)

An EAF summarizes each public health unit's relative position in the provincial distribution. Indicators are combined (added) to create a unique EAF for each public health unit.

Two (2) possible approaches were considered – additive or multiplicative. In the additive approach (e.g., used in the Nova Scotia formula) each scaled indicator is multiplied by a weight, then all the indicators are added together to create an index. In the multiplicative approach (e.g., used in the 1996 and 2001 formulas) the scaled indicators are multiplied by one another to create an index. Under the multiplicative approach, extreme values have more influence on the formula. Under the additive

approach, there is more explicit control over how much a particular indicator contributes to the index. Therefore, the Funding Review Working Group recommends the model employ the additive approach to combining the indicators.

Note: EAF scores, models share values and variances between current public health unit share and funding model share, reviewed by the Funding Review Working Group were anonymized by the Secretariat. This allowed working group members to make recommendations on a system level in a fair and unbiased way.

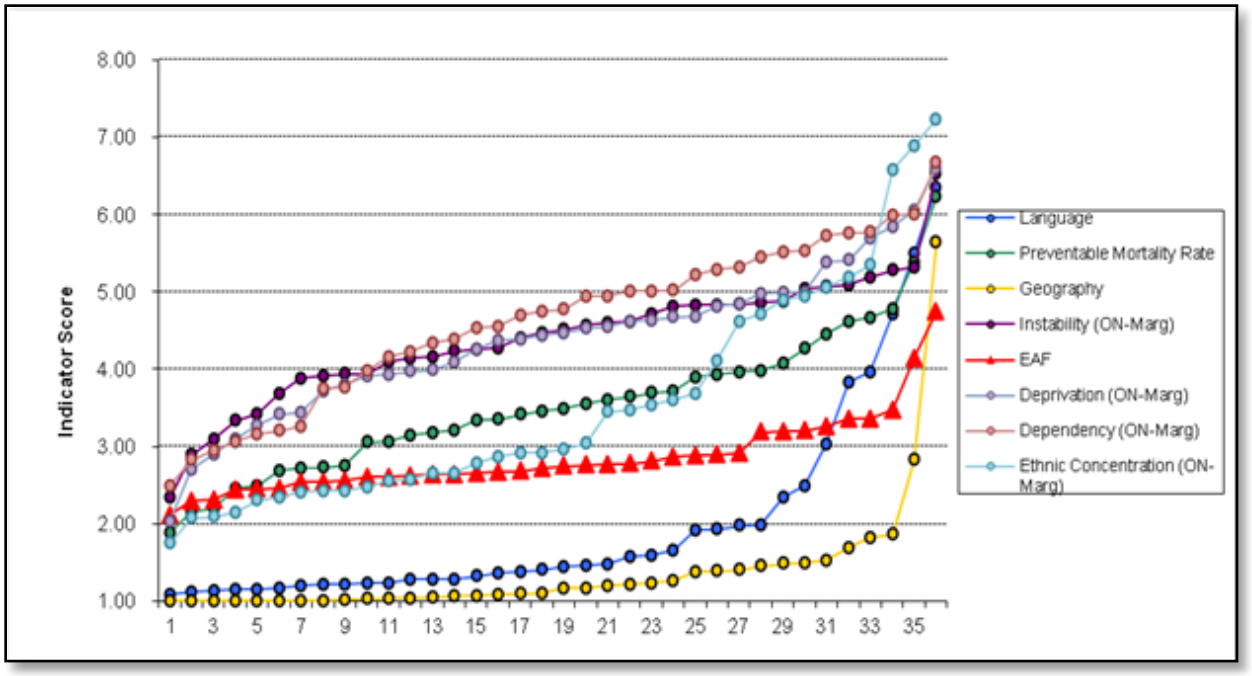
These scores, values, and variances are also presented here anonymously although the Ministry has indicated it may share this information, identified by public health unit, when consulting on implementation methods with the public health sector.

EAF for public health unit #1 (Mandatory Programs)	=	[0.25*Geography] + [0.10*Language] + [0.125* Aboriginal] + [0.075*Residential Stability] + [0.15*Material Deprivation] + [0.10*Ethnic Concentration] + [0.10*Dependency] + [0.10*Preventable Mortality]
EAF for public health unit #1 (Unorganized Territories)	=	[0.35*Geography] + [0.10*Language] + [0.20 Aboriginal] + [0.05*Residential Stability] + [0.10*Material Deprivation] + [0.05*Ethnic Concentration] + [0.05*Dependency] + [0.10*Preventable Mortality]

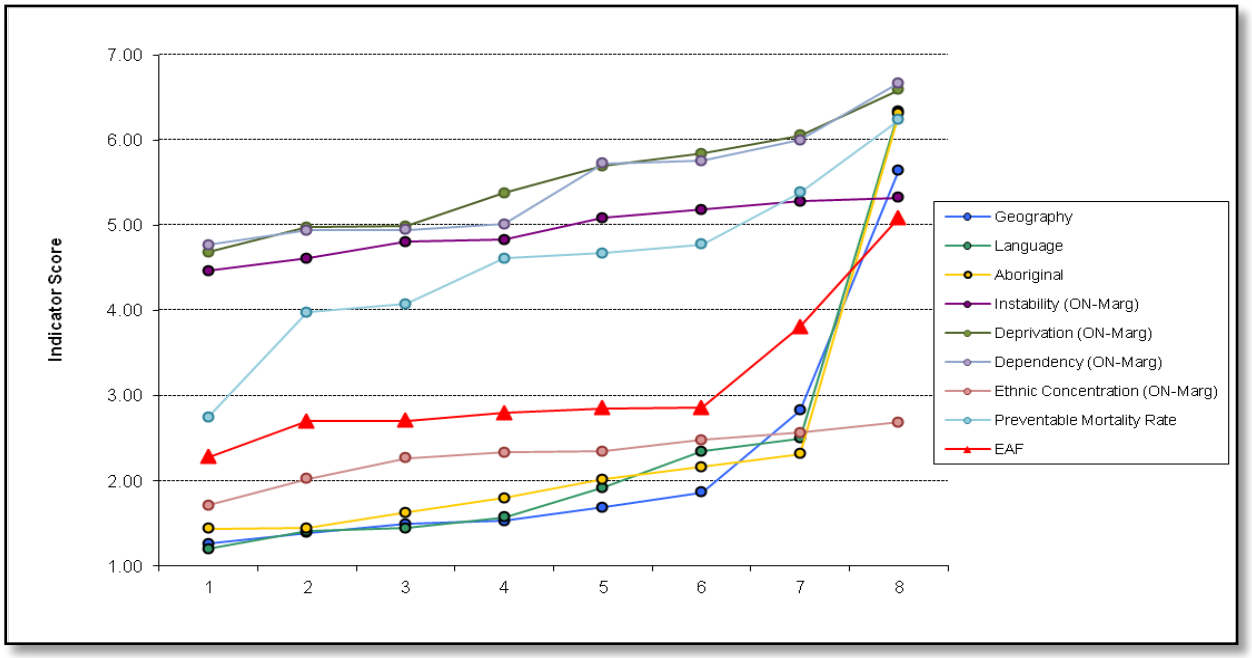
The EAF scores for mandatory programs ranged from 2.14-low to 4.75-high with an average (mean) score of 2.88. The EAF scores for unorganized territories ranged from 2.28-low to 5.09-high with an average (mean) score of 3.14

Appendix 17 provides a table of EAF scores by public health unit (anonymized).

Indicator & EAF Scores for Mandatory Program



Indicator & EAF Scores for Unorganized Territories



Note: Each indicator and EAF was sorted independently (i.e. no single public health unit received the highest or lowest score for all indicators).

3.7.4 Population

The Funding Review Working Group recommends that the most recent Statistics Canada Population Estimates be used for the purposes of the funding model for both mandatory programs and unorganized territories funding as these statistics represent populations in both organized and unorganized areas. Population statistics will be updated annually in order to acknowledge the high growth experienced in certain regions. **Appendix 18** provides a table of population estimates (2011) by public health unit.

Statistics Canada Estimates were deemed to provide the most accurate Aboriginal population numbers as Statistics Canada Post-Censal Estimates include adjustments for incompletely enumerated First Nation Reserves.

It is also recommended that the population data used for the unorganized territories funding model calculations only reflect Statistics Canada Population Estimates for unorganized territories. Any reserves/settlements contained within the boundaries of the unorganized territory will be included in this population count.

The Funding Review Working Group extensively reviewed the possibility for the inclusion of special populations (e.g., corrections, students, seasonal, migrant workers, homeless, commuters, etc.) not captured by the Statistics Canada Population Estimates. However, what few data were available on these populations were not captured consistently across all public health units. Therefore, there are no adjustments included in the model to account for these factors. Correctional facility populations are included in the Statistics Canada census if they have resided in the facility for longer than 6 months. Students who return home to live with their parents during the summer are enumerated at their parents' place of residence.

Ministry of Finance population statistics projections were considered for inclusion in the model, however, it was determined that, due to several issues that would require adjustment to the data (e.g., geographic boundary differences), Statistics Canada's most recent population estimates should be used.

Concerns have been expressed by both the field and more broadly (e.g., in the media) regarding changes to the Census data collection process. In 2011, the federal government announced that the long-form questionnaire would no longer be mandatory and introduced the voluntary National Household Survey. Critics of the change have expressed concerns that the data collected would be less accurate and results skewed as some population groups may be less likely to respond than others. The Funding Review Working Group recommends that the government consider how changes to the Census data collection process will affect the funding model put forward in this report and pursue the most appropriate and accurate data sources, if they become available, in its implementation.

3.7.5 Calculating Model Shares

Each public health unit's equity-adjusted population is computed by multiplying its EAF by its population.

Equity-Adjusted Population (Mandatory Programs)	=	(EAF for public health unit$_{\#1}$) x (Population for public health unit$_{\#1}$)
Equity-Adjusted Population (Unorganized Territories)	=	(EAF for public health unit$_{\#1}$) x (UT Population for public health unit$_{\#1}$)

To determine a public health unit's proportional share of the equity-adjusted population, its equity-adjusted population is divided by the total weighted population for all public health units.

Proportional Share for public health unit$_{\#1}$ (Mandatory Programs)	=	$\frac{\text{Equity-Adjusted Population for public health unit}_{\#1}}{\text{Sum of Equity-Adjusted Populations for all 36 public health units}}$
Proportional Share for public health unit$_{\#1}$ (Unorganized Territories)	=	$\frac{\text{Equity-Adjusted Population for public health unit}_{\#1}}{\text{Sum of Equity-Adjusted UT Populations for all 8 public health units}}$

The model shares for mandatory programs ranged from a low of 0.32% to a high of 24.66% with an average (mean) share of 2.78%. The model shares for unorganized territories ranged from a low of 0.07% to a high of 49.84% with an average (mean) share of 12.5%. **Appendix 19** provides a table of all calculated model shares (anonymized).

In comparison, the 2013 actual allocated share for mandatory programs ranged from a low of 0.52% to a high of 22.39% with an average (mean) share of 2.78%. The 2013 actual allocated share for unorganized territories ranged from a low of 0.93% to a high of 32.69% with an average (mean) share of 12.5%. **Appendix 20** provides a comparison of 2013 shares to model calculated shares (anonymized).

4.0 Implementation

Throughout the development of the funding model, the Funding Review Working Group was cognizant of the fact that the funding model's implementation would ultimately be a government policy decision dependent on available funding and approvals. The Funding Review Working Group understood that the model must be cost neutral and/or within the Ministry's approved funding allocation.

In its simplest application, the amount of provincial public health funding available could be divided based strictly on the calculated model share for each public health unit. However, the Funding Review Working Group does not recommend this approach as resulting changes to funding levels would have a significant impact on public health units that would either benefit from (i.e., receive an increase in funding) or be disadvantaged (i.e., receive a decrease in funding) as a result of this method of application.

The Funding Review Working Group is, therefore, recommending that the Province use the following implementation principles when developing its method for implementing the above recommended funding model:

- The timing to reach equity/model-based share must be balanced with maintaining system stability but should not further exacerbate current funding disparities.
- The Ministry should use incremental funding to the greatest extent possible in the application of the new funding model in order to minimize the disruption to existing service provision.
- Public health units should be provided with sufficient notice regarding the implementation of the funding model for planning purposes. A transition period (e.g., at least 3 years) is necessary to implement changes to funding. The Ministry should work with boards of health and public health units to mitigate the impact on service provision during the transition period.
- The impact of funding changes should be monitored by the Ministry to ensure that service provision is not being unduly impacted.
- The impact of funding changes should be taken into consideration in the setting of targets for Public Health Accountability Agreement indicators.
- The model is not intended to affect the municipal cost-share formula (75% provincial/25% municipal) although there may be impacts on municipal funding contributions resulting from the implementation of the model.
- The impact of funding changes to the municipal cost-share formula (i.e., decreases or increases in provincial funding affecting municipal contribution levels) should be taken into consideration when determining an implementation method.
- The most current data should be used for the public health funding model.

5.0 Next Steps

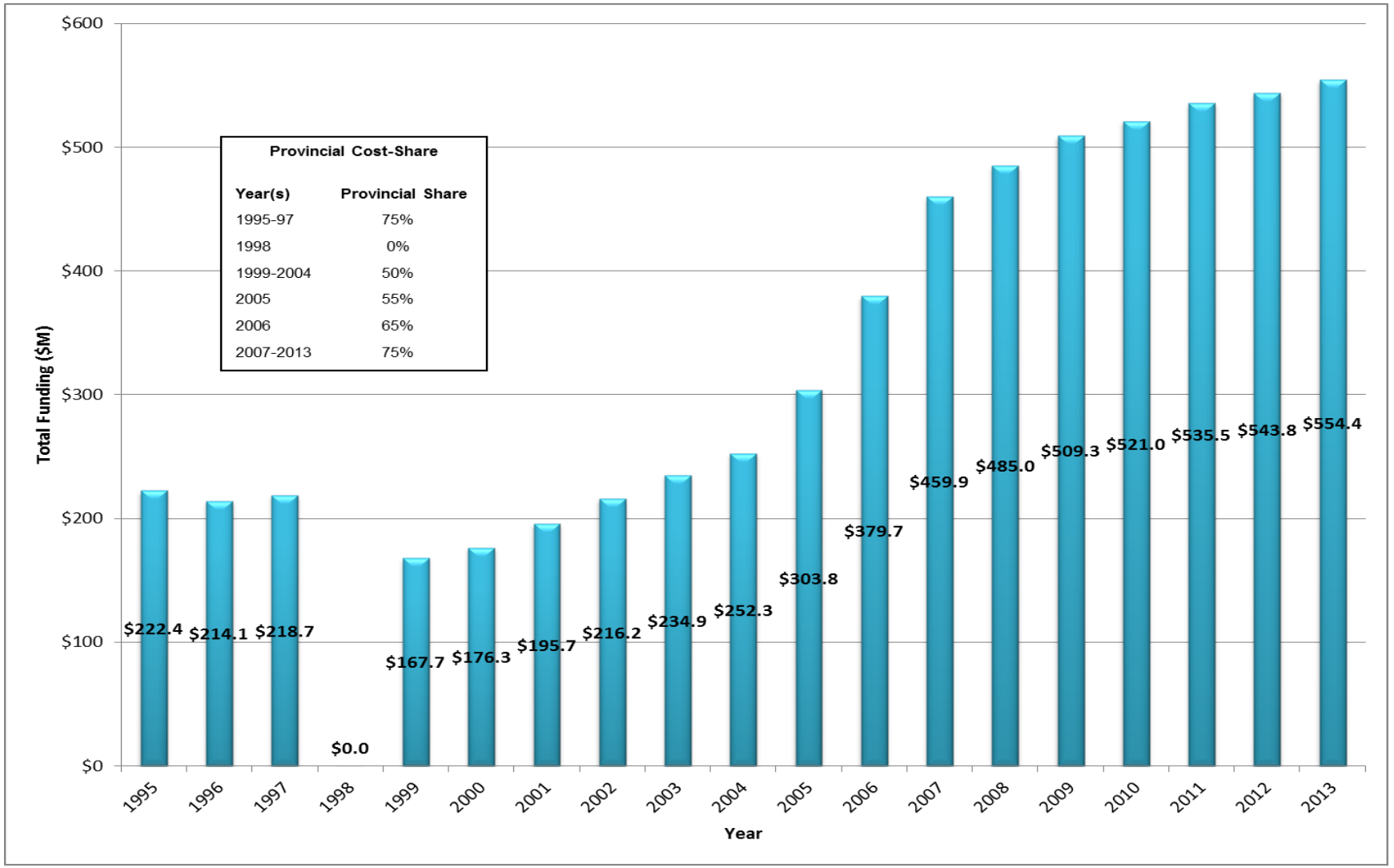
We submit this report and its recommendations to the Ministry with the assumption it will take action to resolve the current inequities in funding across public health units in Ontario. These actions will be important in the creation of a more accountable funding model. More important, however, is the implementation of an equitable funding model that supports the long-term sustainability of public health services in Ontario.

The Ministry, upon receipt of the report, has committed to consider the recommendations made here and conduct its own impact assessment. We strongly encourage the Ministry to develop implementation strategies that are in line with the implementation principles recommended here. In particular, we stress the need for an implementation strategy that achieves a more equitable funding model in a timely way while also maintaining system stability.

Finally, we encourage the Ministry to consult the public health sector on any implementation strategy the Ministry develops prior to implementation. We encourage the Ministry to communicate regularly with the sector throughout its impact assessment of the recommendations made here as well as the development and implementation of a new funding model to mitigate any unforeseen disruptions to the delivery of public health services by public health units.

6.0 Appendices

Appendix 1 – Mandatory Programs Funding 1995-2013

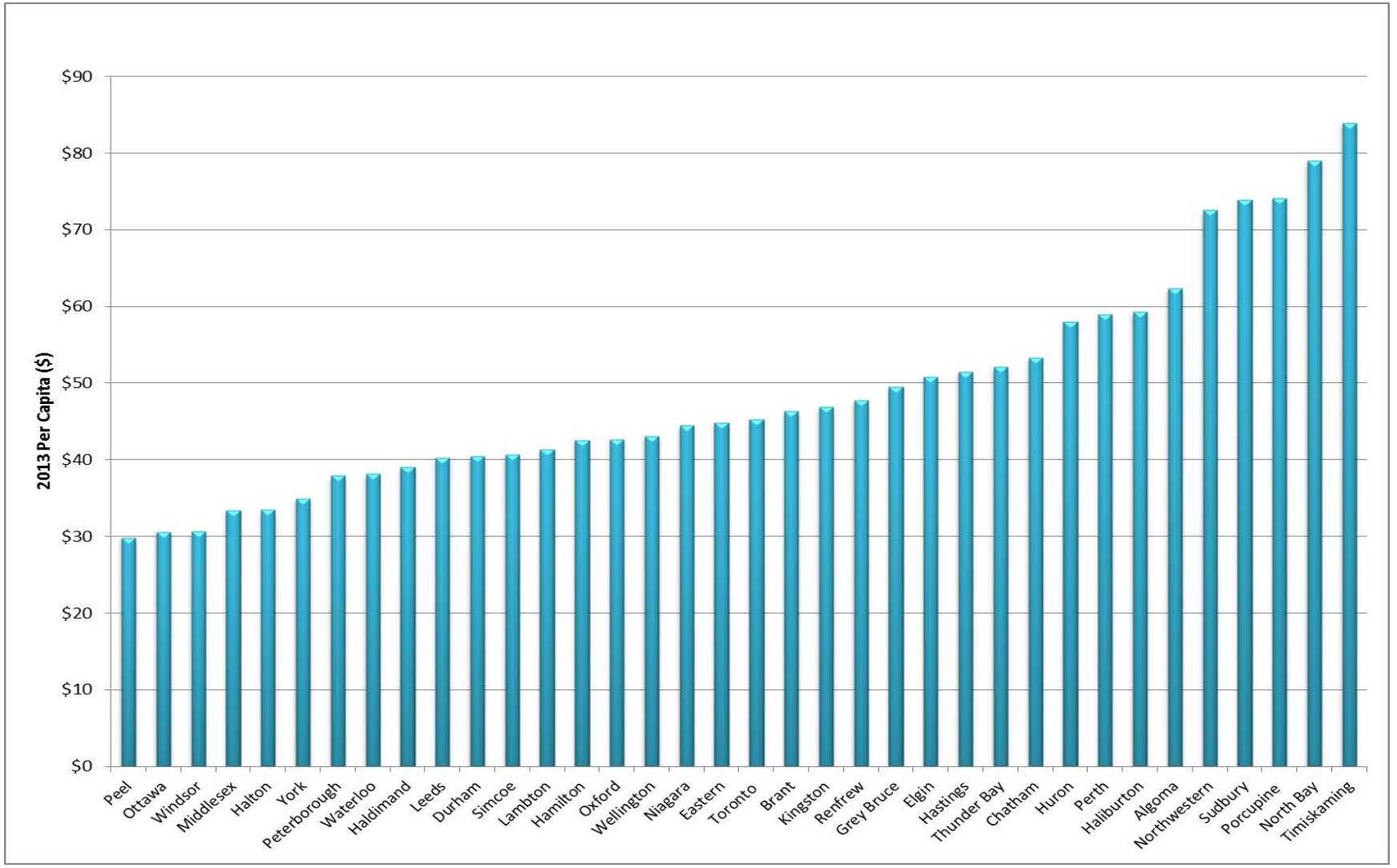


Appendix 2 – 2013 Public Health Unit Per Capita Funding

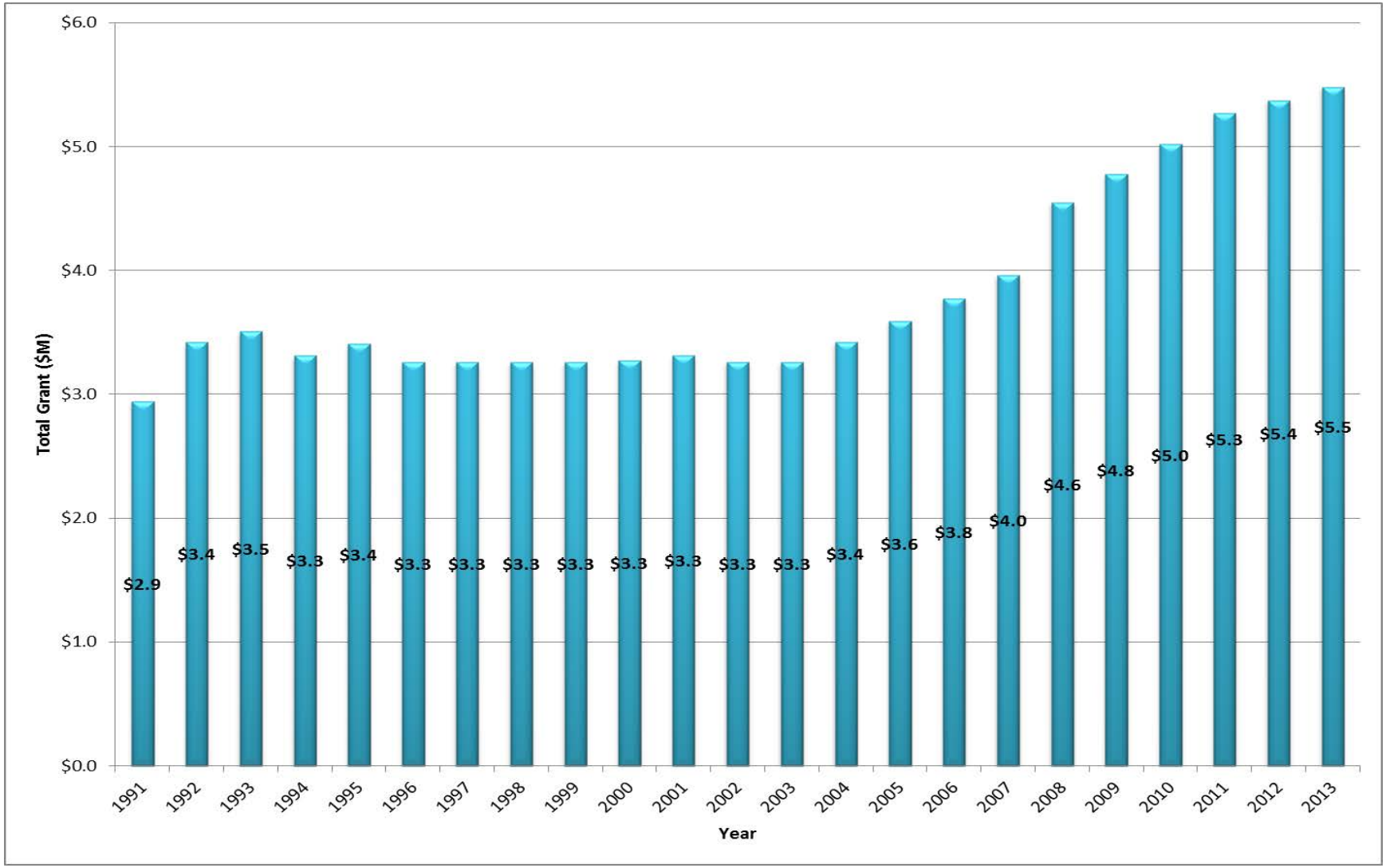
Public Health Unit	2013 Per Capita
Algoma	62.39
Brant County	46.33
Chatham-Kent	53.28
Durham Region	40.44
Eastern Ontario	44.85
Elgin-St. Thomas	50.78
Grey Bruce	49.56
Haldimand-Norfolk	39.05
Haliburton, Kawartha, Pine Ridge District	59.30
Halton Region	33.48
Hamilton	42.57
Hastings & Prince Edward Counties	51.47
Huron County	58.02
Kingston, Frontenac and Lennox & Addington	46.88
Lambton	41.31
Leeds, Grenville & Lanark District	40.27
Middlesex-London	33.42
Niagara Region	44.45
North Bay Parry Sound District	78.98
Northwestern	72.56
Ottawa	30.57
Oxford County	42.65
Peel Region	29.83
Perth District	58.95
Peterborough County-City	37.92
Porcupine	74.16
Renfrew County & District	47.75
Simcoe Muskoka District	40.66
Sudbury and District	73.85
Thunder Bay District	52.12
Timiskaming	83.97
Toronto	45.25
Waterloo Region	38.16
Wellington-Dufferin-Guelph	43.13
Windsor-Essex County	30.66
York Region	34.91

Note: Per capita information calculated using 2013 mandatory programs funding approved for public health units (provincial share) and the most recent Statistics Canada Population Estimates (2011).

Appendix 2 – 2013 Public Health Unit Per Capita Funding (cont'd)



Appendix 3 – Unorganized Territories Funding 1991-2013



Appendix 4 – Funding Review Working Group

Terms of Reference (2010)

BACKGROUND

In Ontario, public health services are delivered by 36 boards of health as mandated by the Health Protection and Promotion Act (HPPA). Each board of health is responsible for programs and services in a defined geographic area known as a public health unit. The Ontario Public Health Standards and Protocols set out the minimum requirements for fundamental public health programs and services (mandatory programs).

Under the HPPA, the legal obligation for board of health funding resides with the municipalities. The province is not legally obliged to provide funding but may make grants under section 76 of the HPPA. In practice, the province has historically shared with municipalities in the funding of mandatory programs. The funding is currently cost-shared with local municipalities at a ratio of 75% provincial funding and 25% municipal funding for approved costs of mandatory programs. In areas without municipal organization, the provincial government currently provides a 100% grant to boards of health for the delivery of mandatory programs.

Despite the significant increases in provincial funding for boards of health since 2004, funding inequities currently exist due to historical funding patterns that have been maintained for a number of years through across-the-board increases. In addition, budget requests were influenced by the capacity of local municipalities to support public health funding.

PURPOSE

The purpose of the Funding Review Working Group is to provide advice to the Ministry of Health and Long-Term Care (MOHLTC) and the Ministry of Health Promotion (MHP) on the development and implementation of a needs based methodology for allocating funds from the provincial envelope to boards of health for the provision of mandatory programs, in both organized and unorganized areas.

CONTEXT

The public health funding review is taking place during a fiscally challenging time. No new funding is currently available to implement review recommendations related to funding levels. Neither will existing base funding be reallocated or redistributed to address the review's recommendations regarding funding. Therefore, any funding adjustments will be implemented on an incremental basis using future increases to the overall provincial funding envelope for public health.

RESPONSIBILITIES

The Funding Review Working Group is charged with the task of providing advice and recommendations on funding models and options, equity factors used in the funding models, risk management and implementation issues. Specifically, the Funding Review Working Group will:

- Review and determine the factors to be used in developing the funding models.

- Provide advice and recommend a model for the allocation of provincial transfer payments to boards of health for the provision of mandatory programs in both organized and unorganized territories for the year 2011 and beyond.
- Provide input into the method of conducting field consultation and determine which model(s) to present for consultation.
- Review the comments of stakeholders following the consultation process.
- Review the draft report once it has been circulated.
- Provide advice with respect to the evaluation process.

MEMBERSHIP

[Notation: See current membership list on pages 2 and 3 of this report.]

ACCOUNTABILITY

Through the co-Chairs, the Funding Review Working Group will be accountable to the Chief Medical Officer of Health, Assistant Deputy Minister, Public Health Division, MOHLTC, and Assistant Deputy Minister, Sport, Public Health and Community Programs, MHP.

TIME FRAME

The funding review will be conducted from March to December 2010 with the implementation of a new funding methodology planned for 2011.

It is anticipated that the Funding Review Working Group will meet primarily from April 2010 to October 2010, in person in Toronto. These meetings will be followed by field consultations which are expected to take place in fall 2010. Further meetings of the Working Group will take place in late fall following the consultation phase and as the final report is being written. Please note that the ministry will cover all travel expenses to Toronto.

Appendix 5 – Sub-Committees' Membership

Unorganized Territories Sub-Committee

- Don West, Chief Administrative Officer, Porcupine Health Unit (Chair)
- Dr. Kim Barker, Medical Officer of Health, The District of Algoma Health Unit
- Colette Barrette, Manager, Accounting Services, Sudbury & District Health Unit
- Catherine Bloskie, Director, Corporate Services, Renfrew County & District Health Unit
- Isabel Churcher, Manager of Finance, North Bay Parry Sound District Health Unit
- Doug Heath, Chief Executive Officer, Thunder Bay District Health Unit
- Mark Perrault, Chief Executive Officer, Northwestern Health Unit
- Randy Winters, Manager of Administration & Finance, Timiskaming Health Unit

Past Members of the Unorganized Territories Sub-Committee:

- Dr. Allan Northan, Former Medical Officer of Health, District of Algoma Health Unit

Infrastructure Sub-Committee

- Patricia Hewitt, Manager, Public Health Administration, Halton Region Health Department
- Anne-Marie Holt, Manager, Epidemiology and Evaluation Services, Haliburton, Kawartha, Pine Ridge District Health Unit
- Dale Jackson, Former Director of Administration, Hastings and Prince Edward Counties Health Unit
- Shirley MacPherson, Director, Finance & Administration, Toronto Public Health
- Dr. David L. Mowat, Medical Officer of Health, Peel Public Health
- Dr. Andrew Pinto, Public Health & Preventative Medicine Specialist, St. Michael's Hospital

Appendix 6 – Indicators Considered But Not Selected

Category	Model Components/Indicators	Definition	Reason for Exclusion
Drivers of Need	**Early Development Instrument**	The Early Development Instrument is a teacher-completed checklist that assesses children's readiness to learn at school in five domains: physical health and well-being, social competence, emotional maturity, language and cognitive development, and communication skills and general knowledge. It also includes two additional scales indicating the child's special skills and problems.	At the time of indicator review (2009) data was not available for use in resource allocation.
Drivers of Need	**Recent Immigrants**	The proportion of the population with immigrant status, with period of immigration 2001 – 2006, to represent increased risk factors.	Recent Immigrants was originally chosen for inclusion in the funding model. However, upon review of the 'healthy immigrant effect' which determined that morbidity issues may present an increased need, it was decided the Ethnic Concentration dimension of ON-Marg would be used to represent these costs.
Drivers of Need	**Visible Minorities**	Visible minority refers to whether a person belongs to a visible minority group as defined by the Employment Equity Act and, if so, the visible minority group to which the person belongs. The Employment Equity Act defines visible minorities as 'persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour.' The visible minority population consists mainly of the following groups: South Asian, Chinese, Black, Filipino, Latin American, Arab, Southeast Asian, West Asian, Korean and Japanese.	Some minority groups do display risk factors for certain health issues; however, it was felt that the inclusion of the Ethnic Concentration dimension of ON-Marg would pick up the bulk of the issues related to health in these groups.
Health Outcomes	**Low Birth Weight**	Infants weighing less than 2,500 grams at birth.	The Working Group decided to go with an "up stream" approach which would focus on determinants of health such as education, income, etc. which are related to health outcomes such as low birth weight.
Health Outcomes	**Potential Years of Life Lost Ratio**	A measure of the relative impact of premature mortality.	The Working Group decided to go with an "up stream" approach which would focus on determinants of health such as education, income, etc. which are related to health outcomes such as potential years of life lost. However, ultimately the Working Group chose to include the Preventable Mortality Rate.
Health Outcomes	**Self-Rated Health**	Population (aged 12 and over from the Canadian Community Health Survey and National Population Health Survey) who reported perceiving their own health status as being either excellent, very good, good, fair or poor.	The Working Group decided to go with an "up stream" approach which would focus on determinants of health such as education, income, etc. which are related to health outcomes such as self-rated health.
Health Outcomes	**Standardized Mortality Ratio**	This ratio compares the mortality experience of a sub-population to that of a standard reference population. A higher mortality rate indicates greater	The Working Group decided to go with an "up stream" approach which would focus on determinants of health such as education, income, etc. which are related to health

Category	Model Components/Indicators	Definition	Reason for Exclusion
		demand for health services as it indicates a greater incidence of disease or risks.	outcomes such as standardized morality ratio.
Health Outcomes	**Teen Pregnancy Rate**	The number of pregnancies (resulting in live births, stillbirths, and therapeutic abortions) per 1,000 females age 15 -19 years.	The Working Group decided to go with an "up stream" approach which would focus on determinants of health such as education, income, etc. which are related to health outcomes such as teen pregnancy rate.
Health Risks	**Daily Smoking**	Population aged 12 and over who reported being a daily smoker. Does not take into account the number of cigarettes smoked. Studies suggest that this factor is associated with diseases affecting heart and lungs, and has a strong negative correlation with lifespan.	The Working Group decided to go with an "up stream" approach which would focus on determinants of health such as education, income, etc. which are related to risk factors such as smoking.
Health Risks	**Obesity - Body Mass Index**	Body Mass Index is a method of classifying body weight according to health risk.	The Working Group decided to go with an "up stream" approach which would focus on determinants of health such as education, income, etc. which are related to risk factors such as obesity.
Health Risks	**Physical Inactivity**	Respondents are classified as active, moderately active or inactive based on an index of average daily physical activity over a 3 month period.	The Working Group decided to go with an "up stream" approach which would focus on determinants of health such as education, income, etc. which are related to risk factors such as physical inactivity.
Replacement Services	**Replacement Services and Other Key Community Services**	Number of physicians, general practitioners, dentists, Midwives Nurses, pharmacies, Health Non-Governmental Organizations and other community services in a given region.	No comprehensive measure of replacement services in a public health unit exists and attempts to construct an adequate measure were unsuccessful due to lack of data or poor data quality. Finding evidence that any constructed measure correlated with the perceived effects of replacements services was unsuccessful.
Service Cost Drivers	**Cost of Living**	The level of prices relating to a range of everyday items.	Consideration was given to a cost of living adjustment to account for the varying costs faced by public health units associated with labour, building occupancy, and services. It was decided that the Cost of Living indicator should not be included due to data quality issues. The indicators considered were not sufficiently representative of the costs.
Service Cost Drivers	**Cost of Living: Average Dwelling Cost**	Average dwelling cost refers to the total monthly shelter cost paid by the household for their dwelling. Shelter costs include the following: For renters: rent and any payments for electricity, fuel, water and other municipal services; For owners: mortgage payments (principal and interest), property taxes, and any condominium fees, along with payments for electricity, fuel, water and other municipal services.	This variable measures the values of residential, not commercial spaces and thus is not an appropriate proxy for public health unit building occupancy costs. It also does not account for costs associated with labour and services.
Service Cost Drivers	**Cost of Living: Average Salary per FTE for Public Health Nurses**	Average Salary per FTE for Public Health Nurses and Public Health Inspectors at public health units.	This measure is not resistant to manipulation as it is collected from the public health units.

Category	Model Components/Indicators	Definition	Reason for Exclusion
	and Public Health Inspectors		
Service Cost Drivers	**Cost of Living: Consumer Price Index**	The Consumer Price Index is an indicator of changes in consumer prices experienced by Canadians. It is obtained by comparing, over time, the cost of a fixed basket of goods and services purchased by consumers.	The Consumer Price Index is measured for only three municipalities in Ontario and thus does not provide enough variation across public health units.
Service Cost Drivers	**Cost of Living: Income for Health Occupations**	This variable measures the average salary for all Health Occupations in an Economic Region of Ontario.	It was decided that this measure was not as good at indicating overall cost of living for a public health unit as it was very specific to certain types of professions.
Service Cost Drivers	**Cost of Living: Nutritious Food Basket**	The National Nutritious Food Basket monitors the cost and affordability of healthy eating. The Nutritious Food Basket describes the quantity (and purchase units) of approximately 60 foods that represent a nutritious diet for individuals in various age and gender groups.	The Nutritious Food Basket was thought to not capture all of the effects desired in a cost of living variable. Furthermore, there was very little variation between the highest and lowest public health unit values.
Service Cost Drivers	**Environmental Health**	The number of food premises, pools, and personal services settings rates per population.	Analysis suggested a fairly even distribution of premises per population across the province in the majority of cases. Given this even distribution, the Working Group determined that the exclusion of environmental health indicators was appropriate.
Service Cost Drivers	**Geography: Rural and Small Community Measure**	The Rural and Small Community Measure represents the proportion of a municipality's population residing in rural areas or small communities. This approach recognizes that some municipalities include a mix of rural and non-rural areas.	As a measure of geography the Rural and Small Community Measure does not account for the dispersion of the population which is a factor the Working group wished to capture to reflect the costs of providing services. The Adapted Concentric Circle model was chosen to represent service costs related to geography.
Service Cost Drivers	**Geography: Population Density**	Measure of the intensity of land use, expressed as number of people per square kilometer or square mile.	As a measure of geography, population density does not account for the dispersion of the population, which is a factor the Working Group wished to capture to reflect the costs of providing services. The Adapted Concentric Circle model was chosen to represent service costs related to geography.
Service Cost Drivers	**Geography: Population Per Km Road**	Number of population per kilometer of road for a given area.	As a measure of geography, population per km of road does not account for the dispersion of the population which is a factor the Working Group wished to capture to reflect the costs of providing services. Furthermore, this measure was only used in the Nova Scotia model due to lack of data available to run the concentric circle model. The Adapted Concentric Circle model was chosen to represent service costs related to geography.
Service Cost Drivers	**Geography: Rurality Index of Ontario**	The Rurality Index of Ontario is a methodology used to identify communities that are underserviced with respect to physician services. The Rurality Index of Ontario methodology establishes an index score for	As a measure of geography, Rurality Index of Ontario did account for distance from health services to the population but this was based on geographic areas that were less relevant to public health units than in the concentric circle

Category	Model Components/Indicators	Definition	Reason for Exclusion
		each community, which is used to help define which communities require additional funding support for accessing physician services. The Rurality Index of Ontario scoring methodology uses a weighted formula which considers three key elements: population size and density, travel time to nearest basic referral centre, and travel time to nearest advanced referral centre.	model. For example, the measure of the rurality of some communities in Northwestern discussed their distance to Winnipeg and not the distance to public health offices in Ontario.
Service Cost Drivers	**Language - Francophone, First Language Neither English Nor French.**	Francophone: People with French as their mother tongue. Mother tongue refers to the first language learned at home in childhood and still understood by the individual at the time of the census. First Language Neither English nor French: Individuals who cannot conduct a conversation in either of the official languages of Canada (in English only, in French only, in both English and French).	Home Language Not English is used in the model to represent the costs of translation and culturally specific programming at public health units.
Service Cost Drivers	**Special Populations**	Short-term corrections, student, seasonal, migrant workers, homeless, commuters, etc. populations.	There are no data sources that accurately and/or consistently record these populations.
Socio-Economic Characteristics	**Deprivation Index - Institut national de santé publique du Québec (INSPQ)**	A measure of social and material deprivation at the neighbourhood level.	Originally chosen as the deprivation index for the model. Once the ON-Marg was brought to the Committee's attention it was decided to use the ON-Marg rather than the Deprivation Index (INSPQ) as ON-Marg considers a much larger list of indicators, including variables similar to those in the INSPQ.
Socio-Economic Characteristics	**Education**	The proportion of the population who did not complete High School. Areas that have a higher proportion of people with low education may experience greater demand for services. People with more education are more likely to be able to access safe environments, tend to smoke less, to be more physically active and to eat healthier foods.	Since ON-Marg is to be used an education measure is not needed as this is included in the index.
Socio-Economic Characteristics	**Housing Quality: Owner's versus Renters**	The number of home owners versus renters in a given region.	Since ON-Marg is to be used this variable, considered as a measure of relative wealth, is not needed as this is included in the index.
Socio-Economic Characteristics	**Lone Parent Families**	The proportion of families headed by a single parent.	Since ON-Marg is to be used a lone parent family measure is not needed as this is included in the index.
Socio-Economic Characteristics	**Low Income Population**	The proportion of the population for which the income level at which a family may be in straitened circumstances because it has to spend a greater proportion of its income on necessities than the average family of similar size.	Since ON-Marg is to be used a low income measure is not needed as this is included in the index.
Socio-Economic Characteristics	**Median Income**	Median income is the amount which divides the income distribution into two equal groups, half having incomes above the median, half having	Since ON-Marg is to be used an income measure is not needed as this is included in the index.

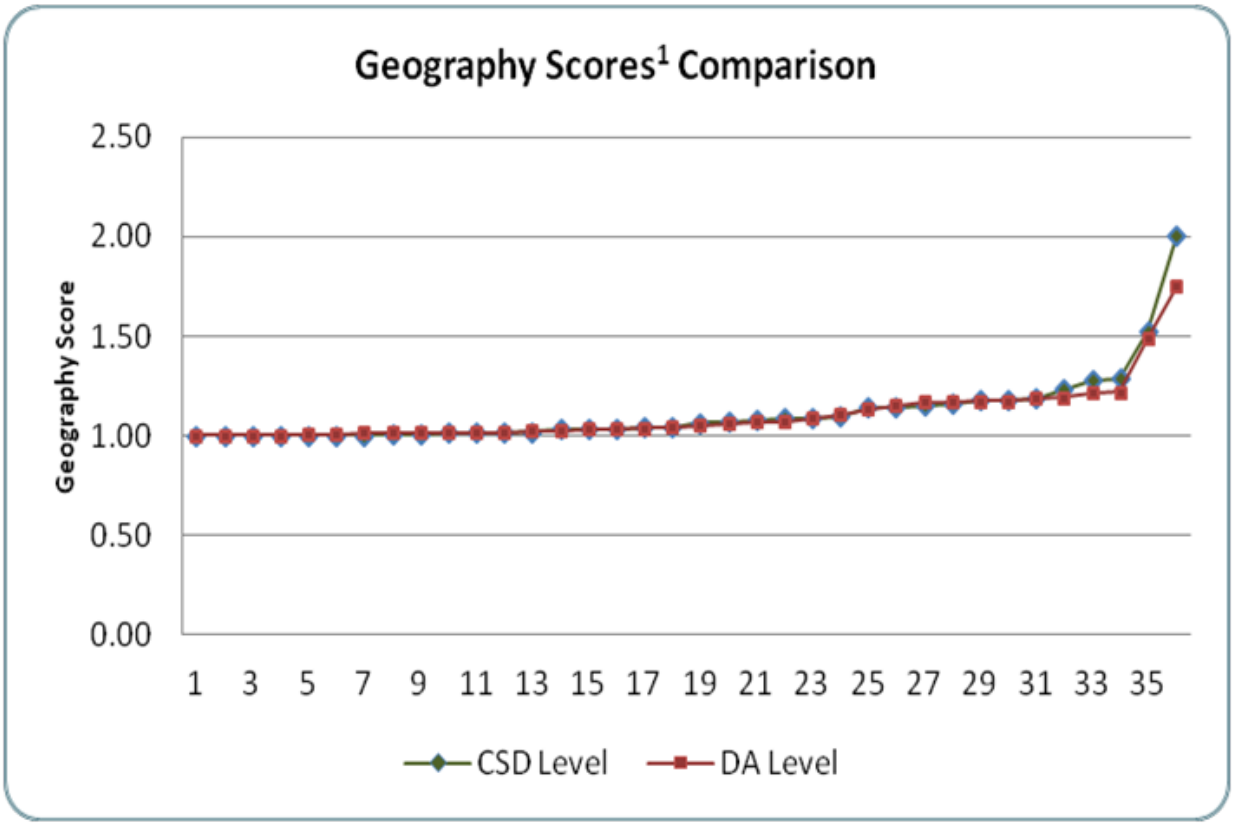
Category	Model Components/Indicators	Definition	Reason for Exclusion
		incomes below the median.	
Socio-Economic Characteristics	**Unemployment**	Unemployment occurs when people are without work and actively seeking work.	Since ON-Marg is to be used an unemployment measure is not needed as this is included in the index.

Appendix 7 – Public Health Unit Largest Office

Public Health Unit	Largest Office Address
Algoma	294 Willow Ave., Sault Ste. Marie
Brant County	194 Terrace Hill St., Brantford
Chatham-Kent	325 Grand Ave W, Chatham
Durham Region	605 Rossland Rd E, Whitby
Eastern Ontario	1000 Pitt St., Cornwall
Elgin-St. Thomas	99 Edward St., St. Thomas
Grey Bruce	101 17th St. E, Owen Sound
Haldimand-Norfolk	12 Gilbertson Drive, Simcoe
Haliburton, Kawartha, Pine Ridge District	200 Rose Glen Rd., Port Hope
Halton Region	1151 Bronte Rd, Oakville
Hamilton	35 King St E., Hamilton
Hastings & Prince Edward Counties	179 North Park St., Belleville
Huron County	77722B London Rd., Clinton
Kingston, Frontenac and Lennox & Addington	221 Portsmouth Ave., Kingston
Lambton	160 Exmouth St., Point Edward
Leeds, Grenville & Lanark District	458 Laurier Blvd., Brockville
Middlesex-London	50 King St., London
Niagara Region	2201 St. David's Road Campbell E, Thorold
North Bay Parry Sound District	681 Commercial St., North Bay
Northwestern	210 First St. N, Kenora
Ottawa	100 Constellation Cresc., Ottawa
Oxford County	410 Buller St., Woodstock
Peel Region	7120 Hurontario St., Mississauga
Perth District	653 West Gore St., Stratford
Peterborough County-City	10 Hospital Dr., Peterborough
Porcupine	169 Pine St. S, Timmins
Renfrew County & District	7 International Dr., Pembroke
Simcoe Muskoka District	15 Sperling Dr., Barrie
Sudbury and District	1300 Paris St., Sudbury
Thunder Bay District	999 Balmoral St., Thunder Bay
Timiskaming	247 Whitewood Ave., New Liskeard
Toronto	277 Victoria St., Toronto
Waterloo Region	99 Regina St. S, Waterloo
Wellington-Dufferin-Guelph	503 Imperial Rd. N., Guelph
Windsor-Essex County	1005 Ouellette Ave., Windsor
York Region	50 High Tech Rd., Richmond Hill

Note: The largest office represents the office for which the greatest number of staff were reported on the 2013 Program-Based Grants Occupancy Report.

Appendix 8 – Census Subdivision (CSD) and Dissemination Area (DA) Comparison



Note[1]:

(i) Geography Score = Weighted population / Un-weighted population.

(ii) Caveat – CSD level geography score is calculated based on the 2011 population estimates while DA level geography score is based on the 2011 census population counts.

(iii) Each geography score line is sorted independently.

Appendix 9 – Adapted Concentric Circle Model Scores (Geography)

Public Health Unit	Adapted Concentric Circle Model Score
BRANT COUNTY	1.00
HALTON REGION	1.00
HAMILTON	1.00
OTTAWA	1.00
PEEL REGION	1.00
TORONTO	1.00
WATERLOO REGION	1.00
CHATHAM-KENT	1.00
MIDDLESEX-LONDON	1.01
DURHAM REGION	1.01
YORK REGION	1.01
NIAGARA REGION	1.02
PETERBOROUGH COUNTY-CITY	1.02
ELGIN-ST. THOMAS	1.03
OXFORD COUNTY	1.03
PERTH DISTRICT	1.03
LAMBTON	1.04
WINDSOR-ESSEX COUNTY	1.04
KINGSTON, FRONTENAC AND LENNOX & ADDINGTON	1.06
HASTINGS & PRINCE EDWARD COUNTIES	1.06
HURON COUNTY	1.08
HALDIMAND-NORFOLK	1.08
WELLINGTON-DUFFERIN-GUELPH	1.09
SUDBURY AND DISTRICT	1.10
SIMCOE MUSKOKA DISTRICT	1.14
RENFREW COUNTY & DISTRICT	1.14
GREY BRUCE	1.15
EASTERN ONTARIO	1.16
LEEDS,GRENVILLE & LANARK DISTRICT	1.17
NORTH BAY PARRY SOUND DISTRICT	1.17
TIMISKAMING	1.19
ALGOMA	1.24
HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT	1.27
THUNDER BAY DISTRICT	1.28
PORCUPINE	1.52
NORTHWESTERN	2.01

Source: Health Analytics Branch, Ministry Health and Long-Term Care (Population estimates July 1, 2011, Census Subdivisions, Ontario; Source: Statistics Canada, Demography Division, customized data and Ministry of Health and Long-Term Care Geographic Conversion File, consgc11.xls).

Appendix 10 – Percentage of Home Language not English Population

Public Health Unit	Home Language not English Population %
HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT	1.4%
LEEDS,GRENVILLE & LANARK DISTRICT	2.1%
PETERBOROUGH COUNTY-CITY	2.2%
HASTINGS & PRINCE EDWARD COUNTIES	2.5%
GREY BRUCE	2.6%
LAMBTON	2.9%
RENFREW COUNTY & DISTRICT	3.3%
SIMCOE MUSKOKA DISTRICT	3.5%
OXFORD COUNTY	3.5%
HURON COUNTY	3.8%
HALDIMAND-NORFOLK	3.8%
KINGSTON, FRONTENAC AND LENNOX & ADDINGTON	4.5%
PERTH DISTRICT	4.5%
BRANT COUNTY	4.5%
CHATHAM-KENT	5.1%
DURHAM REGION	5.6%
ELGIN-ST. THOMAS	5.8%
ALGOMA	6.3%
THUNDER BAY DISTRICT	6.8%
WELLINGTON-DUFFERIN-GUELPH	7.0%
NIAGARA REGION	7.2%
NORTHWESTERN	8.4%
HALTON REGION	8.7%
MIDDLESEX-LONDON	9.4%
NORTH BAY PARRY SOUND DISTRICT	12.2%
WATERLOO REGION	12.4%
WINDSOR-ESSEX COUNTY	12.9%
HAMILTON	12.9%
TIMISKAMING	16.4%
SUDBURY AND DISTRICT	17.7%
OTTAWA	21.8%
YORK REGION	27.0%
PEEL REGION	27.7%
TORONTO	31.7%
EASTERN ONTARIO	35.4%
PORCUPINE	38.9%

Source: Statistics Canada. 2007. 2006 Community Profiles. 2006 Census. The latest data was not available at the time of writing this report.

Appendix 11 – Percentage of Aboriginal Population

Public Health Unit	Aboriginal Status Population %
YORK REGION	0.4%
PEEL REGION	0.5%
HURON COUNTY	0.5%
TORONTO	0.5%
HALTON REGION	0.6%
PERTH DISTRICT	0.7%
WELLINGTON-DUFFERIN-GUELPH	0.9%
OXFORD COUNTY	0.9%
WATERLOO REGION	1.0%
ELGIN-ST. THOMAS	1.1%
DURHAM REGION	1.2%
OTTAWA	1.5%
HAMILTON	1.5%
MIDDLESEX-LONDON	1.6%
WINDSOR-ESSEX COUNTY	1.6%
NIAGARA REGION	1.6%
HALDIMAND-NORFOLK	1.9%
HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT	2.0%
EASTERN ONTARIO	2.0%
LEEDS,GRENVILLE & LANARK DISTRICT	2.1%
GREY BRUCE	2.4%
CHATHAM-KENT	2.5%
KINGSTON, FRONTENAC AND LENNOX & ADDINGTON	2.6%
SIMCOE MUSKOKA DISTRICT	3.1%
PETERBOROUGH COUNTY-CITY	3.2%
BRANT COUNTY	3.5%
HASTINGS & PRINCE EDWARD COUNTIES	3.5%
LAMBTON	4.6%
TIMISKAMING	5.6%
RENFREW COUNTY & DISTRICT	5.7%
NORTH BAY PARRY SOUND DISTRICT	7.6%
SUDBURY AND DISTRICT	9.2%
ALGOMA	11.1%
PORCUPINE	12.3%
THUNDER BAY DISTRICT	13.5%
NORTHWESTERN	32.0%

Source: Statistics Canada. 2007. 2006 Community Profiles. 2006 Census. The latest data was not available at the time of writing this report.

Appendix 12 – Deprivation Indices Considered

Measure	Jarman	Carstairs	Townsend	SEFI	INSPQ	GDI	Matheson, Moineddin, Glazier	ON-Marg
Type of index								
Material Deprivation	x	x	x	x	x	x	x	x
Social Deprivation	x	x		x	x	x		x
Variables used								
Income		x		x	x	x	x	x
Housing	x	x	x			x	x	x
Demographic	x			x	x	x		x
Mobility	x	x	x					
Education				x	x	x	x	x
Employment	x	x	x	x	x	x	x	x
Social class	x	x					x	x
Weighting method								
Principal component analysis				x	x	x		x
Log transformations			x					
Expert weighting	x							
Multiple linear regression				x			x	

Note: See section 7.0 for references.

Appendix 13 – Healthy Immigrant Effect Review

References to publications from which data was extracted and presented to the Funding Review Working Group in support of discussion:

Adhiraki R & Sanou D. 2012. Risk factors of diabetes in Canadian immigrants: a synthesis of recent literature. Canadian Journal of Diabetes, vol. 36: 142-150.

Belanger A & Gilbert S. 2003. The fertility of immigrant women and their Canadian-born daughters. In: Report on the demographic situation in Canada. Current demographic analysis. Ottawa: Alain Belanger Ministry of Industry. p. 127-51.

Creatore MI, Moineddin R, Booth G, et al. 2010. Age- and sex-related prevalence of diabetes mellitus among immigrants to Ontario, Canada. CMAJ, vol. 182(8): 781-789.

Collins CH, Zimmerman C & Howard LM. 2011. Refugee, asylum seeker, immigrant women and postnatal depression: rates and risk factors. Arch Womens Ment Health, vol. 14: 3-11.

Dassanayake J, Gurrin L, Payne WR, et al. 2010. Cardiovascular disease risk in immigrants: what is the evidence and where are the gaps? Asian-Pacific Journal of Public Health, vol. 23(6): 882-895.

Gagnon AJ, Zimbeck M, Zeitlin J, et al. 2009. Migration to western industrialised countries and perinatal health: A systematic review. Social Science & Medicine, vol. 69:934-946.

Gagnon AJ, McDermott S, Rigol-Chachamovich J, et al. 2011. International migration and gestational diabetes mellitus: a systematic review of the literature and meta-analysis. Paediatric and Parinatal Epidemiology, vol. 25:575-592.

Greenaway C, Sandoe A, Vissandjee B, et al. 2011. Tuberculosis: evidence review for newly arriving immigrants and refugees. CMAJ, vol. 183(12): E939-E951.MacPherson DW, Gushulak BD. 2008. Syphilis in immigrants and the Canadian immigration medical examination. J Immigrant Minority Health, vol. 10: 1-6.

McElroy R, Laskin M, Jiang D, et al. 2009. Rates of rubella immunity among immigrant and non-immigrant pregnant women. J Obstet Gynaecol Can, vol. 31(5): 409-413.

Minuk GY & Uhanova J. 2001. Chronic hepatitis B infection in Canada. Can J Infect Dis, vol. 12(6): 351-356.

Ng, E. 2011. The healthy immigrant effect and mortality rates. Health Reports, vol 22(4):25-29. Statistics Canada Catalogue no. 82-003-XPE

Ravel A, Nesbitt A, Marshall B, et al. 2011. Description and burden of travel-related cases caused by enteropathogens reported in a Canadian community. Journal of Travel Medicine, vol. 18(1): 8-19.

Appendix 14 – ON-Marg Dimensions Scores

Public Health Unit	Residential Instability Score	Material Deprivation Score	Dependency Score	Ethnic Concentration Score
ALGOMA	3.15	3.52	3.97	1.93
BRANT COUNTY	2.78	2.94	3.00	2.74
CHATHAM-KENT	2.87	3.39	3.60	2.32
DURHAM REGION	2.18	2.36	2.22	3.58
EASTERN ONTARIO	2.67	3.05	3.31	2.26
ELGIN-ST. THOMAS	2.58	3.03	3.20	2.61
GREY BRUCE	2.83	2.85	3.85	1.77
HALDIMAND-NORFOLK	2.34	3.03	3.57	2.02
HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT	2.73	2.91	3.96	1.91
HALTON REGION	2.30	1.67	2.45	3.51
HAMILTON	2.91	3.11	3.03	3.42
HASTINGS & PRINCE EDWARD COUNTIES	2.96	3.13	3.73	2.29
HURON COUNTY	2.55	2.99	3.69	1.80
KINGSTON, FRONTENAC AND LENNOX & ADDINGTON	2.99	2.63	3.29	2.62
LAMBTON	2.85	2.69	3.46	2.07
LEEDS,GRENVILLE & LANARK DISTRICT	2.72	2.77	3.62	1.98
MIDDLESEX-LONDON	3.07	2.69	2.77	3.27
NIAGARA REGION	2.98	2.91	3.46	2.70
NORTH BAY PARRY SOUND DISTRICT	3.17	3.59	3.85	2.08
NORTHWESTERN	2.81	3.20	3.33	1.76
OTTAWA	2.97	2.16	2.37	3.66
OXFORD COUNTY	2.58	2.71	3.21	2.36
PEEL REGION	2.08	2.43	2.02	4.63
PERTH DISTRICT	2.65	2.72	3.12	2.13
PETERBOROUGH COUNTY-CITY	3.06	2.98	3.73	2.29
PORCUPINE	2.97	3.68	3.42	1.97
RENFREW COUNTY & DISTRICT	2.87	3.06	3.83	1.98
SIMCOE MUSKOKA DISTRICT	2.57	2.58	2.89	2.66
SUDBURY AND DISTRICT	2.96	3.38	3.46	2.21
THUNDER BAY DISTRICT	3.07	3.19	3.42	2.13
TIMISKAMING	3.11	3.91	4.31	1.54
TORONTO	3.65	3.20	2.78	4.45
WATERLOO REGION	2.71	2.45	2.42	3.44
WELLINGTON-DUFFERIN-GUELPH	2.46	2.26	2.48	2.99
WINDSOR-ESSEX COUNTY	2.68	2.96	3.09	3.33
YORK REGION	1.80	2.06	2.30	4.30

Notes:

- Source: Ontario Marginalization Index (ON-Marg_2006_updated_May_2012.xls).
- ON-Marg data will only be refreshed when its updates become available.

Appendix 15 – Health Status Indicator Correlations

		Health Status Indicators	
		Age Std. Preventable Mortality Rate	Age Std. Preventable PYLL Rate
Service Cost Drivers	Language	-0.14005	-0.16732
	Geography	0.58977	0.65436
Drivers of Need	Recent Immigrants	-0.64667	-0.56995
	Aboriginal	0.67509	0.82904
ON-Marg	Instability	0.32285	0.32039
	Deprivation	0.73253	0.63506
	Ethnic Concentration	-0.68300	-0.60255
	Dependency	0.62069	0.56068
	Age Std. Preventable Mortality Rate	1.00000	0.92232
	Age Std. Preventable PYLL Rate		1.00000

The correlation analysis above discusses indicators that have moderate to high correlations.

- Moderate correlation is from 0.5 to 0.79
- High correlation is from 0.8 to 1

Note: * Highlights in blue indicate moderate correlations (positive or negative)
* Highlights in green indicate strong correlations (positive or negative)

Appendix 16 – Preventable Mortality Rate

Public Health Unit	Age Standardized Preventable Mortality Rate (per 100,000 population)
YORK REGION	62.9
PEEL REGION	76.3
HALTON REGION	78.4
OTTAWA	90.4
TORONTO	91.6
WELLINGTON-DUFFERIN-GUELPH	99.3
WATERLOO REGION	101.1
DURHAM REGION	101.2
RENFREW COUNTY & DISTRICT	102
GREY BRUCE	113.3
PERTH DISTRICT	113.7
MIDDLESEX-LONDON	116.1
KINGSTON, FRONTENAC AND LENNOX & ADDINGTON	117.3
HALDIMAND-NORFOLK	118.5
SIMCOE MUSKOKA DISTRICT	122.8
WINDSOR-ESSEX COUNTY	123.1
HAMILTON	125.1
NIAGARA REGION	126.5
PETERBOROUGH COUNTY-CITY	127.3
HURON COUNTY	129.6
HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT	130.9
LAMBTON	132.2
ELGIN-ST. THOMAS	133.6
EASTERN ONTARIO	134.5
LEEDS,GRENVILLE & LANARK DISTRICT	139.4
CHATHAM-KENT	140.3
OXFORD COUNTY	141.3
NORTH BAY PARRY SOUND DISTRICT	141.8
THUNDER BAY DISTRICT	144.4
HASTINGS & PRINCE EDWARD COUNTIES	149.4
BRANT COUNTY	154
TIMISKAMING	158.1
ALGOMA	159.4
SUDBURY AND DISTRICT	161.9
PORCUPINE	175.4
NORTHWESTERN	192.1

Source: Public Health Ontario. Snapshots: Windsor-Essex County Health Unit: Mortality from preventable causes - age standardized rate (both sexes combined) 2009. Toronto, ON: Ontario Agency for Health Protection and Promotion; 2013 Mar 12 [cited 2013 Apr 30]. Available from: http://www.publichealthontario.ca/en/DataAndAnalytics/Snapshots/Pages/Mortality-from-Preventable-Causes.aspx.

Appendix 17 – Equity Adjustment Factor Scores

PHU	Mandatory Programs
1	3.37
2	2.76
3	2.91
4	2.33
5	3.20
6	2.70
7	2.68
8	2.61
9	2.87
10	2.14
11	2.92
12	2.92
13	2.64
14	2.64
15	2.61
16	2.73
17	2.68
18	2.78
19	3.27
20	4.75
21	2.58
22	2.57
23	2.69
24	2.45
25	2.78
26	4.16
27	2.79
28	2.56
29	3.22
30	3.20
31	3.48
32	3.41
33	2.49
34	2.33
35	2.84
36	2.50

PHU	Unorganized Territories
1	2.85
2	2.70
3	5.09
4	3.81
5	2.28
6	2.70
7	2.80
8	2.86

Note: Public health units were randomized independently in the tables.

Appendix 18 – Public Health Unit Population Estimates (2011)

Public Health Unit	Population
TIMISKAMING	34,449
HURON COUNTY	60,339
PERTH DISTRICT	77,130
NORTHWESTERN	81,942
PORCUPINE	86,701
ELGIN-ST. THOMAS	91,418
RENFREW COUNTY & DISTRICT	102,960
OXFORD COUNTY	108,226
CHATHAM-KENT	108,580
HALDIMAND-NORFOLK	110,709
ALGOMA	117,812
NORTH BAY PARRY SOUND DISTRICT	127,320
LAMBTON	131,415
PETERBOROUGH COUNTY-CITY	140,545
BRANT COUNTY	140,816
THUNDER BAY DISTRICT	156,550
HASTINGS & PRINCE EDWARD COUNTIES	162,713
GREY BRUCE	164,837
LEEDS,GRENVILLE & LANARK DISTRICT	170,163
HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT	179,006
KINGSTON, FRONTENAC AND LENNOX & ADDINGTON	197,335
SUDBURY AND DISTRICT	197,707
EASTERN ONTARIO	201,119
WELLINGTON-DUFFERIN-GUELPH	278,462
WINDSOR-ESSEX COUNTY	403,396
NIAGARA REGION	445,363
MIDDLESEX-LONDON	460,850
HALTON REGION	518,660
SIMCOE MUSKOKA DISTRICT	525,492
WATERLOO REGION	530,248
HAMILTON	540,234
DURHAM REGION	631,270
OTTAWA	909,862
YORK REGION	1,069,780
PEEL REGION	1,365,849
TORONTO	2,743,738

Public Health Unit	Unorganized Territory Population
RENFREW COUNTY & DISTRICT	77
SUDBURY AND DISTRICT	3,196
TIMISKAMING	3,372
NORTH BAY PARRY SOUND DISTRICT	4,965
ALGOMA	6,791
PORCUPINE	8,375
THUNDER BAY DISTRICT	13,809
NORTHWESTERN	23,803

Source: Statistics Canada, Demography Division, customized data and Ministry of Health and Long-Term Care Geographic Conversion File, consgc11.xls.

Appendix 19 – Public Health Funding Model Shares

PHU	Mandatory Programs
1	4.16%
2	0.95%
3	1.10%
4	3.27%
5	1.22%
6	1.68%
7	1.71%
8	24.66%
9	0.91%
10	3.02%
11	0.76%
12	2.93%
13	1.17%
14	3.88%
15	3.26%
16	1.03%
17	0.83%
18	3.54%
19	1.32%
20	7.04%
21	0.73%
22	1.37%
23	0.50%
24	1.26%
25	1.03%
26	1.70%
27	1.36%
28	3.49%
29	9.71%
30	6.19%
31	0.32%
32	1.05%
33	0.65%
34	0.42%
35	1.03%
36	0.76%
Total	**100%**

PHU	Unorganized Territories
1	7.98%
2	5.53%
3	49.84%
4	13.14%
5	0.07%
6	3.55%
7	15.92%
8	3.97%
Total	**100%**

Note: Public health units were randomized independently in the tables.

Appendix 20 – Public Health Funding Model Share Differences (Model Share - 2013 Current Share)

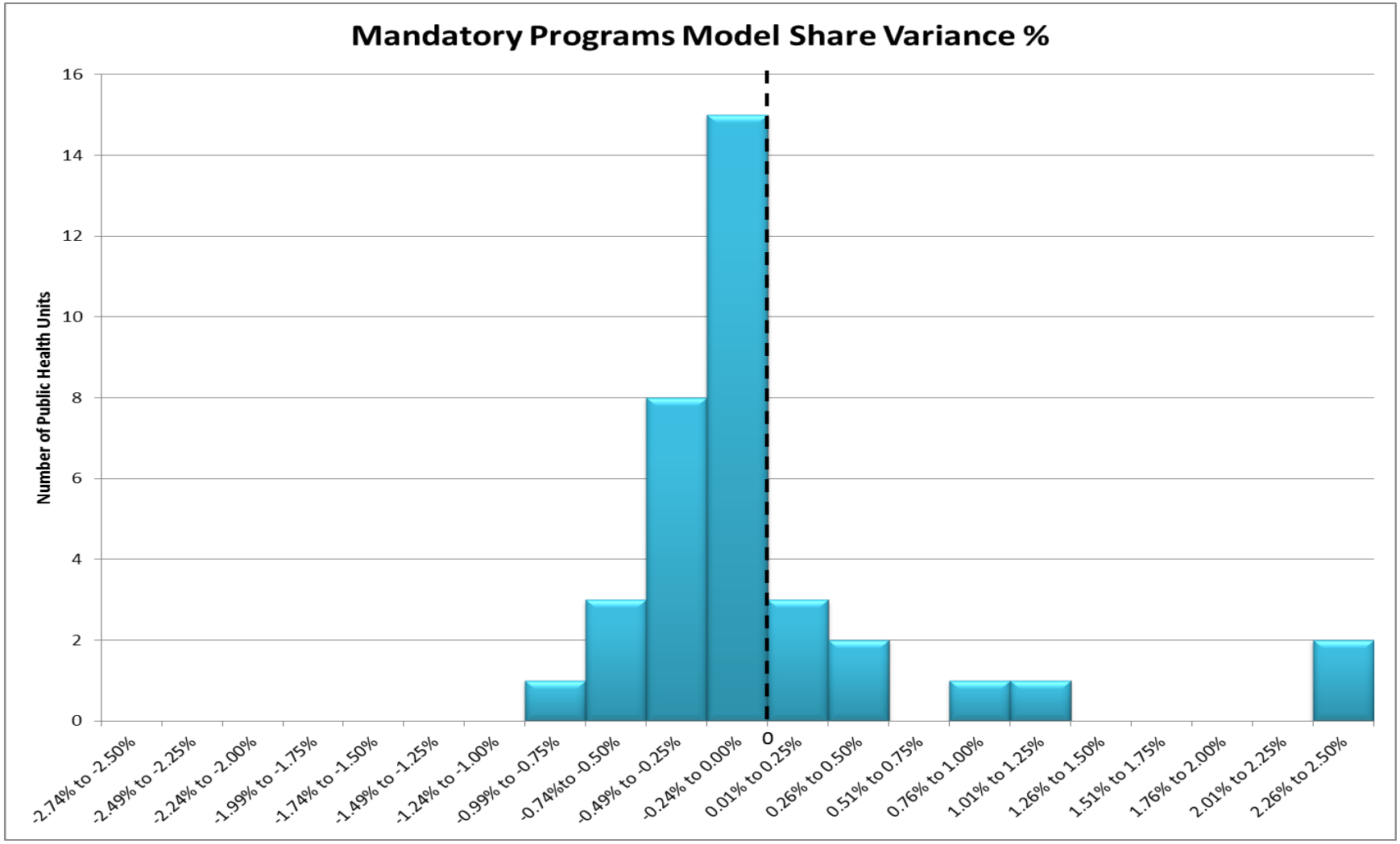
Mandatory Programs		
PHU	**Model Share Variance %**	**Model Share Variance $**
1	-0.19%	-$ 1,033,872
2	0.31%	$ 1,704,295
3	-0.31%	-$ 1,720,128
4	-0.15%	-$ 832,860
5	-0.21%	-$ 1,169,028
6	-0.16%	-$ 882,734
7	2.36%	$ 13,067,975
8	-0.71%	-$ 3,954,668
9	-0.10%	-$ 545,603
10	-0.04%	-$ 249,019
11	0.07%	$ 386,235
12	0.01%	$ 50,132
13	0.07%	$ 403,027
14	-0.14%	-$ 717,908
15	-0.30%	-$ 1,680,994
16	-0.21%	-$ 1,167,233
17	-0.31%	-$ 1,702,881
18	-0.21%	-$ 1,156,071
19	2.28%	$ 12,590,007
20	-0.02%	-$ 91,446
21	-0.20%	-$ 1,111,189
22	-0.21%	-$ 1,138,990
23	-0.25%	-$ 1,414,627
24	-0.56%	-$ 3,086,920
25	1.18%	$ 6,509,864
26	-0.73%	-$ 4,042,022
27	-0.16%	-$ 837,492
28	-0.32%	-$ 1,784,895
29	0.48%	$ 2,677,298
30	-0.95%	-$ 5,296,283
31	0.79%	$ 4,390,166
32	-0.01%	-$ 67,683
33	-0.29%	-$ 1,630,126
34	-0.28%	-$ 1,545,725
35	-0.07%	-$ 409,230
36	-0.45%	-$ 2,509,373

Unorganized Territories		
PHU	**Model Share Variance %**	**Model Share Variance $**
1	-0.86%	-$ 47,113
2	-10.50%	-$ 575,350
3	2.52%	$ 138,336
4	-12.20%	-$ 668,596
5	0.18%	$ 9,853
6	2.65%	$ 145,298
7	1.05%	$ 57,506
8	17.15%	$ 940,065

Note: The Funding Review Working Group is not recommending that budgets be changed by the amounts calculated here. Rather, the tables represent the dollar difference between the provincial grant under the full implementation of the funding model and the current grant. It is recommended that, over time the grant move towards the amount represented by the model share. The model share amount will be adjusted annually based on population changes and EAFs for each public health unit.

Public health units were randomized independently in the tables.

Appendix 20 – Public Health Funding Model Share Differences (Model Share - 2013 Current Share) (cont'd)



7.0 References and Resources

Funding Model Indicators

Variable	Data Source
Geography	Health Analytics Branch, Ministry Health and Long-Term Care (Population estimates July 1, 2011, Census Subdivisions, Ontario; Source: Statistics Canada, Demography Division, customized data and Ministry of Health and Long-Term Care Geographic Conversion File, consgc11.xls)
Language	Statistics Canada. 2007. 2006 Community Profiles. 2006 Census.
Aboriginal	Statistics Canada. 2007. 2006 Community Profiles. 2006 Census.
ON-Marg (Instability)	Ontario Marginalization Index (ON-Marg_2006_updated_May_2012.xls)
ON-Marg (Deprivation)	Ontario Marginalization Index (ON-Marg_2006_updated_May_2012.xls)
ON-Marg (Dependency)	Ontario Marginalization Index (ON-Marg_2006_updated_May_2012.xls)
ON-Marg (Ethnic Concentration)	Ontario Marginalization Index (ON-Marg_2006_updated_May_2012.xls)
Age Standardized Preventable Mortality Rate	Public Health Ontario. Snapshots: Windsor-Essex County Health Unit: Mortality from preventable causes - age standardized rate (both sexes combined) 2009. Toronto, ON: Ontario Agency for Health Protection and Promotion; 2013 Mar 12 [cited 2013 Apr 30]. Available from: http://www.publichealthontario.ca/en/DataAndAnalytics/Snapshots/Pages/Mortality-from-Preventable-Causes.aspx

Deprivation Indices Considered

Indices	Reference
Jarman	JARMAN B. Identification of underprivileged areas. BMJ 1983; 286: 1705-09.
Carstairs	CARSTAIRS V, MORRIS R. Deprivation and Health in Scotland. 1991 Aberdeen University Press.
Townsend	TOWNSEND P. Deprivation. Journal of Social Policy 1987; 16, 2, 125-146
Socio-economic Factor Index (SEFI)	http://mchp-appserv.cpe.umanitoba.ca/viewDefinition.php?definitionID=103587
Deprivation Index, INSPQ	http://www.inspq.qc.ca/santescope/indicedefavoeng.asp?NoIndD=9&Lg=en
General Deprivation Index (GDI)	Langlois, A. and Kitchen, P. (2001) Identifying and measuring dimensions of urban deprivation in Montreal: An analysis of the 1996 census data, Urban Studies, 38(1), pp. 119-139.
Matheson, Moineddin, Glazier	Matheson, F.I., Moineddin, R., & Glazier, R.H. (2008). The weight of place: A multilevel analysis of gender, neighborhood material deprivation, and body mass index among Canadian adults. Social Science and Medicine, 66 (3), 675-690.
ON-Marg g	Overview http://www.torontohealthprofiles.ca/onmarg/additionalResources/OverviewOfONMarg06July2012.pdf User Guide http://www.crunch.mcmaster.ca/documents/ON-Marg_user_guide_1.0_FINAL_MAY2012.pdf FAQ http://www.torontohealthprofiles.ca/onmarg_faq.php#faq6

Indices	Reference
	http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/

Report References & Resources

Report	Reference
Health Protection and Promotion Act	http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90h07_e.htm
Health System Funding Reform	http://health.gov.on.ca/en/pro/programs/ecfa/funding/hs_funding.aspx
Ontario Public Health Standards	http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/
Operation Health Protection	http://www.health.gov.on.ca/en/common/ministry/publications/reports/consumer_04/oper_healthprotection.aspx
Provincial Auditors Reports	2003: http://www.auditor.on.ca/en/reports_en/en03/309en03.pdf 1997: http://www.auditor.on.ca/en/reports_en/en97/310en97.pdf
Resource Allocation: Weighted Capitation Formula, 6th Edition (United Kingdom)	http://www.traffordccg.nhs.uk/Library/Board_Papers/Items_for_Discussion/2009/01_JAN/Item%206.9%20Resource%20Allocation%20-%20Weighted%20Capitation%20Formula.pdf
Revitalizing Ontario's Public Health Capacity: The Final Report of the Capacity Review Committee (May 2006)	http://www.health.gov.on.ca/en/common/ministry/publications/reports/capacity_review06/capacity_review06.pdf

8.0 Acronyms

Acronym	Term
alPHa	Association of Local Public Health Agencies
AMO	Association of Municipalities of Ontario
CAN-Marg	Canadian Marginalization Index
CMA	Census Metropolitan Area
CSD	Census Subdivision
DA	Dissemination Area
EAF	Equity Adjustment Factor
FNIHB	First Nations Inuit Health Branch (Health Canada)
GIS	Geographic Information System
HPPA	Health Protection and Promotion Act
INSPQ	Institut national de santé publique du Québec (INSPQ)
LSR	Local Services Realignment
MOHLTC (or Ministry)	Ministry of Health and Long-Term Care
ON-Marg	Ontario Marginalization Index
OPHS	Ontario Public Health Standards
PHU	Public Health Unit
PYLL	Potential Years of Life Lost
UT	Unorganized Territory(ies)

Ministry of Health and Long-Term Care

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Bureau du directeur général

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393 avenue University, 21e étage
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Division de la Promotion de la santé
777, rue Bay, 19e étage
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September 4, 2015

TO: Chairs, Boards of Health
Medical Officers of Health/Chief Executive Officers, Public Health Units

RE: Update on Public Health Funding Review

As you are aware, the Ministry of Health and Long-Term Care (the "ministry") launched a review of the provincial funding provided to public health units. The review looked at how provincial funding could be allocated in a more equitable, transparent, and accountable manner to support the provision of public health programs and services to all residents in Ontario.

A stakeholder committee, the Funding Review Working Group, was struck in 2010 with a mandate to investigate the current status of public health funding, advise the ministry on a potential public health funding model, and advise the ministry on principles that could guide the implementation of a future public health funding model.

We are pleased to provide you with the attached report, *Public Health Funding Model for Mandatory Programs: The Final Report of the Funding Review Working Group*. The recommendations in the report support the creation of a public health funding model with an "upstream" approach incorporating socio-economic determinants of health. The funding model, which takes into account population as well as equity measures, identifies an appropriate funding share for each public health unit that reflects its needs in relation to all other public health units.

As you may recall, field input sessions were held in January 2013 which provided the Funding Review Working Group with an opportunity to share its draft findings and obtain feedback from the field with respect to the public health funding model. At the field input sessions, the Funding Review Working Group committed to responding to your feedback, which we are also attaching for your information (see **Appendix 1**).

The ministry has accepted the report and recommendations. In 2015, the ministry will begin the process of implementing a new public health funding formula for mandatory programs that improves accountability and transparency of provincial public health funding, aligns public health funding with other ministry funding processes, and supports a more equitable approach to public health funding.

…/2

This year, two per cent growth funding (or approximately $11 million) for mandatory programs will be distributed proportionately to the public health units that have not reached their model-based share. No public health unit's current base funding for mandatory programs will be reduced to minimize disruption to current levels of service provision.

The ministry will also continue to maintain and/or enhance its funding for 75 per cent and 100 per cent provincially funded related public health programs and initiatives, such as increased investments for the Healthy Smiles Ontario Program, Smoke-Free Ontario Strategy, and Unorganized Territories.

The 2015 provincial funding approvals will be announced very shortly. Ministry staff will continue to work with boards of health and public health units to ensure that local and provincial priorities are taken into consideration in all funding decisions. Education and other transitional supports pertaining to the public health funding formula and implementation approach will be provided to assist boards of health and public health units.

We are also pleased to announce that the ministry will be undertaking a review of the Ontario Public Health Standards in an effort to ensure that the standards reflect current practice, are responsive to emerging evidence and priority issues in public health, and are aligned with the government's strategic vision and priorities for public health. The review will be initiated in 2015.

The ministry would like to thank the Funding Review Working Group members who contributed to the findings and recommendations of the report, and for the public health sector for providing input into the development of the funding model.

Should you have any questions and/or require further information, please contact Brent Feeney, Manager, Public Health Standards, Practice & Accountability Branch, at 416-212-6397 or by email at Brent.Feeney@ontario.ca.

Yours truly,

Original signed by

Roselle Martino
Executive Director

Original signed by

Martha Greenberg
Assistant Deputy Minister (A)

Enclosure

c: Business Administrators, Public Health Units
Giuliana Carbone, Deputy City Manager, City of Toronto
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Pat Vanini, Executive Director, Association of Municipalities of Ontario
Dr. David Williams, Chief Medical Officer of Health (A)
Paulina Salamo, Director (A), Public Health Standards, Practice & Accountability Branch
Laura Pisko, Director, Health Promotion Implementation Branch

10b) Attachment

PublicHealth
WELLINGTON-DUFFERIN-GUELPH
Stay Well.

September 10, 2015

VIA E-MAIL

Ministry of Municipal Affairs & Housing
777 Bay Street, 17th Floor
Toronto, ON M5G 2E5

Attention: Mr. Ted McMeekin, Minister

Ministry of Health and Long-Term Care
Public Health Division
393 University Ave., Suite 2100
Toronto, ON M5G 2M2

Attention: Dr. Eric Hoskins, Minister

Dear Minister McMeekin & Minister Hoskins:

Re: Request for Changes to the *Municipal Act* to Authorize the Use of Electronic Means of Participation of Local Boards and Committees of Local Boards

The Board of Health for the Wellington-Dufferin-Guelph Health Unit (WDGPH) is a large autonomous Board of Health with a geographic area covering 4,142Km^2, which includes the County of Wellington, the County of Dufferin and the City of Guelph. Due to this large geography, and sometimes severe weather conditions, the WDGPH Board of Health considered how best to fulfil its governance obligations with respect to attendance at Board of Health meetings.

Boards of Health are considered a local board under the *Municipal Act* and the *Act* does not provide for electronic participation at meetings. A letter dated June 30, 2015, from David L. Mowat, the Interim Chief Medical Officer of Health, identified that in order for WDGPH to use electronic participation for meetings, the *Municipal Act* needs to be amended (see attached). Therefore, WDGPH has passed a Resolution (see attached) requesting that the *Act* be amended to specifically authorize the use of electronic means of participation at meetings of local boards and committees of boards with prescribed measures in place.

…/2

160 Chancellors Way, Guelph, ON N1G 0E1
Telephone: 519-822-2715 | **Fax:** 519-836-7215 | **www.wdgpublichealth.ca**

Public health emergencies may occur at any time and require Boards of Health to be able to convene a quorum and make decisions in a timely manner. Severe weather conditions within the Province of Ontario can also negatively impact the ability of a board to convene a quorum for regularly scheduled meetings which are necessary for Boards of Health to fulfill their legislative obligations. Large geographic distances also means that members of the public are not equally able to access open session Public Health meetings.

Electronic communication strategies continue to advance and are the preferred method of communication for business, education and Ontario youth. Additionally, many public and not-for-profit boards within the Province of Ontario are successfully utilizing electronic communication including; LHIN Boards, Boards of Education and Hospital Boards.

Electronic participation does not preclude public access and closed session content can be secured with encryption technologies. By specifically authorizing local boards to use electronic participation with prescribed measures in place this could increase public access and decrease some of the geographic and environmental challenges facing local boards of health.

Thank you in advance for your consideration of this matter.

Yours very truly,

Doug Arnold,
Chair, WDGPH Board of Health

Attachments (Letter of June 30/15 + Resolution)

c.c. Deputy Minister of Health (MOHLTC) – via e-mail
c.c. Chief Medical Officer of Health (MOHLTC) – via e-mail
c.c. Association of Municipalities of Ontario – via e-mail
c.c. Ontario Public Health Units (BOH Chairs) – via e-mail
c.c. Association of Local Public Health Agencies (alPHa) – via e-mail
c.c. Ted Arnott, MPP (Wellington-Halton Hills) – via e-mail
c.c. Liz Sandals, MPP (Guelph) – via e-mail
c.c. Sylvia Jones, MPP (Dufferin-Caledon) – via e-mail
c.c. Randy Pettapiece, MPP (Perth-Wellington – via e-mail

Ministry of Health and Long-Term Care

Chief Medical Officer of Health

Public Health Division
21st Floor, 393 University Avenue
Toronto ON M7A 2S1

Telephone: (416) 212-3831
Facsimile: (416) 325-8412

Ministère de la Santé et des Soins de longue durée

Médecin hygiéniste en chef

Division de la santé publique
393 avenue University, 21e étage
Toronto ON M7A 2S1

Téléphone: (416) 212-3831
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June 30th, 2015

Dr. Nicola Mercer, Medical Officer of Health, CEO
Wellington Dufferin Guelph Public Health
160 Chancellors Way,
Guelph, ON N1G 0E1

Dear Dr. Mercer:

RE: Proposed Changes to the Board of Health for the Wellington-Dufferin-Guelph Health Unit (WDGPH) By-Laws

Thank you for your letter of June 15th 2015, informing us of the proposed bylaw permitting electronic participation in committee meetings, and also for a copy of By-Law no. 1. We are only addressing the issue of electronic participation.

Legal Services of MOHLTC has consulted with their counterparts in MMAH concerning the requirements of the *Municipal Act*. We have been advised that the proposed approach is not consistent with that Act, which requires meetings to be open to the public. The *City of Toronto Act* has an exception that allows for electronic participation at board meetings. There is no similar exception in the *Municipal Act*. Boards of Health are defined as local boards for purposes of the *Municipal Act*. No distinction is made between board meetings and committee meetings.

We have no objection to the substance of your proposal, only its feasibility in law. You may wish to advocate for a change in the Act to permit electronic participation. In this case, I suggest that the most effective course would be to engage alPHa to request that the MOHLTC approach MMAH to propose a statutory change to the Municipal Act.

Yours truly,

David L. Mowat, MBChB, MPH, FRCPC
Interim Chief Medical Officer of Health

PublicHealth
WELLINGTON-DUFFERIN-GUELPH
Stay Well.

Support for Boards of Public Health Using Electronic Participation at Meetings

SPONSOR: Board of Health for the Wellington-Dufferin-Guelph Health Unit (WDGPH).

WHEREAS Boards of Health are required to meet on a regular basis to fulfill their obligations under the *Health Protection and Promotion Act* and Ontario Public Health Organizational Standards;

AND WHEREAS Boards of Health are also considered a local board under the *Municipal Act*;

AND WHEREAS the *Municipal Act* neither prohibits nor provides for electronic participation at meetings;

AND WHEREAS Boards of Health are comprised of appointees from the municipalities that legislatively govern the Board of Health;

AND WHEREAS many Boards of Health are composed of large geographic areas;

AND WHEREAS appointees to Boards of Health may have to travel long distances to attend Board of Health meetings or Standing Committee meetings of Boards of Health;

AND WHEREAS winter weather conditions make driving hazardous in many parts of the Province; and

AND WHEREAS public health emergencies may occur at any time and require Boards of Health to be able to convene a quorum and make decisions in a timely and occasionally on an emergency basis;

AND WHEREAS electronic participation does not preclude public accessibility to meetings;

AND WHEREAS security of electronic participation for Closed Session matters can be ensured by encryption and hardware technologies;

AND WHEREAS many public and not-for-profit boards within the Province of Ontario, including hospital boards, LHIN boards, Boards of Education, and not-for-profit corporations incorporated under the Canada Not-for-profit Corporations Act and the Ontario Corporations Act are currently utilizing electronic participation at meetings successfully;

AND WHEREAS communication technologies continues to advance and be the preferred method of communication for business and education;

NOW THEREFORE BE IT RESOLVED THAT the Board of Health for the Wellington-Dufferin-Guelph Health Unit (WDGPH) requests that the Ontario Ministry of Municipal Affairs amend the *Municipal Act* to specifically authorize the use of electronic means of participation at meetings of local boards and committees of boards, with the following prescribed measures in place:

1. Public participation and access shall be ensured throughout any public meeting of a local board or committee of a board using electronic participation;
2. Encryption technologies shall be utilized to secure the content of information using electronic participation for Closed Session matters;
3. Policies and Procedures for electronic participation shall be publicly posted;
4. Notices and minutes of meetings using electronic participation shall clearly indicate the method of participation for attendees;
5. All participants in a meeting which includes electronic participation shall be able to communicate instantaneously and simultaneously with each other;
6. Participants who attend a meeting by electronic means shall be deemed to be present, shall be counted for quorum, and shall be eligible to vote on all matters before the board.

BE IT FURTHER RESOLVED THAT the Minister and Deputy Minister of Health and Long-Term Care, the Chief Medical Officer of Health, Association of Municipalities of Ontario and all Boards of Health within the Province are so advised.

The Children's Rehabilitation Centre Algoma Board of Directors is pleased to host this year's Board Development Workshop:

Equipping Your Board for Governing in a Shared Service Environment
Saturday, October 24, 2015
9:00 am to 3:00 pm
Quattro Conference Centre
229 Great Northern Road

Background
Several non-profit organizations delivering children's mandated and non-mandated services in Algoma, have engaged in "all Boards" training over the past several years. They include:

- Algoma Family Services,
- Algoma Public Health,
- Child Care Algoma,
- Children's Aid Society of Algoma,
- Children's Rehabilitation Centre Algoma,
- Community Living Algoma,
- Nog-Da-Win-Da-Min Family & Community Services,
- Superior Children's Centre.

The agencies rotate responsibility for organizing the board development and this year, Children's Rehabilitation Centre Algoma (CRCA) has this responsibility.

Topic & Objectives
This year's session is an opportunity to engage in a generative dialogue regarding how governance is evolving in an increasingly collaborative environment. These days more agencies and their boards are interested in the considerations behind or leading to strategic alliances, shared services and integrated service delivery models. This is a trend as funders and the public expect more seamless service delivery and coordination amongst providers.

This inter-dependency raises some unique and new challenges at the governance level. This session will explore the system pressures leading to increased collaboration and integration, and what these arrangements are intended to achieve. We will examine governance in the context of the Integrated Service Delivery system and will consider:

- types of relationships and connections along a continuum of integration;
- good questions for directors to ask in order to critically and ethically analyze these types of opportunities and situations to make *go/no go* decisions and/or to create conditions for success (towards a model for good decision-making);
- the impact on oversight – financial, quality and organizational performance, and
- ways to optimize the potential of these relationships and service integrations.

The objectives of the session are to assist participants to:

- Understand the nature of interdependency with other agencies regarding the achievement of outcomes
- Discuss the nature of any agency's board role in this environment
- Identify governance-level questions to ask in decision-making

- To discuss whether and how an agency in the Lead Agency role in a collaboration creates *shared* governance requirements and what these might look like
- Set out opportunities for improved oversight of collaborative ventures.

This session is open to Board Directors and agency Chief Executive Officers/Executive Directors. Space permitting, additional senior leadership may be able to participate.

Agenda for the day:

9:00 Morning – *Welcome & Introductions*
Mapping types of relationships and connections for the participants and along a continuum of integration
Exploring Delegated/Mutual Accountability in Integrated Service Delivery • How would you know a situation is not working? What would be the signs and symptoms? • How do you know that things are going well? What would be the indicators?
Creating governance requirements for a healthy performing relationship with another organization: Decision-making model - creating a checklist - questions governors ask prior to engagement, elements to put into place to support success, what is monitored (and by whom) to know the delegated accountabilities are working
LUNCH (provided)
12:45 Afternoon – *Case Study Situations*
Emerging Guiding Principles for Governance of Delegated/Mutual Accountability in Integrated Service Delivery
2:30 *Closing Comments*

Cost-Sharing

As has been the practice previously, the cost of the presenter and workshop food/refreshments will be shared across all participating agencies. We estimate this year's costs to be similar to last year's Board Development session hosted by the Children's Aid Society of Algoma – approximately $1000.00 per participating agency and approximately $40/participant for workshop food/refreshments.

About Lyn McDonell…

Ms. McDonell's bio is attached.

Please RSVP Monique Anich at manich@crcalgoma.ca with the anticipated number of participants by September 25, 2015. Thank you.

Lyn McDonell

Lyn McDonell leads The Accountability Group by bringing experience, skill, diplomacy, and commitment to every client organization and its unique context.

About Lyn

Lyn McDonell is a governance, strategy and organizational effectiveness consultant. She is a Certified Association Executive (CAE), a Chartered Director (C. Dir) and a Certified Management Consultant (CMC).

Lyn has deep hands-on leadership experience gained from senior positions in provincial and national Canadian not-for-profit organizations as Executive Director, COO and CEO. As COO of the Canadian Diabetes Association (CDA), Lyn helped a board task force lead governance change. That initiative later earned the CDA the Conference Board of Canada/Spencer Stuart 2005 National Award for Not-for-Profit Governance. As CEO of the Canadian Breast Cancer Foundation, Lyn gained experience in a dynamic multi-level organization that joined grassroots motivation and governance, corporate sponsorship support, and caring Canadians.

Lyn earned her Masters of Arts (MA) in organizational development focusing on the life cycle of organizations. She has specialized training in strategy development gained from the Advanced Strategy Executive Program of the Richard Ivey School of Business (University of Western Ontario) and the USA-based Balanced Scorecard Collaborative/The Palladium Group. She knows how to develop and map sound strategy using the Balanced Scorecard method.

Lyn has developed a special interest and expertise in quality oversight and brings new perspectives on this important aspect of accountability to boards seeking to assure themselves of optimal organizational performance and impact. Approaches and techniques learned from the Institute of Healthcare Improvement in the US can be applied across every sector to improve results and assure performance.

In governance, Lyn earned her professional designation (Chartered Director - C.Dir.) from The Directors College, accredited by McMaster University.

Lyn is Vice-Chair of the board of Canada's largest urban community hospital, The Scarborough Hospital, and Chair of its Performance Monitoring and Stewardship Committee. She also serves on the Not-for-Profit Organizations Task Force of The Canadian Institute of Chartered Accountants (CICA), contributing advice regarding its publications on governance. Lyn is Co-Chair of Scarborough - Governance Advisory Council for the Central East LHIN. Lyn is a member of BoardSource and the Canadian Society of Association Executives.

Lyn works with her own clients and provides consulting support to the clients of Leader Quest Inc., Humber Corporate Education, and the Association Resource Centre.

http://www.theaccountabilitygroup.com/

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-065
DATE:	O: June 17, 2015 R:	**SECTION:**	Board
PAGE:	1 of 2	**SUBJECT:**	Algoma Board of Health Reserve Fund

Purpose

To provide guidance on the establishment, maintenance, and use of a reserve fund.

Policy

The Board of Health for the Algoma Public Health has established reserves as follows:

Background:

The Health Protection and Promotion Act (the "Act") requires, in section 72(1), that the expenses incurred by or on behalf of a Board of Health and the Medical Officer of Health/Chief Executive Officer in the performance of their functions and duties under the Act or any other act shall be borne and paid by the Municipalities in the health unit served by the Board of Health.

Section 72(5)(1) of the Act requires the Board of Health to cause the preparation of an annual estimate of expenses for the next year. Such estimate of expenses may from time to time be too high or too low resulting in an excess or a shortfall respectively of funds paid by the Municipalities.

The Board of Health considers it prudent and expedient to establish reserve funds, which include reserves, into which, inter alia, any excess funds received in any year be paid to be applied to cover any shortfall of funds in future years.

Section 417(1) of the Municipal Act empowers the Board of Health in each year to provide in its estimate of expenses for the establishment or maintenance of a reserve fund for any purpose for which it has authority to expend funds.

Section 417(2) of the Municipal Act only requires the approval of the Councils of the majority of the Municipalities in a health unit for the establishment and maintenance of a reserve fund if the Board of Health is required to obtain such approval for capital expenditures.
Section 52(4) of the Act only requires the Board of Health to seek the approval of the Councils of the majority of Municipalities in a health unit for capital expenditures made to acquire and hold real property.

To obviate the need to seek the approval of the Councils of the majority of the Municipalities in the Algoma Health Unit to establish and maintain a reserve fund, the reserve fund will contain a restriction that the funds therein shall not be used for capital expenditures to acquire real property without first obtaining the approval of the Councils of the majority of the Municipalities in the Algoma Health Unit as required by section 52(4) of the Act.

Motion: 2015-91 ALGOMA BOARD OF HEALTH UNIT RESERVE FUNDS

THEREFORE BE IT RESOLVED THAT

1) The Board of Health forthwith establish and maintain reserve funds for Working Capital, Human Resources Management, Public Health Initiatives and Response, Corporate Contingencies, and Facility and Equipment Repairs and Maintenance; and,
2) The reserve funds shall be used and applied only to pay for expenses incurred by or on behalf of the Board of Health and the Medical Officer of Health in the performance of their functions and duties under the Health Protection and Promotion Act or any other Act; and,
3) None of the reserve funds shall be used or applied for capital expenditures to acquire and hold real property unless the approval of the Councils of the majority of the Municipalities in the Algoma Health Unit have been first obtained pursuant to section 52(4) of the Act; and,
4) The Board of Health in each year may provide in its estimates for a reasonable amount to be paid into the reserve funds provided that no amount shall be included in the estimates which is to be paid into the reserve funds when the cumulative balance of all the reserve funds in the given year exceeds 15 percent of the regular operating revenues for the Board of Health approved budget for the mandatory cost shared programs and services; and,
5) All lease revenues, received by the Board of Health under leases of part of its premises, in excess of the actual operating costs attributable to the leased premises, shall be paid annually into the reserve funds; and,
6) Any over-expenditures in any year shall be paid firstly from the reserve funds and only when the reserve funds shall have been exhausted will the Board of Health seek additional funds from the Municipalities to pay for such over-expenditures; and,
7) Any excess revenues in any year resulting from an over estimate of expenses shall be paid into the reserve funds; and,
8) The Medical Officer of Health/Chief Executive Officer shall in each year direct the allocation of excess funds to such reserve fund or funds as the Medical Officer of Health shall decide; and,
9) The Medical Officer of Health/Chief Executive Officer shall be entitled to transfer funds from one reserve fund to another reserve fund at any time and from time to time.

The Medical Officer of Health/Chief Executive Officer shall be responsible for the management of the reserves in accordance with respective Board of Health motions and Board By-law 2015-1.

The approval of the Board of Health shall be required for any transfers from the Board’s reserves that constitute part of the annual budget approval process or that are in excess of $50,000 per transaction.

APPROVED BY:	Board of Health	**BY-LAW #:**	95-2
DATE:	O: December 13, 1995 R: June 17, 2015	**SECTION:**	Board
PAGE:	1 of 2	**SUBJECT:**	To Provide for Banking and Finance

The Board enacts as follows:

1. In this By-law:

a) "Act" means the Health Protection and Promotion Act, S.O. Ontario 1983, Chapter 10 as amended.

b) "Board" means the THE BOARD OF HEALTH FOR THE DISTRICT OF ALGOMA HEALTH UNIT.

2. Signing Authorities:

a) The Board will maintain a formal list of names, titles and signatures of those individuals who have signing authority.

b) Signing authorities for all accounts shall be restricted to:

i) the Chair of the Board of Health
ii) one other Board member, designated by Resolution
iii) the Medical Officer of Health/Chief Executive Officer
iv) the Chief Financial Officer

c) All cheques issued shall have two signatures from the list above in 2b).

3. Budgets and Accounts:

a) The Medical Officer of Health/Chief Executive Officer shall:

i) ensure that all annual budgets are prepared and presented to the Board in accordance with all Board and Ministries guidelines;

ii) have over-all responsibility for the control of expenditures as authorized by Board and Ministry approvals of the individual annual budgets under the jurisdiction of the Board;

iii) ensure the security of all funds, grants and monies received in the course of provision of service by the programs under the jurisdiction of the Board; and

iv) ensure that all reports are prepared and distributed to the appropriate bodies, in accordance with established Board and Ministry(ies) guidelines.

b) The Chief Financial Officer shall:

i) prepare, or ensure the preparation of, all annual budgets under the jurisdiction of the Board for submission to the Board;

ii) control, or ensure control of, expenditures as authorized by Board and Ministry approvals of the individual annual budgets under the jurisdiction of the Board;

iii) secure, or ensure the security of, all funds, grants and monies received in the course of provision of service by the programs under the jurisdiction of the Board;

iv) prepare, or ensure the preparation of, financial and operating statements for the Board and for the appropriate Ministries or agencies, in accordance with established Ministry policies, indicating the financial position of the Board with respect to the current operations of all programs under the jurisdiction of the Board;

v) maintain and secure, or ensure the maintenance and security of, the books of account and accounting records of the Board required to be kept by the laws of the Province;

vi) arrange, or ensure the arrangement, for an annual audit of all accounting books and records, in conjunction with the Auditor;

vii) Register the Health Unit as a charitable organization and follow the legal requirements associated therewith,

viii) report to the Board on all financial and banking matters initiated by the Chief Executive Officer;

ix) reconcile all balances with the appropriate Ministries upon receipt of final year end settlements; and

x) enter into an agreement with a recognized chartered bank or trust company which will provide the following services”

1. Current accounts
2. provision of monthly bank statements
3. payment of interested or surplus funds held at the institution
4. payroll services, as needed
5. lending of money to the Board, as required

xi) perform other duties as the Board may direct.

Enacted and passed by the Algoma Health Unit Board this 13th day of December 1995.

Original signed by
I. Lawson, Chair
G. Caputo, Vice-chair

Revised and passed by the Algoma Health Unit Board this 18th day of November 1998
Revised and passed by the Board of Health for Algoma Public Health this 17th day of June 2015

Algoma Public Health GENERAL ADMINISTRATIVE – Policies and Procedures Manual

APPROVED BY:	Board of Health	**BY-LAW #:**	95-3
DATE:	O: December 13, 1995 Revised: June 17, 2015 R:	**SECTION:**	Board
PAGE:	1 of 1	**SUBJECT:**	To Provide for the Duties of the Auditor of the Board of Health

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The Board of Health for the District of Algoma Health Unit enacts as follows:

1. In accordance with the Health Protection and Promotion Act and the Municipal Act, the Board shall, appoint an Auditor who shall not be a member of the Board and shall be licensed under the Public Accountancy Act.

2. The Auditor shall:

    a) audit the accounts and transactions of the Board;

    b) perform such duties as are prescribed for the Auditor by the Health Protection and Promotion Act; by the Ministry of Municipal Affairs with respect to local Boards under the Municipal Act and the Municipal Affairs Act;

    c) perform such other duties as may be required by the Board;;

    d) have the right of access at all reasonable hours to all books, records (with signed consent, if consent is required under the Municipal Freedom of Information and Protection of Privacy Act), documents, accounts and vouchers of the Board; the auditor is entitled to require from the members of the Board and from the Officers of the Board such information and explanation as in his or her opinion may be necessary to enable him to carry out such duties as are prescribed under the Health Protection and Promotion Act;

    e) be entitled to attend any meeting of members of the Board that concerns him or her as auditor and to receive all notices relating to any such meeting that any member is entitled to receive and to be heard at any such meeting that he or she attends. .

Enacted and passed by the Algoma Health Unit Board this 13th day of December 1995.

Original signed by
I Lawson, Chair

Original signed by
G. Caputo, Vice-chair

Reviewed and passed by the Board of Health for Algoma Public Health this 17th day of June, 2015

APPROVED BY:	Board of Health	**BY-LAW #:**	2015-01
DATE:	O: June 17, 2015	**SECTION:**	Board
PAGE:	1 of 2	**SUBJECT:**	To Provide the Management of Property of the Board of Health

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The Board of Health for the District of Algoma Health Unit enacts as follows:

1. The Board shall acquire and hold title to any real property acquired by the by the Board for the purpose of carrying out the functions of the Board and may sell, exchange, lease, mortgage or otherwise charge or dispose of real property owned by it in accordance with the Act [Health Protection and Promotion Act R.S.O. 1990, c.H.7, s.52(3)].

2. Clause 1 is subject to the requirement that the Board of Health first obtain the consent of the councils of the majority of the municipalities within the Health Unit served by the Board of Health [Health Protection and Promotion Act R.S.O. 1990, c.H.7,s 52(4);2002, c. 18, Sched I.s.9(8)].

3. Prior to the sale of any real property owned by the Board of Health, the Board shall,

    a. By by-law or resolution passed at a meeting open to the public, declare the real property to be surplus;
    b. Obtain not more than one(1) year before the date of sale at least one appraisal of the fair market value of the real property from such person as the Medical Officer of Health/Chief Executive Office considers qualified

4. Notice to the public of a proposed sale of real property owned by the Board of Health shall be given prior to the date of the sale by publication in a newspaper that is of sufficiently general paid or unpaid circulation within the Health Unit area to give the public reasonable notice of the proposed sale.

5. Despite the requirement of clause 3(b) of the by-law, and subject to the requirements of clause 2, the Board of Health may sell any real property owned by it to any one of the following classes of public bodies without first obtaining an appraisal:

    a. Any municipality within the Health Unit served by the Board of Health;
    b. A local board as defined in the Health Protection and Promotion Act.
    c. The Crown In Right of Ontario or of Canada and their agencies.

6. The Medical Officer of Health/Chief Executive Officer shall establish and maintain a public register listing and describing all real property owned or leased by the Board and which should, to the extent that is reasonable possible, include the following information:
    a. A brief legal description of the property
    b. The assessment roll number of the property;
    c. The municipal address or the real property, if available;
    d. The date of purchase;

e. The name of the person to whom the property was purchased;
f. The instrument number of the transfer or deed by which title was transferred to the municipality;
g. The purchase price of the real property;
h. A brief description of improvements, if any, on the real property;
i. The date of the sale of the property;
j. The name of the person to whom the property was sold;
k. The sale price of the real property.

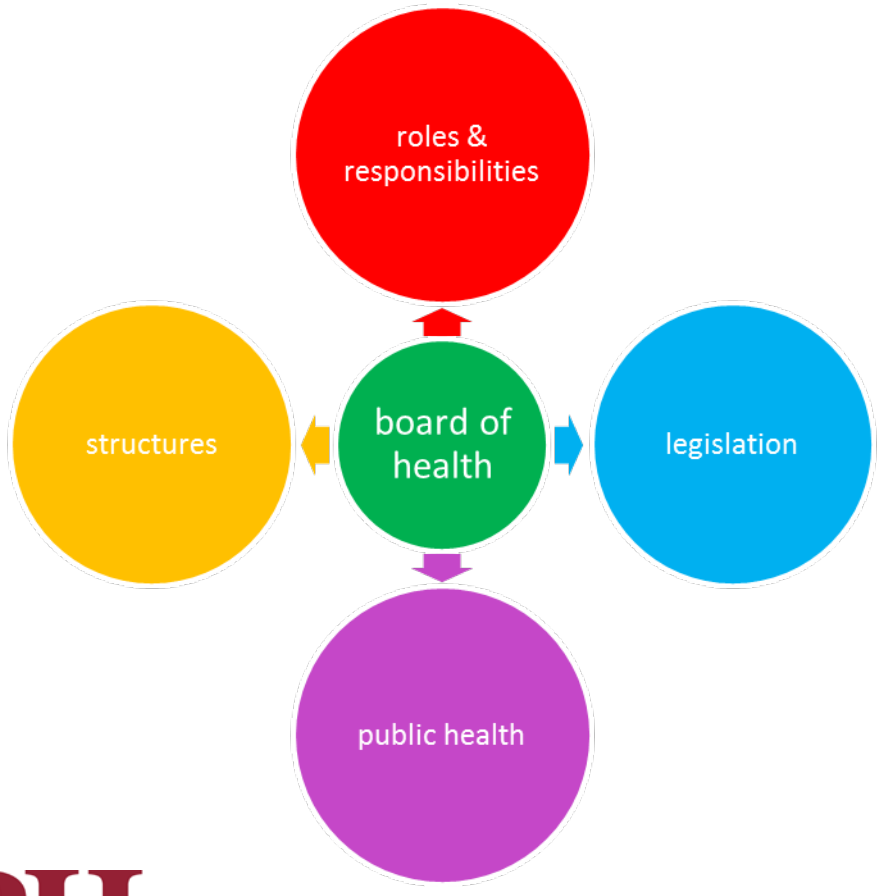
7. The CFO/Director of Operations through the Medical Officer of Health/Chief Executive Officer shall be responsible for the care and maintenance of all properties required by the Board

8. Such responsibility shall include, but shall not be limited to, the following:
    a. The replacement of , or major repairs to, capital items such as heating, cooling and ventilation systems; roof and structural work; plumbing; lighting and wiring;
    b. The maintenance and repair of the parking areas and the exterior of the building;
    c. The care and upkeep of the grounds of the property;
    d. The cleaning, maintaining, decorating and repairing the interior of the building;
    e. The maintenance of up-to-date fire and liability insurance coverage.

9. The Board shall ensure that all such properties comply with applicable statutory requirements contained in either local, provincial or federal legislation (e.g. building and fire code).

Read a first and second time this 17th day of June 2015.

2015
ORIENTATION MANUAL
FOR
BOARDS OF HEALTH



alPHa
Association of Local
PUBLIC HEALTH
Agencies

2015 Orientation Manual for Boards of Health

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Preamble to the 2015 Edition

The Association of Local Public Health Agencies (alPHa) is pleased to provide the 2015 edition of the Orientation Manual for Boards of Health. The manual brings together in one place key information for board of health (BOH) members. A quick perusal of the Table of Contents will give you a sense of the areas covered by the manual. It includes information about public health and public health units; the structures, roles and responsibilities of boards of health; and relevant legislation.

The preamble to the 2011 edition included information that is important to review as the provincial and local responses to public health events since the year 2000 played a significant role in shaping the public health system in Ontario today.

Prior to the outbreak of Severe Acute Respiratory Syndrome (SARS) in 2003, the public health system in Ontario had been tested by the 2000 outbreak of E. coli O157:H7 in Walkerton, the emergence of West Nile virus and some well-publicized food safety issues. While each event was used as evidence to support calls for improvements to an under-funded public health system that was consistently operating below its mandated standards, it was the 2003 outbreak of SARS that was the wake-up call that prompted several reviews that included the capacity of the sector to respond to public health emergencies.

The recommendations of three reports; the Ontario Expert Panel on SARS and Infectious Diseases (Walker), the National Advisory Committee on SARS and Public Health (Naylor), and the SARS Commission (Campbell), identified serious systemic deficiencies resulting from years of political neglect in the structures that provide the programs and services that protect and promote health, prevent disease and monitor community health.

The provincial government responded to these reviews by launching *Operation Health Protection: An Action Plan to Prevent Threats to our Health and to Promote a Healthy Ontario* in 2004 which introduced a number of policy and funding changes. Also, the *Final Report of the Capacity Review Committee, Revitalizing Ontario's Public Health Capacity*, released in May of 2006, included 50 recommendations for the public health work force, accountability, governance and funding, strengthening local service delivery, research and knowledge exchange, strategic partnerships and next steps for Ontario's 36 local health units. An important outcome of the Capacity Review Committee recommendations was the replacement of the outdated *Mandatory Health Programs and Services Guidelines* with the 2008 *Ontario Public Health Standards*, a comprehensive set of evidence-based guidelines for the provision of public health services.

The Walker, Naylor and Campbell reports also included recommendations regarding the creation of a public health agency for Ontario with the mandate to focus on the provision of scientific and technical support to the government, public health units and front-line health care workers. In 2007, Public Health Ontario (formerly called the Ontario Agency for Health Protection and

Promotion) was established to provide on-going professional development to public health professionals and evidence to support public health programs and services.

Since the last edition of this orientation manual in 2011, the Ministry of Health and Long-Term Care has released its *Ontario Public Health Organizational Standards* for boards of health in Ontario. The standards focus on the governance of public health units and complement the *Ontario Public Health Standards* which focus on programs and services.

In 2011, the first accountability agreements between BOHs and the Ministry of Health and Long-Term Care were put in place. These three-year agreements included performance indicators with performance targets that were established with each BOH. Initially, the indicators focused on the program-based *Ontario Public Health Standards* and in 2012 reporting on the governance-based Organizational Standards was added.

At the provincial level, the Minister of Health and Long-Term Care released the *Ontario Action Plan for Health Care* in 2012 with the goal "to make Ontario the healthiest place in North America to grow up and grow old". The Action Plan includes a focus on helping people stay healthy through promoting healthy habits and behaviours, supporting lifestyle changes and better management of chronic conditions. This focus led to the formation of the Healthy Kids Council which produced 23 recommendations to combat childhood obesity in their report *No Time to Wait: The Healthy Kids Strategy*. The report also included 12 actions to move the recommendations forward.

The Action Plan is just one way that the Ontario Government has acknowledged the pressing need to place more emphasis on promoting a healthy population. In 2005, the Ministry of Health Promotion and Sport (initially called Health Promotion) was created to focus on programs dedicated to healthy lifestyles. In 2012, this Ministry was dissolved and its health promotion programs and activities were transferred to the newly created Health Promotion Division within the Ministry of Health and Long-Term Care. In 2014, following the provincial election, the Associate Minister of Health and Long-Term Care (Long-Term Care and Wellness) was added to the Ontario Cabinet.

Since the implementation of the *Ontario Public Health Standards*, public health programs and services have included a stronger focus on the social determinants of health. It has been more formally recognized that the health of individuals and communities is significantly influenced by complex interactions between social and economic factors, the physical environment, and individual behaviours and conditions. The *Ontario Public Health Standards* incorporate and address the determinants of health throughout, and include a broad range of population-based activities designed to promote the health of the population and reduce health inequities by working with community partners.

Social Determinants of Health

- Income and social status
- Social support networks
- Education and literacy
- Employment/working conditions
- Social and physical environments
- Personal health practices & coping skills
- Healthy child development
- Biology and genetic endowment
- Health services
- Gender
- Culture
- Language

Introduction

Purpose

The alPHa Board of Health Orientation Manual has been prepared to provide new Board members with background information on public health in Ontario. It provides useful contextual information that relates to the functioning of a BOH. It includes information about public health and public health units; the structures, roles and responsibilities of boards of health; and relevant legislation. BOH policies specific to a public health unit or health department are not covered as each organization will have its own set of standards under which the BOH functions. A companion document titled, *Governance Toolkit for Ontario Boards of Health*, provides boards of health with practical tools and templates to help them govern more effectively.

What is Public Health?

Public health is the science and art of protecting and improving the health and well-being of people in local communities and across the country. It focuses on the health of the entire population or segments of it, such as high-risk groups, rather than individuals. Public health uses strategies to protect and promote health, and prevent disease and injury in the population. Because a population-based approach is employed, public health works with members of communities and community agencies to ensure long-term health for all.

Public health is what we, as a society, do collectively to assure the conditions in which people can be healthy.

Public health:

- *protects* health by controlling infectious diseases through regulatory inspections and enforcement, and by preventing or reducing exposure to environmental hazards;
- *promotes* health by educating the public on healthy lifestyles, working with community partners, and advocating for public policy that promotes a healthy population; and
- *prevents* disease and injury by the surveillance of outbreaks, screening for cancer, immunization to control infectious disease, and conducting research on injury prevention.

In Ontario, public health programs and services are delivered in communities by the 36 local health units, each of which is governed by a BOH.

History of Health Units in Ontario

The pattern of local public health services administration for Ontario was established in 1833 when the Legislature of Upper Canada passed an Act allowing local municipalities "*to establish Boards of Health to guard against the introduction of malignant, contagious and infectious disease*

in this province." This delegation of public health responsibility to the local level established 150 years ago has persisted to the present day. There are currently 36 BOHs in Ontario: 25 independent of local municipal government; 7 regional health departments; and 4 boards established under a city-specific act with municipal administration.

Important Milestones

1873 The first *Public Health Act* was passed.

1882 The first board of health was established.

1884 A more comprehensive *Public Health Act* was prepared by Dr. Peter B. Bryce. This Act established the position of the medical officer of health and the relationship with the board of health. Within two years of passage, 400 boards of health were in operation.

1912 The *Public Health Act* was amended so that health units could be established on a county basis.

1934 The first county-wide health unit was established with a grant from the Rockefeller Foundation. It included the four eastern counties of Stormont, Dundas, Glengarry, and Prescott. At this time, Ontario had 800 local boards of health and 700 medical officers of health, most of whom were part-time.

1945 The *Public Health Act* was amended so that provincial grants could be provided to municipalities for the establishment of health units. Six health units were in place by the end of 1945.

1948 The World Health Organization defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".

1950 Twenty-five county and 12 municipal health units were in place which served two thirds of the population of Ontario.

1965 Fifty-four boards of health were in place, which served 95 percent of the population.

1967 The *Public Health Act* was amended so that organized municipalities were required to provide full-time public health services. The District health unit concept was introduced based on the collective experience of operating health units in Ontario. Economies of scale concepts were introduced which suggested optimum population sizes (100,000) for health unit catchment areas. The province encouraged health units to regroup on a multi-county basis to become more efficient.

1983 The *Health Protection and Promotion Act* (HPPA) was proclaimed, replacing the Public Health Act. The Act was amended in 1990 making slight changes to its contents.

1997 The HPPA was revised as part of Bill 152, the *Services Improvement Act*. The *Mandatory Health Programs and Services Guidelines* were published.

2004 Following the outbreak of SARS, the government of Ontario announced *Operation Health Protection: an Action Plan to Prevent Threats to our Health and to Promote a Healthy Ontario.*

2005 The government of Ontario announced the creation of the new Ministry of Health Promotion to focus on programs dedicated to healthy lifestyles. The name was later changed to the Ministry of Health Promotion and Sport.

2006 The *Smoke-Free Ontario Act* was introduced, which banned smoking in all enclosed public places.

2006 The government of Ontario introduced the *Health System Improvements Bill* (#171) that included enabling legislation for an Ontario Agency for Health Protection and Promotion, Ontario's "CDC of the North".

2007 The Ontario Agency for Health Protection and Promotion was established in Toronto.

2008 The *Ontario Public Health Standards* were completed in collaboration with boards of health and Ontario public health professionals. They came into effect on January 1, 2009 and replaced the *Mandatory Health Programs and Services Guidelines*.

2009 The *Initial Report on Public Health* was released by the Ministry of Health and Long-Term Care as the first step in developing an accountability framework for boards of health.

2010 The Ontario Agency for Health Protection and Promotion changed its operational name to Public Health Ontario.

2011 The Ministry of Health and Long-Term Care released its *Ontario Public Health Organizational Standards* for boards of health in February 2011.

2011 The first accountability agreements are put in place between boards of health and the Ministry of Health and Long-Term Care.

2012 The former Ontario Ministry of Health Promotion and Sport was dissolved. Its health promotion programs and activities were transferred to the newly created Health Promotion Division within the Ministry of Health and Long-Term Care.

2013 The first strategic plan for the public health sector in Ontario, *Make No Little Plans*, is released by the Chief Medical Officer of Health.

2014 Following the provincial election, the Associate Minister of Health and Long-Term Care (Long-Term Care and Wellness) was added to the Ontario Cabinet.

Legislation Governing Boards of Health

The following is a summary of existing provincial legislation that is most significant to the activities of BOHs, medical officers of health, and their designates. It is presented to promote a working knowledge of the origin of the most important of the legislated responsibilities. It is neither a detailed nor comprehensive itemization of what those responsibilities are, as local by-laws, federal statutes nor other provincial acts containing public health-related clauses may delegate additional responsibilities to the groups named above. There is some additional detail on legislation that affects boards of health and their directors in the companion document, ***A Review of Board of Health Liability*** **(Appendix 9)**. Also helpful is the government's E-Laws Web site, where all of Ontario's Acts and their associated Regulations have been posted: http://www.e-laws.gov.on.ca/. Some key pieces of legislation are:

1. The Health Protection and Promotion Act
   http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90h07_e.htm
2. Emergency Management and Civil Protection Act
   http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90e09_e.htm
3. Immunization of School Pupils Act
   http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90i01_e.htm
4. Day Nurseries Act
   http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_900262_e.htm
5. Municipal Freedom of Information and Protection of Privacy Act
   http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90m56_e.htm
6. Personal Health Information Protection Act
   http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_04p03_e.htm
7. Smoke Free Ontario Act
   http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_94t10_e.htm
8. Safe Drinking Water Act
   http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_02s32_e.htm
9. Fluoridation Act
   http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90f22_e.htm
10. Skin Cancer Prevention Act
    http://www.search.e-laws.gov.on.ca/en/isysquery/ee33827b-a1f6-4765-9585-87bc6376411f/1/doc/?search=browseStatutes&context=#hit1

As a BOH member, you are encouraged to keep up to date on current, announced or proposed changes, as well as opportunities to provide input at consultations. alPHa does its best to keep all of its members informed of such changes and opportunities to influence them.

Legislation Specific to Public Health

The Health Protection and Promotion Act, Revised Statutes of Ontario, 1990 Chapter H.7

The *Health Protection and Promotion Act* (HPPA) is the most important piece of legislation for a BOH, as it prescribes the existence, structures, governance and functions of boards of health, as well as the activities of medical officers of health and certain public health functions of the Minister. It is also the enabling statute for the regulations and guidelines that prescribe the more detailed requirements that serve the purpose of the Act, which is to "*provide for the organization and delivery of public health programs and services, prevention of the spread of disease and the promotion and protection of the health of the people of Ontario"* (R.S.O. 1990, c. H. 7, s. 2).

There are currently 21 different Regulations made under the HPPA, including those that govern BOH composition, food safety, swimming pool health and safety, rabies control, school health, and communicable disease control.

Background

The most recent revision of the HPPA was passed by the legislature in December 4, 2014. The original HPPA came into force on July 1, 1984, replacing the *Public Health Act*, the *Venereal Disease Prevention Act* and the *Sanatoria for Consumptives Act*.

The old *Public Health Act* provided a clear mandate to boards of health in community sanitation and communicable disease control, but provided little or no direction on additional preventive programs considered part of the modern day approach to public health. Section 5 of the HPPA expands this mandate to require boards of health to provide or ensure the provision of health programs and services in the areas of preventive dentistry, family health, nutrition, home care and public health education.

Section 7 further serves the modern approach by empowering the Minister of Health to publish guidelines for the provision of these mandatory programs and services. The first Mandatory Health Programs and Services Guidelines (MHPSG) were published in 1984, providing minimum province-wide standards for programs and services aimed at reducing chronic and infectious diseases and improving family health. These were revised into the *Ontario Public Health Standards* (OPHS) that came into effect on January 1, 2009. This revision was accomplished with extensive support from Ontario public health professionals and the OPHS are published as a living document at:
http://www.health.gov.on.ca/english/providers/program/pubhealth/oph_standards/ophs/index.html.

The full suite of documents that comprise the OPHS includes a set of 15 standards, protocols for each standard, and guidance documents that provide information on evidence and best practices.

The Ten Parts of the Health Protection and Promotion Act

Part I	Part II	Part III	Part IV	Part V	Part VI	Part VII	Part VIII	Part IX	Part X
Interpretations	Health Programs & Services	Community Health Protection	Communicable Diseases	Rights of Entry and Appeals from Orders	Health Units & Boards of Health	Administration	Regulations	Enforcement	Transition

Part I - Interpretations

Definitions essential to interpreting the application of the Act and its regulations.

Part II - Health Programs and Services

Introduces the requirements for the delivery of a number of basic mandatory health programs and services. This is the section that gives the *Ontario Public Health Standards* the status of legal requirements. It also authorizes boards of health to provide additional programs and services that may be specific to local needs.

HPPA Part II, Section 9

A board of health may provide any other health program or service in any area in the health unit served by the board of health if,

(a) the board of health is of the opinion that the health program or service is necessary or desirable, having regard to the needs of persons in the area; and

(b) the councils of the municipalities in the area approve of the provision of the health program or service. R.S.O. 1990, c. H.7, s. 9.

Part III - Community Health Protection

Provisions relating essentially to the monitoring and enforcement activities that are necessary for the prevention, elimination or reduction of the effects of health hazards in the community. These include the traditional duties of public health inspectors (e.g. restaurant inspections, health hazard complaint response) and the types of corrective actions that may be taken to manage risks to health (e.g. issuing orders, seizure and destruction, closing premises). Part III of the HPPA also includes several clauses specifically addressing health hazards in food.

Part IV - Communicable Diseases

This part is similar to Part III, but is specific to decreasing or eliminating risks to health presented by communicable disease. In addition to setting out the types of actions a medical officer of health (MOH) or the Minister of Health may take to address these risks, this part sets out the reporting requirements that form the basis for monitoring communicable diseases in the community.

Part V - Rights of Entry and Appeals from Orders

This is the part that authorizes designated people (e.g. public health inspectors) to enter any premises in order to inspect, take samples, and perform tests and other duties under the Act. It is

also the section that sets out the process by which a person to whom an order has been issued can appeal it.

Part VI - Health Units and Boards of Health

Part VI specifies the composition, operation and authority of boards of health, their legal status, and the relationship with provincial and municipal authorities. It contains the specific requirement that municipalities pay for costs incurred by the BOH for its duties under the Act (s. 72), but also enables the province to make offsetting grants (s.76). It also includes rules for the appointment of the MOH.

Part VII - Administration

Noteworthy provisions under this part include:

- empowering the Minister to ensure that boards of health are in compliance with the Act;
- the establishment of public health labs;
- the appointment, qualifications and duties of the Chief Medical Officer of Health (CMOH); and
- protecting individuals carrying out duties in good faith under the Act from personal liability.

Part VIII - Regulations

The Lieutenant Governor in Council (also known as the provincial Cabinet) is empowered to make regulations to prescribe more detailed standards and requirements for a variety of areas important to public health. An important example of this is the *Food Premises Regulation*, which sets out detailed standards for the maintenance and sanitation of food premises, as well as for the safe handling, storage and service of food.

Part IX - Enforcement

This Part contains the enforcement provisions under the Act and provides for a range of penalties for a range of offences.

Part X - Transition

Effective July 1 1984, this Part ensures the continuance of public health units, boards of health, and medical officers of health under the newly enacted HPPA. Several Statutes are repealed with the appropriate provisions thereof being incorporated into HPPA.

Ontario Public Health Standards

The *Ontario Public Health Standards* (OPHS) are province-wide standards that steer the local planning and delivery of public health programs and services by boards of health. They set minimum requirements for fundamental public health programs and services targeting the prevention of disease, health promotion and protection, and community health surveillance. They are published by the Minister of Health and Long-Term Care under the authority of Section 7 of the HPPA, which also obliges boards of health to comply with them.

Where Section 5 of the HPPA specifies the areas in which programs and services must be provided the OPHS set out goals and outcomes for both society and boards of health. Requirements for assessment and surveillance, health promotion and policy development, and disease prevention are also laid out. The OPHS are mandatory and they ensure the maintenance of minimum standards for core public health programs and services for all Ontario. They are broad in scope and not restrictive, leaving room for boards of health to tailor programs and services and to deliver additional ones according to local needs.

Section 5 - Mandatory health programs and services

Every board of health shall superintend, provide or ensure the provision of health programs and services in the following areas:

1. Community sanitation, to ensure the maintenance of sanitary conditions and the prevention or elimination of health hazards.
   1.1 The provision of safe drinking water by small drinking water systems.
2. Control of infectious diseases and reportable diseases, including provision of immunization services to children and adults.
3. Health promotion, health protection and disease and injury prevention, including the prevention and control of cardiovascular disease, cancer, AIDS and other diseases.
4. Family health, including,
   i. counselling services,
   ii. family planning services,
   iii. health services to infants, pregnant women in high risk health categories and the elderly,
   iv. preschool and school health services, including dental services,
   v. screening programs to reduce the morbidity and mortality of disease,
   vi. tobacco use prevention programs, and
   vii. nutrition services.
   4.1 Collection and analysis of epidemiological data.
   4.2 Such additional health programs and services as are prescribed by the regulations.

The OPHS establish requirements for fundamental public health programs and services which are articulated in 14 standards, 148 requirements and 27 protocols. Boards of health are responsible for oversight of the assessment planning, delivery, management, and evaluation of a variety of public health programs and services that address multiple health needs, as well as maintaining an understanding of the contexts in which these local needs occur.

The OPHS are built on a set of Principles and a Foundational Standard. The next diagram depicts the relationship between the Principles, the Foundational Standard, and the Program Standards.

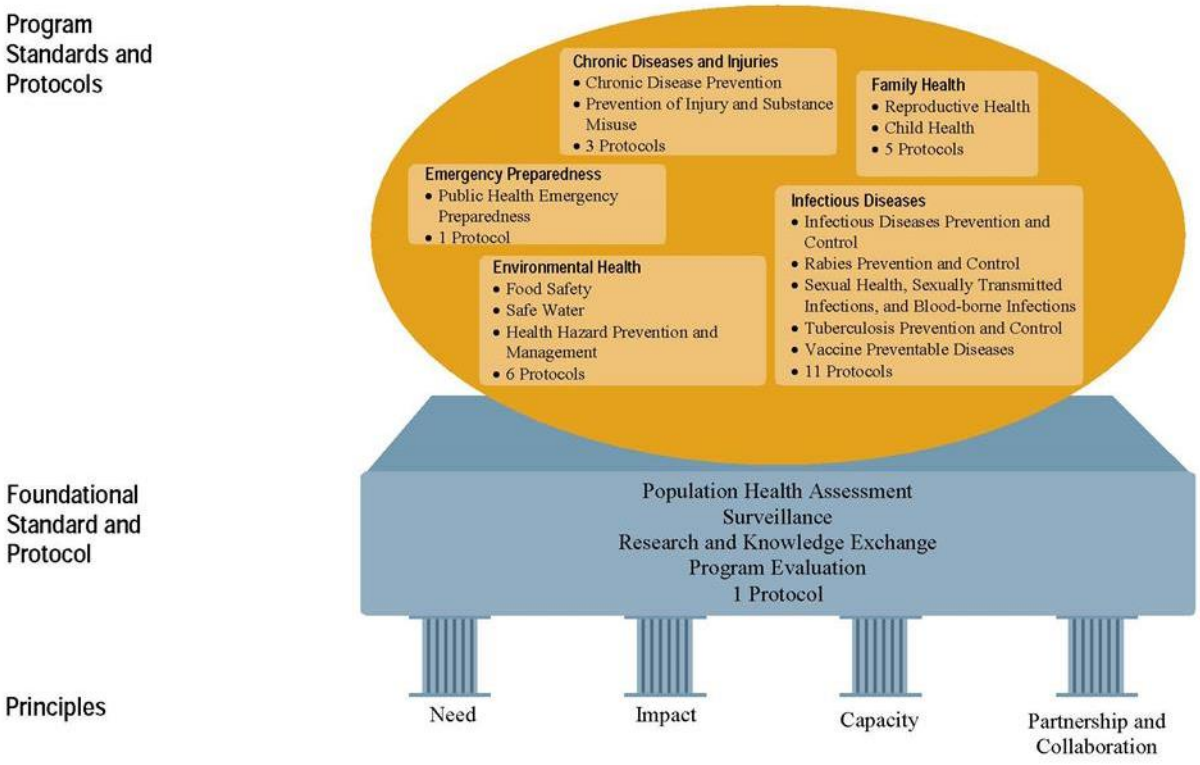
Principles

The delivery of public health programs and services occurs in diverse and complex geographic, physical, cultural, social, and economic environments that differ significantly across Ontario. There are systemic differences in health status that exist across socio-economic groups (i.e. health inequities). Thus, there are both common and diverse factors that influence and shape the public health response required to achieve a desired health outcome.

Effective public health programs and services take into account communities' needs, which are influenced by the determinants of health. As well, an understanding of local public health capacity and the resources required including collaboration with partners to achieve outcomes is essential for effective management of programs and services.

To ensure that boards of health assess, plan, deliver, manage, and evaluate public health programs and services to meet local needs, while continuing to work towards common outcomes, boards of health shall be guided by the following principles:

1. Need
2. Impact
3. Capacity
4. Partnership and Collaboration



Foundational Standard

Public health programs and services that are informed by evidence are the foundation for effective public health practice. Evidence-informed practice is responsive to the needs and emerging issues of the health unit and uses the best available evidence to address them. Population health assessment, surveillance, research, and program evaluation generate evidence that contributes to the public health knowledge base and ultimately improves public health programs and services.

Population health assessment includes measuring, monitoring, and reporting on the status of a population's health, including determinants of health and health inequities. Population health assessment provides the information necessary to understand the health of populations through the collaborative development and ongoing maintenance of population health profiles, identification of challenges and opportunities, and monitoring of the health impacts of public health practice.

Program Standards

Program Standards are published for the following areas:

Chronic Diseases and Injuries
Programs whose collective goal is to increase length and quality of life by preventing chronic disease (e.g. through healthy eating, tobacco use reduction, promotion of physical activity, etc.), early detection of cancer, and injury and substance abuse prevention.

Family Health
This category focuses on the health of children, youth and families. Its components are child health, which focuses on healthy development through parenting and supportive environments; sexual health, which deals with healthy sexual relationships and personal responsibility; and reproductive health, whose focus is promoting behaviours and environments conducive to healthy pregnancies.

Examples of some specific programs include the promotion of breastfeeding, the establishment of sexual health clinics, and ensuring the availability of educational services for pregnant women.

Infectious Diseases
Where the above two areas make best use of the educational capacities of public health providers, this area deals specifically with the management of more immediate risks to health. The strategy applied here is a combination of risk assessment, surveillance, case-finding, contact tracing, immunization, and infection control, whose goal is to reduce or eliminate infectious diseases.

The programs required by this category include Infection Prevention and Control (e.g. in hospitals, day cares and long-term care facilities), Rabies Prevention and Control, Sexual Health/Sexually Transmitted Diseases (STDs) including HIV/AIDS, Tuberculosis (TB) Prevention and Control, and Vaccine Preventable Diseases (VPDs).

Environmental Health
The programs in this area encompass food safety, safe water, and health hazard prevention and management. The standards seek to prevent or reduce the burden of food- and water-borne illness, injury related to recreational water use, and the burden of illness created by health hazards in the physical environment.

Emergency Preparedness
This program requires the existence of emergency response protocols to enable and ensure a consistent and effective response to public health emergencies and emergencies with public health impacts.

Legislation Supporting Public Health

In addition to the HPPA, the following legislation supports the provision of public health programs and services.

Immunization of School Pupils Act

The purpose of this Act is to increase the protection of the health of children against diseases designated under the ISPA. The following diseases are currently designated: diphtheria; tetanus; poliomyelitis; measles; mumps and rubella. This is an important Act as it requires parents to produce a record for the health unit indicating that their children are vaccinated for these diseases before they are permitted to attend Ontario schools.

Among other provisions, the Act:

- requires medical officers of health to maintain a record of immunization containing the information prescribed in regulations in respect of each pupil attending school within their jurisdictions;
- requires parents to cause their children (who are pupils) to complete the prescribed program of immunization. It also allows for exemptions from the immunization requirements upon receipt by the MOH of a statement of medical exemption or conscience or religious belief;
- gives the MOH authority to order the person who operates the school to suspend from school, pupils for whom the MOH has not received a completed record of immunization or a statement of exemption; and
- also gives the MOH authority to order the person who operates the school to exclude from school, pupils without evidence of immunization or immunity in the event of an outbreak of the diseases against which immunization is required.

Day Nurseries Act

This act lays out the expectations for day nursery operators and includes regulations that:

- specify the minimum regulations and standards for day nurseries; and
- provide the legislative authority for medical officers of health or their designates (public health inspectors) to inspect day nurseries, to ensure that children are properly immunized, that the premises and equipment are safe, and that procedures are in place to appropriately manage ill children and outbreaks of communicable diseases.
- Note: The Day Nurseries Act will be repealed and replaced by the Child Care and Early Years Act, 2014 which will come into force on a date set by Proclamation of the Lieutenant Governor.

Smoke-Free Ontario Act

The *Smoke-Free Ontario Act* (SFA) came into force on May 31 of 2006, replacing the *Tobacco Control Act* (TCA) of 1994, enhancing restrictions on the sale, provision and use of tobacco products. Most notably, it bans smoking in virtually all enclosed public spaces, eliminating the allowances under the TCA for designated smoking areas and rooms. These allowances led many municipalities to enact their own by-laws to further reduce exposure to second-hand smoke, as the TCA allowed local municipalities to enact more stringent controls. This resulted in a patchwork of rules that meant differing protection from tobacco smoke depending on where one was in the province. A major purpose of the *Smoke-Free Ontario Act* is to ensure that no one in Ontario will be involuntarily exposed to second hand smoke in an enclosed space.

The SFA:

- bans smoking in enclosed public places and all enclosed workplaces as of May 31, 2006;
- eliminates designated smoking rooms (DSRs) in restaurants and bars;
- protects home health care workers from second-hand smoke when offering services in private residences;
- prohibits smoking on patios that have food and beverage service if they are either partially or completely covered by a roof;
- toughens the rules prohibiting tobacco sales to minors;
- prevents the promotion of tobacco products in entertainment venues; and
- restricts the retail promotion of tobacco products and imposes a complete ban on the display of tobacco products as of May 31, 2008.

The act also enables the designation of inspectors for the purposes of the Act. Ontario's boards of health are assigned responsibility for enforcing the SFA by the *Ontario Public Health Standards* (under the Chronic Disease Prevention program) and receive specific funding from the Ministry of Health Promotion for this activity.

Safe Drinking Water Act

The *Safe Drinking Water Act* (SDWA) was passed in 2002 as a response to the regulatory needs identified in the Report of the Walkerton Inquiry, which identified significant deficiencies in the management and oversight of treatment and distribution of safe drinking water Ontario's local drinking water supplies. The Act sets out requirements for testing, treatment and monitoring of drinking water distribution systems (excluding private wells).

The regulation of drinking water in Ontario has undergone several revisions since the introduction of the SDWA as practical difficulties or inefficiencies are identified, often following recommendations of the Ontario Drinking Water Advisory Council (ODWAC), which was itself established following a recommendation in the Walkerton report. The Council recommended that responsibility for the oversight of certain categories of drinking water systems be transferred from the Ministry of the Environment (MOE) to public health inspectors.

Ontario Regulation 319/08

Ontario Regulation 319/08 regulates drinking water systems (SDWS) serving non-residential and seasonal residential uses. Responsibility for the oversight of SDWS was transferred to the public health units from the Ministry of the Environment on December 1, 2008, as recommended by the Advisory Council on Drinking Water Quality and Testing Standards. After the transfer of responsibility, public health units began conducting site-specific risk assessments and developing system-specific water protection plans to ensure compliance with provincial drinking water quality standards. There are approximately 18,000 SDWS in Ontario. O. Reg. 319/08 does not apply to municipal and private systems that provide water to year-round residential developments or *Designated Facilities* under Ontario Regulation 170/03. Designated facilities remain the responsibility of the Ministry of Environment and include children's camps, child and youth care facilities, health care and social care facilities, a school or private school, a social care facility, a university, college or institution with authority to grant degrees.

Ontario Regulation 903/90

This is the regulation that governs the construction and maintenance of wells in Ontario, but it contains no clauses to ensure ongoing monitoring, testing or treatment to ensure water quality. This means that the many Ontarians who rely on private well water supplies are responsible for their own drinking water safety. Public health units will often be asked by members of the community to provide advice and testing services.

Fluoridation Act

The Fluoridation Act was introduced in 1990 and establishes the ability for municipalities to fluoridate their municipal water systems. The Council of a local or regional municipality may pass a by-law to require the operation of a fluoridation system for the municipal water system or may

submit the question to electors before passing the by-law (ss. 2, 2.1). The Council may discontinue the fluoridation system by by-law or by a vote of electors prior to passing the by-law (s. 3). For joint waterworks (for two or more municipalities), the fluoridation system can only be operated where a majority of the municipalities pass a by-law requiring fluoridation of the water supply (s. 5). If Council obtains its water supply from a public utility company, then the council can pass a by-law to fluoridate the water and the public utility company must establish the service. If the company and Council cannot agree on the terms and conditions for establishing the fluoridation system, then arbitration may take place under the Arbitration Act (s. 6).

Skin Cancer Prevention Act (Tanning Beds)

Passed in 2013, the Skin Cancer Prevention Act (Tanning Beds) bans the use of tanning beds by youth under 18 years of age. The Act is in support of evidence that tanning bed use increases the risk of the deadliest form of skin cancer, malignant melanoma. It took effect on May 1, 2014 and includes the following:

- Prohibits the sale, advertising and marketing of tanning services to youth under 18;
- Requires that tanning bed operators request identification from anyone who appears under 25 years old;
- Requires tanning bed operators to post signs stating the ban on minors and the health risks of tanning bed use;
- Requires that all individuals using tanning beds are provided with protective eyewear;
- Requires that all tanning bed operators provide written notice of their location and business contact information to their local MOH;
- Sets fines for tanning bed owners/operators who fail to comply; and
- Authorizes inspectors to inspect and enforce these requirements.

Mandatory Blood Testing Act

Passed in December 2006, this Act calls for the mandatory drawing and analyzing of blood where a possible exposure has occurred to a communicable disease. Under the Act, a person may apply to a MOH to have the blood of another person tested for viruses. The MOH is empowered to request a blood sample for analysis or evidence of seropositivity. If the person who is requested to provide a blood sample or other evidence does not voluntarily provide it within two days after the request is made, the MOH must refer the application to the Ontario Consent and Capacity Board, which may make an order to provide a blood sample.

Acts Pertaining to Health Units as Public Bodies

Municipal Act

- specifies the manner in which municipalities interact with their local boards, including boards of health.

Municipal Conflict Of Interest Act

- specifies the duties of members of local boards, including boards of health, who may have any pecuniary interest, direct or indirect, in any matter before the board. The member must disclose his or her interest in the matter and abstain from any discussion or vote pertaining to the matter. The mechanism to follow for contravention of the Act is also specified.

French Language Services Act

- guarantees that provincial services are provided in both English and French and that all provincial Bills and Legislation are enacted in both English and French. Also, it guarantees that municipal services in all designated areas, including Toronto, are available in both English and French.

Accessibility for Ontarians with Disabilities Act, 2005

- was established with the goal to have standards to improve accessibility across the province. The Accessibility Standards for Customer Service is the first of four common standards under the Act. Other common standards that are being developed include: built environment, employment, information and communication. Public health units that are part of municipalities needed to comply as of January 01, 2010. The remaining health units needed to comply by January 01, 2012.

Municipal Freedom of Information and Protection of Privacy Act (MFIPPA)

- gives individuals the legal right of access to information held by municipal governments, local boards and commissions. There are exceptions to this right but they are limited to the specific provisions of the legislation.
- also gives individuals a right of access to their personal information. Individuals also have the right to request correction of the personal information if they believe it contains errors or omissions.

- requires established standards of municipal governments, etc. that ensure personal information is kept confidential and stored in a safe place.

The Personal Health Information Protection Act, 2004 (PHIPA)

The Personal Health Information Protection Act, 2004 is an Ontario law that governs the collection, use and disclosure of personal health information within the health sector. The object is to keep personal health information confidential and secure, while allowing for the effective delivery of health care and services. Medical Officers of Health are considered to be health information custodians under this legislation.

Roles and Responsibilities

The Board of Health (BOH)

The *Health Protection and Promotion Act* (HPPA), and its regulations, authorize the governing body, usually the BOH and its staff, to control communicable disease and other health hazards in the community. It also mandates the health unit to perform proactive functions in the areas of health promotion and disease prevention. The *Ontario Public Health Services (OPHS*), published by the Ministry of Health and Long-Term Care (MOHLTC), describe how these programs are to be implemented.

In carrying out its mandate, the governing body should provide a policy framework within which its staff can define the health needs of the community and design programs and services to meet these needs. All programs and services are approved by the BOH.

The board should adopt a philosophy and management process that allows it to carry out its mandate in an efficient, effective, and economical manner. This should be complemented with a sound organizational structure that reflects the responsibilities of the component parts. The BOH is the governing body, the policy maker of the health unit. It monitors all operations within the unit and is accountable to the community and to the MOHLTC.

The primary functions of the BOH are to provide good governance and strategic leadership to the organization. More information on good governance and overall BOH functions can be found in *The Governance Toolkit for Ontario Boards of Health* that was released by alPHa in January 2015. It is important to note that while the BOH works closely with the MOH/CEO, it is the MOH/CEO's responsibility to lead the health unit in achieving board-approved directions. Therefore, the responsibility for the day-to-day management and operations of the health unit lies with the MOH/CEO.

Board of Health Responsibilities

- establishes general policies and procedures which govern the operation of the health unit and provide guidance to those empowered with the responsibility to manage health unit operations ;
- upholds provincial legislation governing the mandate of the BOH under the *Health Protection and Promotion Act* and others;
- accountable to the community for ensuring that its health needs are addressed by the appropriate programs and ensuring that the health unit is well managed;
- ensures program quality and effectiveness and financial viability;
- establishes overall objectives and priorities for the organization in its provision of health programs and services, to meet the needs of the community;

- hires the MOH and associate medical officer(s) of health with approval of the Minister;
- responsible for assessing the performance of the MOH and associate medical officer(s) of health;
- responsible for assessing the Board's own performance and ensuring Board effectiveness; and
- monitor elements of the accountability agreements with the MOHLTC such as the setting and achievement of performance management indicators.

The Medical Officer of Health (MOH)

The MOH reports to the BOH and all information pertaining to board operation is the responsibility of the MOH. This is supported by legislation. In regional government, there exists the position of the chief administrative officer (CAO), who controls and is accountable to Regional Council for all administrative matters. The MOH reports to the CAO, often referred to as the "Commissioner of Health" in these situations.

Due to the mandate of the MOH (Section 67(3) of the HPPA), a practical and reasonable working relationship is essential for the smooth and effective operation of the health unit. The public must be assured that their health needs are being assessed by qualified medical personnel and that the board will act on such advice. To clarify the relationship between the BOH and the MOH, the following is a summary of administrative roles and responsibilities:

Medical Officer of Health Responsibilities

- responsible to the BOH for the management and overall provision of health programs and services under the HPPA and any other Act;
- provides advice to the BOH on health unit policy;
- directs staff in the implementation of board policies and procedures;
- accountable to the board for day-to-day operations of the health unit;
- responsible for the direct supervision and performance appraisal of senior staff and advises or assists department heads in hiring staff;
- encourages and promotes the continuing education of all staff;
- evaluates the effectiveness of programs and services; and
- recommends appropriate changes and reports these findings regularly to the board.

Governance

In general terms, governance can be thought of as the stewardship of the affairs—particularly the strategic direction—of an organization. The BOH, acting in its governance role, sets the desired goals for an organization and establishes the systems and processes to support achievement of those goals. Critical elements of an effective health unit governance policy framework include:

- Principles of Governance and Board accountabilities;
- A statement of the Board's obligations to act in the best interest of the health unit;
- Roles and responsibilities of the Board of Directors;
- Roles and responsibilities of individual Directors;
- Guidelines for the selection of Directors;
- A range of specific skills and expertise;
- Board Standing and Ad Hoc Committees which are streamlined to support the Board;
- Clear differentiation between governance and management;
- Board focused on strategic leadership and direction;
- Board establishes policies, makes decisions and monitors performance of the; and organization's business and its own effectiveness.

Guidelines for Board of Health Members

A clearly written description should be provided, outlining the expectations and responsibilities of board members and information about any benefits, such as meeting remuneration and mileage allowance, etc.

A member of a BOH should:

- commit to and understand the purpose, policies and programs of the health unit;
- attend board meetings, and actively participate on committees and serve as officers;
- actively participate in setting the strategic directions for the organization;
- acquire a clear understanding of the financial position of the health unit and ensure that the finances are adequate and responsibly spent;
- serve in a volunteer capacity without regard for remuneration or profit;
- be able to work and participate within a group, as a team;
- be supportive of the organization and its management;
- know and maintain the lines of communication between the board and staff;
- take responsibility for continuing self-education and growth;
- represent the health unit in the community;
- be familiar with local resources;
- be aware of changing community trends and needs;
- attend related community functions;
- have a working knowledge of parliamentary procedure; and
- be aware of the definition of Conflict of Interest and when to declare it.

Organizational Standards

The Ontario Public Health Organizational Standards outline expectations for the effective governance of boards of health and effective management of public health units. The Organizational Standards communicate the government's expectations for governance and

administrative practices that are based on generally accepted principles of good governance and management excellence. The Standards contain expectations of both the BOH as the governing body (first 5 categories) and the public health unit as the administrative body (final category entitled Management Operations). The Organizational Standards include the following six categories. Each category is further defined through 3 to 15 requirements depending on the category.

	Category	Goal
1	Board Structure (8 Requirements)	To ensure that the structure of the BOH facilitates effective governance and respects the required partnership with municipalities as well as the need for local flexibility in board structure.
2	Board Operations (10 Requirements)	To enable boards of health to operate in a manner that promotes an effective board, effective communication and transparency.
3	Leadership (3 Requirements)	To ensure the BOH members develop a shared vision for the organization, use a proactive, problem solving approach to establishing the organization's strategic directions, and take responsibility for governing the organization to achieve their desired vision.
4	Trusteeship (3 Requirements)	To ensure that BOH members have an understanding of their fiduciary roles and responsibilities, that their operations are based on the principles of transparency and accountability, and that BOH decisions reflect the best interests of the public's health.
5	Community Engagement & Responsiveness (3 Requirements)	To ensure that the BOH is responsive to the needs of the local communities and shows respect for the diversity of perspectives of its communities in the way it directs the administration of the health unit in planning, operating, evaluating and adapting its programs and services.
6	Management Operations (15 Requirements)	To ensure that the administration of the BOH uses a proactive, problem solving approach to establishing its operational directions, demonstrates its organizational priorities and objectives through its actions on program delivery, and functions in an efficient and effective manner. *Note that the requirements in this category require that the board delegate tasks to the senior staff of the health unit.*

Accountability Agreements

A signed formal, legal agreement is required between a BOH and the MOHLTC as a condition of funding approval. Ministry funding for mandatory and related programs is governed by the Public Health Funding and Accountability Agreement (Accountability Agreement), which sets out the obligations of the Ministry and BOH. It includes most of the funding provided by the Ministry to BOHs with a few exceptions (e.g. Healthy Babies Healthy Children).

The Accountability Agreement incorporates financial reporting requirements, performance indicators, and continuous quality improvement tools. Performance indicators focus on BOH outcomes and have program-based targets that are negotiated between individual BOHs and the Ministry. Performance expectations and financial data are refreshed annually and additional

measures may be incorporated in the Accountability Agreement to address issues specific to certain BOHs. The Accountability Agreement is to be reviewed every 5 years to determine if amendments are required.

Key Provisions in Accountability Agreements

Grant (Article 4)

- the Provincial grant is provided for purposes of carrying out obligations under
  - the HPPA and its regulations;
  - the *Ontario Public Health Standards*;
  - the Ontario Public Health Organizational Standards; and
  - the requirements set out in the Accountability Agreement.

Performance Improvement (Article 5)

- sets out the elements of the performance improvement process including measurement and monitoring of performance indicators for BOHs against established targets
- includes provisions for performance and compliance reporting

Disclosure of Conflicts of Interest to the Province (Article 7)

- requires BOH members to disclose "any situation that a reasonable person would interpret as an actual, potential or perceived Conflict of Interest"

Reporting, Accounting and Review (Article 8)

- requires boards of health to submit reports to the province
- authorizes the ministry to conduct an inspection, audit or investigation of the board

Schedules (Article 27)

- Schedule A (Program-Based Grants)
- Schedule B (Policies and Guidelines)
- Schedule C (Reporting Requirements)
- Schedule D (Performance Obligations)
- Schedule E (BOH Financial Controls)

Board of Health Members and Structures

BOH Members

There are three categories of BOH members.

1. Elected Officials. These may be appointed to an autonomous BOH to represent their municipality. In the case of the seven regional boards of health, Regional Council acts as the BOH and all members are elected officials.

2. Public Appointees. The composition of autonomous BOHs is outlined in Section 49 of the HPPA. Section 49(3) provides for the appointment of one or more provincial members by the Lieutenant Governor in Council. Boards of health have the opportunity to participate in the recruitment, nomination and recommendation of individuals for public appointment positions on their boards of health. The guiding principle is that in recognition of unique local demographics, the local board is positioned to best determine public representation and geographic characteristics of the area they serve. Applications to be a provincial member on a BOH can be made through an open competition (i.e. advertising) conducted by the board or by direct application to the Public Appointments Secretariat (http://www.pas.gov.on.ca).

3. Citizen Representatives. Five boards of health provide for representation by citizen members, who are often appointed by local council to the board.

BOH Structures

Autonomous – Established Under the HPPA

In autonomous boards of health, the health unit staff operates separately from the municipal administrative structure. Most autonomous boards of health have multi-municipal representation, and may have citizen representatives appointed by municipalities and public appointees. There are 25 autonomous boards of health in Ontario:

- Algoma
- Brant County
- Chatham-Kent
- Eastern Ontario
- Elgin-St. Thomas
- Grey Bruce
- North Bay Parry Sound
- Northwestern
- Perth
- Peterborough
- Porcupine
- Renfrew

- Haliburton-Kawartha-Pine Ridge
- Hastings-Prince Edward
- Huron
- Kingston, Frontenac, Lennox & Addington
- Lambton
- Leeds, Grenville, Lanark
- Middlesex-London
- Simcoe Muskoka
- Sudbury
- Thunder Bay
- Timiskaming
- Wellington-Dufferin-Guelph
- Windsor-Essex

Regional – Established as Regional Municipalities

In this type of BOH, staff operates under the administration of regional government. According to the Association of Municipalities of Ontario, a regional government is a federation of the local municipalities within its boundaries. Regional boards of health have no citizen representatives and no public appointees. The 7 regional boards of health in Ontario are:

- Durham
- Halton
- Niagara
- Oxford
- Peel
- Waterloo
- York

Municipal – Established Under City-Specific Acts

In municipal boards, the staff of the health unit operates under the municipal administrative structure. Presently, there are 4 municipal boards of health two of which operate independently of a municipal council and 2 of which have municipal council acting as the BOH. They have no provincial appointees and the 2 cases where the BOH is independent of municipal council, citizen appointees are possible.

- Haldimand-Norfolk - Council acts as BOH
- Hamilton - Council acts as BOH
- Ottawa - BOH is independent of Council
- Toronto - BOH is independent of Council

The following diagram summarizes the features of the different BOH structures.

<table>
<tr>
<td> 
25</td>
<td>Established under the Health Protection and Promotion Act
Features:
• Independent/autonomous, stand-alone BOHs
• Obligated municipalities appoint majority of members
• Province appoints a minority of members
• see O. Reg. 559 in HPPA
Examples: Brant County Health Unit, Eastern Ontario Health Unit</td>
</tr>
<tr>
<td> 
7</td>
<td>Established as Regional Municipalities
Features:
• Regional Municipality takes on responsibilities of the BOH
• No provincial appointees
• Staff are employees of the region
Examples: Durham, Halton, Niagara, Peel</td>
</tr>
<tr>
<td rowspan="2"> 
4</td>
<td colspan="2">Established or continued under City-specific Acts</td>
</tr>
<tr>
<td>Features:
• Municipal Council takes on the responsibilities of the BOH
• No provincial appointees
• Staff are employees of municipality
Examples: City of Hamilton, County of Norfolk</td>
<td>Features:
• Municipal Council appoints members to a separate BOH
• Council approves budget and staffing
• No provincial appointees
• Staff are employees of municipality
Examples: City of Toronto, City of Ottawa</td>
</tr>
</table>

The Ministry of Health and Long-Term Care

Minister

Under the HPPA, the Minister of Health and Long-Term Care is given the ability to publish guidelines for the provision of mandatory health programs and services. It is under this authority that the Ministry has produced the *Ontario Public Health Standards*. The Minister may also make regulations specifying diseases as reportable, communicable and virulent and for purposes of "immunizing agents".

Section 76 of the HPPA gives the Minister the power to make discretionary grants for the purposes of the HPPA on such terms and conditions as the Minister considers appropriate. This is the authority under which provincial grants are used to fund boards of health. This also allows the Minister to specify terms and conditions in Accountability Agreements with the boards of health.

The Minister also has the power to appoint assessors to determine whether a BOH is providing health programs and services specified in the HPPA and is complying in all respects with the HPPA and the regulations. Assessments are also used to ascertain the quality of the management or administration of the affairs of the BOH. Assessments may be "for cause" or random.

The Minister must approve all MOH and Associate MOH appointments, as well as any dismissal of a MOH or an Associate MOH by the BOH. As of 2011, the Minister and CMOH must approve acting MOH appointments that are more than 6 months.

Following the provincial election in 2014, the cabinet position of Associate Minister of Health and Long-Term Care was established with an emphasis on long-term care and wellness. It is not clear if the Associate Minister has all of the powers of the Minister.

Public Health and Health Promotion Divisions

Two divisions within the Ministry fund Boards of Health – the Public Health Division (PHD) and the Health Promotion Division (HPD). PHD has the primary provincial responsibility for public health in Ontario. The following Standards are funded by the PHD: Foundational, Infectious Diseases, Environmental Health, and Emergency Preparedness. HPD is responsible for funding the two remaining standards: Chronic Diseases and Injuries; and Family Health. In addition PHD funds one-time requests from boards of health and HPD provides funding for special health promotion initiatives like the Healthy Kids Community Challenge.

In partnership with boards of health, the both divisions provide overall direction and program leadership in public health. Additionally, the divisions have a responsibility to assist boards of

health to implement public health programs through the provision of professional, technical and administrative consultation. The divisions are responsible for setting, monitoring and enforcing their respective areas of the *Ontario Public Health Standards*, on behalf of the province's health minister.

As part of their mandates, PHD and HPD have broad responsibilities to support the Minister of Health and Long-Term Care. Furthermore, they are responsible for working with and informing other branches within the government on public health issues, and liaising with other provinces, territories and the federal government regarding public health in Ontario.

In October 2006, the province announced that the MOHLTC would be changing its focus and moving toward a stewardship model of guiding and planning for the health system and away from the planning of delivery of health care which had become the responsibility of the Local Health Integration Networks (LHINs). The new structure for the Ministry is now in place, however the Public Health and Health Promotion Divisions have uniquely retained a program planning focus. This, in part, is due to the fact that public health does not fall under the funding and planning responsibilities of the LHINs.

There are four branches within the Public Health Division:

- *Emergency Management Branch* which serves the entire ministry and health sector as it responds to urgent and/or emergency situations as well as develops ministry emergency readiness plans, informs health sector planning and directs, as necessary, health sector emergency response and recovery. It implements strategies to ensure continuity of critical ministry services during and emergency; and ensures compliance with the Emergency Management and Civil Protection Act and other relevant legislation.
- *Public Health Planning and Liaison Branch* which develops policy and plans to support the implementation of divisional programs and priorities for public health. The branch also informs program and divisional priorities.
- *Public Health Policy and Programs Branch* which provides continuous assessment and management of public health risks through surveillance and interpretation of public information and data.
- *Public Health Standards, Practice and Accountability Branch* which develops public health policy to support public health system standards; and develops, implements and monitors the public health performance management framework. The branch also reports on system performance and accountability.

The Health Promotion Division has two branches:

- *Health Promotion Implementation Branch* which is responsible for working with partners to implement policies and programs that keep Ontarians healthy. Their main functions include program design and oversight in the areas of healthy/active living, public health accountability and tobacco control.

- *Strategic Initiatives Branch* which oversees the Healthy Kids Community Program, healthy living initiatives, and tobacco control initiatives.

For further information on the MOHLTC and the Public Health and Health Promotion Divisions, visit http://www.moh. gov.on.ca.

Chief Medical Officer of Health (CMOH)

Appointed for a term of five years by the Ontario Provincial Legislature, the CMOH safeguards the health of Ontarians and provides advice on public health matters to the health sector, the Public Health and Health Promotion Divisions, other ministries and the provincial government. The CMOH provides oversight and takes appropriate steps to promote and protect the health of Ontarians. They also provide advice and direction to boards of health, medical officers of health and to the people of Ontario.

The CMOH, when directed by the Minister of Health and Long-Term Care, is empowered as specified under the HPPA to:

- act anywhere in Ontario with the powers of a MOH;
- provide, and ensure provision of, required public health programs not being provided by a BOH;
- investigate, advise, guide and, if remedial action is not taken, issue a written direction in cases where the Minister of Health and Long-Term Care is of the opinion that a BOH has failed to comply with the Act, its regulations or provincial program standards. If the BOH fails to comply with the direction, the CMOH may act on behalf of the BOH.
- investigate situations, which, in the opinion of the Minister of Health and Long-Term Care, constitute or may constitute a risk to the health of persons; and take appropriate action to prevent, eliminate and decrease the risk to health caused by the situation.

In 2004, the CMOH was granted greater independence in a number of areas including the responsibility to make annual reports directly to the Ontario Legislature, and the freedom to speak directly to the public on health issues whenever the CMOH considers it to be appropriate.

There also a number of Associate Chief Medical Officer of Health positions to support the CMOH and act in his or her place as required.

Public Health Funding

The funding of public health and the delivery of public health programs in Ontario is unique in Canada. In other provinces, public health is funded provincially and operates as part of regional health authorities. According to the HPPA,

> 72. (1) The obligated municipalities in a health unit shall pay,
>
> (a) the 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; and
>
> (b) the expenses incurred by or on behalf of the medical officer of health of the board of health in the performance of his or her functions and duties under this or any other Act. 1997, c. 30, Sched. D, s. 8.
>
> (2) In discharging their obligations under subsection (1), the obligated municipalities in a health unit shall ensure that the amount paid is sufficient to enable the board of health,
>
> (a) to provide or ensure the provision of health programs and services in accordance with sections 5, 6 and 7, the regulations and the guidelines; and
>
> (b) to comply in all other respects with this Act and the regulations. 1997, c. 30, Sched. D, s. 8.

This means that legally speaking, the municipalities within a health unit are solely responsible for underwriting the costs of delivering public health programs and services. That said, Section 76 of the HPPA states the following:

> 76. The Minister may make grants for the purposes of this Act on such conditions as he or she considers appropriate. 1997, c. 15, s. 5 (2).

This enables the Province to provide funding for these programs and services, and it has traditionally done so, but is not under the same obligation.

The past decade has seen a number of changes in the way public health has been funded in Ontario. Prior to 1997, funding responsibility for public health was shared by the province and municipalities which contributed 75 percent and 25 percent, respectively, except in the former Metropolitan Toronto, where the province funded 40 percent and the six boroughs funded 60 percent. Then as now, a number of selected public health programs, such as sexual health clinics, were funded 100 percent by the province.

On January 1, 1998, as part of the Local Services Realignment initiative, the Province of Ontario transferred all funding responsibility for public health to municipalities. This arrangement lasted little more than a year. On March 24, 1999, the Minister of Health and Long-Term Care announced that a grant, up to 50 percent of the budgeted amount for public health services within the Health

Unit, would be provided to help offset the costs on the obligated municipalities. This 50-50 ratio of cost-shared funding between the province and municipalities continued until 2005. As part of Operation Health Protection, the province increased its funding share to 55 percent in 2005, 65 percent in 2006, and 75 percent in 2007. Municipalities, in comparison, saw their funding share decrease to 45 percent in 2005, 35 percent in 2006, and 25 percent in 2007. Since 2007, the Ministry has managed the increases to their contributions such that their 75 percent has not been allowed to grow by more than a stipulated amount, e.g. up to 5 percent, or up to 2 percent, more recently. This has resulted in a number of boards of health contributing more than 25 percent.

Currently, the province funds 100 percent the following programs:

- Preschool Speech and Language Services
- Healthy Babies, Healthy Children - through the Ministry of Children and Youth Services
- Public Health Research Education and Development (PHRED) (at the time of publishing, the functions of this program are being transferred to the Ontario Agency for Health Protection and Promotion)
- Speech and Audiology
- Genetics Counselling
- Sexual Health Hotline and Resource Centre
- Unincorporated areas
- Infection Control (following SARS)
- Chief Nursing Officer Position
- Infection Control Nurse Position
- Social Determinants of Health Nurse Position
- Healthy Smiles Ontario
- Smoke Free Ontario

The provincial government also continues to fund vaccines for immunization programs and drugs for use in treatment of sexually transmitted diseases, tuberculosis and leprosy.

It should also be noted that the Ministry of Children and Youth Services funds the Healthy Babies, Healthy Children program that is delivered by boards of health.

Related Organizations

Association of Local Public Health Agencies

http://www.alphaweb.org

The Association of Local Public Health Agencies (alPHa) is a not-for-profit organization that provides leadership and services to boards of health and public health units in Ontario. Members include BOH members of health units (i.e. **Board of Health Section**), medical and associate medical officers of health (i.e. **Council of Ontario Medical Officers of Health**), and senior managers across a variety of public health disciplines (i.e. **Affiliates**).

What We Do

alPHa advises and lends expertise to members on the governance, administration and management of health units. The Association also collaborates with governments and other health organizations, advocating for a strong, effective and efficient public health system in the province. Through policy analysis, discussion, collaboration, and advocacy, alPHa members and staff act to promote public health policies that form a strong foundation for the improvement of health promotion and protection, disease prevention and surveillance services in all of Ontario's communities.

How We Do It

alPHa is governed by a Board of Directors, which provides strategic direction to the Association, and is led by an Executive Director, who is responsible for the day-to-day operations. The Board meets at least five times per year to discuss emerging and ongoing issues in public health policy, funding, programs and services.

Representatives on the alPHa Board include seven BOH members (forming the BOH Section Executive Committee) and seven medical officer of health members (i.e. COMOH Executive Committee), one non-voting representative from the Ontario Public Health Association, and an individual from each of the following seven Affiliate organizations:

- ANDSOOHA-Public Health Nursing Management
- Association of Ontario Public Health Business Administrators (AOPHBA)
- Association of Public Health Epidemiologists (APHEO)
- Association of Public Health Inspectors of Ontario (ASPHIO)
- Health Promotion Ontario (HPO)
- Ontario Association of Public Health Dentistry (OAPHD)
- Ontario Society of Nutrition Professionals in Public Health (OSNPPH).

The Association also conducts regular meetings of its **Board of Health Section** and **Council of Medical Officers of Health** to discuss issues particular to their positions. The **alPHa Advocacy Committee** meets regularly to discuss action plans for Association Resolutions, as well as emerging issues raised by members, public, government or media. This committee is designed to give opportunity for wider participation in alPHa business by interested health unit staff.

alPHa organizes an annual conference and additional face-to-face meetings for its members each year. These meetings provide opportunities for professional development, collaboration with government and other partner organizations, and member networking. Through these meetings, alPHa has conducted day-long workshops including orientation sessions for new board members, and professional development on topics such as risk communications, West Nile virus, and drinking water safety. alPHa also arranges for teleconferences on unexpected policy announcements, and in-services at health units on labour relations and liability issues.

The staff regularly consults with other partners in the health and policy sector, including government ministries, the Association of Municipalities of Ontario, the Ontario Medical Association, the Ontario Public Health Association, Cancer Care Ontario and the Ontario Health Providers' Alliance. alPHa is also an active member of the Ontario Chronic Disease Prevention Alliance.

Value-Added Membership Benefits

Services/Products:

- Electronic mailing lists
- alPHa Web site
- Educational services
- Membership surveys
- Directories
- Board of Health Governance Toolkit

Affinity Programs:

- Teleconferencing
- Group purchasing
- Long-distance calling
- Employee benefits
- Group rates on personal home and auto insurance

Association of Municipalities of Ontario

http://www.amo.on.ca

The Association of Municipalities of Ontario (AMO) is a non-profit organization representing almost all of Ontario's 445 municipal governments. The mandate of the organization is to promote, support and enhance strong and effective municipal government in Ontario.

AMO develops policy positions and reports on issues of general interest to municipal governments; conducts ongoing liaison with provincial government representatives; informs and educates governments, the media and the public on municipal issues; provides services to the municipal sector; and maintains a resource centre on municipal issues.

Since the transferring of public health funding from the province to municipalities in 1999, alPHa and AMO have collaborated on a number of initiatives to improve public health in Ontario.

Local Health Integration Networks

http://www.lhins.on.ca/

Local Health Integration Networks (LHINs) are 14 local entities that are designed to plan, integrate and fund health care services, including hospitals, community care access centres, home care, long-term care and mental health within specified geographic areas. They reflect the reality that a community's health needs and priorities are best understood by local people.

LHINs were created in 2006 to allow patients better access to health care in a system that is currently fragmented, complex and difficult to navigate. This change in the way health services are managed in Ontario will break down barriers faced by patients and ensure decisions are made in the interest of patient care.

While they will not directly provide services, LHINs are mandated to:

- engage the input of the community on their needs and priorities;
- work with local health providers on addressing these local needs;
- develop and implement accountability agreements with local health service providers;
- evaluate and report on their local health system's performance; and
- provide funds to local health providers and advice to the MOHLTC on capital needs.

Public health does not have a role within LHINs, and there has been no indication to date that the the provincial government intends to include health units and boards of health in its vision for LHINs. As LHIN roles evolve over the next few years, it remains to be seen whether this situation will change. Most health units, however, participate on LHIN committees and are engaged with the LHIN(s) in their geographic region in a number of health service planning areas. Some receive funding for projects and others partner on initiatives aimed at the improvement of community health.

Public Health Ontario

Public Health Ontario (PHO) was established in 2007 as The Ontario Agency for Health Protection and Promotion. After a name change to Public Health Ontario in 2010, it continued as an arms-length government agency that supports the CMOH and provides expert scientific leadership and advice to government, public health units, and the health care sector. The Agency is a centre for specialized research and knowledge of public health, focusing in the areas of infectious disease, infection control and prevention, health promotion, chronic disease and injury prevention, and environmental health.

PHO's responsibilities include the provision of specialized public health laboratory services to support timely health surveillance, support of infection control, provision of communicable disease information, and assistance with emergency preparedness (e.g. provincial outbreak of pandemic influenza, local outbreaks). PHO is also responsible for the provision of professional development to all public health professionals.

Ontario Public Health Association

http://www.opha.on.ca

The Ontario Public Health Association (OPHA) represents the collective advocacy interests of approximately 3,000 individuals in public and community health in Ontario through individual and constituent society memberships. Its mission is to strengthen the impact of people who are active in community and public health throughout Ontario.

OPHA provides education opportunities and up-to-date information in community and public health; access to local, provincial and multi-disciplinary community health networks; mechanisms to seek and discuss issues and views of members; issue identification and advocacy on behalf of members; and expertise and consultation in public and community health.

alPHa and OPHA continue to partner on resolutions and advocacy issues for a strengthened provincial public health system.

Appendix 1- Glossary

alPHa	Association of Local Public Health Agencies
AMO	Association of Municipalities of Ontario
ANDSOOHA	Association of Nursing Directors and Supervisors in Ontario's Official Health Agencies (now referred to as ANDSOOHA - Public Health Nursing Management)
AOPHBA	Association of Ontario Public Health Business Administrators
APHEO	Association of Public Health Epidemiologists of Ontario
ASPHIO	Association of Supervisors of Public Health Inspectors in Ontario
BOH	Board of Health
CAO	Chief Administrative Officer
CDC	American Centers for Disease Control and Prevention
CMOH	Chief Medical Officer of Health
COMOH	Council of Ontario Medical Officers of Health
HPD	Health Promotion Division, Ministry of Health and Long-Term Care
HPPA	Health Protection and Promotion Act
HPO	Health Promotion Ontario
ISPA	Immunization of School Pupils Act
LHINs	Local Health Integration Networks
MOE	Ministry of Environment
MOH	Medical Officer of Health
MOHLTC	Ministry of Health and Long-Term Care
OCCHA	Ontario Council on Community Health Accreditation
ODWAC	Ontario Drinking Water Advisory Council
OHPA	Ontario Health Providers' Alliance
OPHA	Ontario Public Health Association
OPHS	Ontario Public Health Standards
O. Reg.	Ontario Regulation
OSNPPH	Ontario Society of Nutrition Professionals in Public Health
OAPHD	Ontario Association of Public Health Dentistry
PHD	Public Health Division, Ministry of Health and Long-Term Care
PHO	Public Health Ontario
SARS	Severe Acute Respiratory Syndrome
SDWA	Safe Drinking Water Act
SFA	Smoke-Free Ontario Act
STDs	Sexually Transmitted Diseases
TB	Tuberculosis
VPD	Vaccine Preventable Disease

Appendix 2 - Web Sites

Government Reports and Initiatives

Final Report of the Capacity Review Committee: Revitalizing Ontario's Public Health Capacity
http://www.health.gov.on.ca/english/public/pub/ministry_reports/capacity_review06/capacity_review06.pdf

Government of Ontario Web Page on Public Health
https://www.ontario.ca/health-and-wellness/public-health-ontario

Healthy Kids Community Challenge
http://www.health.gov.on.ca/en/public/programs/healthykids/

Healthy Kids Panel Report
http://www.health.gov.on.ca/en/public/programs/obesity/

Ontario's Action Plan for Health Care
http://www.health.gov.on.ca/en/ms/ecfa/healthy_change/

Legislation

Ontario Public Health Standards
http://www.health.gov.on.ca/english/providers/program/pubhealth/oph_standards/ophs/index.html

Ontario Acts and Associated Regulations
http://www.e-laws.gov.on.ca

Public Appointments

Public Appointments Secretariat
http://www.pas.gov.on.ca

Organizations

Association of Local Public Health Agencies
http://www.alphaweb.org

Association of Municipalities of Ontario
http://www.amo.on.ca

Local Health Integration Networks
http://www.lhins.on.ca

Ministry of Children and Youth Services
http://www.children.gov.on.ca/

Ontario Ministry of Health and Long-Term Care
http://www.health.gov.on.ca

Ontario Public Health Association
http://www.opha.on.ca

Public Health Ontario
http://www.publichealthontario.ca

Appendix 3 - Health Units Map

Appendix 4 - Ontario Health Unit Contacts

Note: Due to the recent municipal elections, BOH Chairs may not be correct

Algoma Health Unit
294 Willow Avenue
Sault Ste. Marie, ON P6B 0A9
Tel: (705) 942-4646
Fax: (705) 759-1534
Web: http://www.algomapublichealth.com
MOH: Dr. Penny Sutcliffe (Acting)
BOH Chair: Marchy Bruni

Brant County Health Unit
194 Terrace Hill Street
Brantford, Ontario N3R 1G7
Tel: (519) 753-4937
Fax: (519) 753-2140
Web: http://www.bchu.org/
MOH: Dr. Malcolm Lock
BOH Chair: Robert Chambers

Chatham-Kent Public Health Services
435 Grand Avenue, P.O. Box 1136
Chatham, Ontario N7M 5L8
Tel: (519) 352-7270
Fax: (519) 352-2166
Web: http://www.chatham-kent.ca/
MOH: Dr. David Colby
BOH Chair: Joe Faas

Durham Region Health Department
605 Rossland Road East, PO Box 730
Whitby, Ontario L1N 0B2
Tel: (905) 668-7711
Fax: (905) 666-6214
Web: http://www.durham.ca/
Commissioner & MOH: Dr. Robert Kyle
BOH Chair: Lorne Coe

Eastern Ontario Health Unit
1000 Pitt Street
Cornwall, Ontario K6J 5T1
Tel: (613) 933-1375
Fax: (613) 933-7930
Web: English - www.eohu.ca/home/index_e.php
Web: Francais - www.eohu.ca/home/index_f.php
MOH & CEO: Dr. Paul Roumeliotis
BOH Chair: Gary Barton

Elgin-St. Thomas Health Unit
230 Talbot Street
St. Thomas, ON N5P 1G9
Tel: (519) 631-9900
Fax: (519) 633-0468
Web: http://www.elginhealth.on.ca/
Acting MOH: Dr. Joyce Lock
BOH Chair: Heather Jackson

Grey Bruce Health Unit
101 17th Street East
Owen Sound, ON, N4K 0A5
Tel: (519) 376-9420
Fax: (519) 376-0605
Web: http://www.publichealthgreybruce.on.ca/
MOH: Dr. Hazel Lynn
BOH Chair: Mike Smith

Haldimand-Norfolk Health Unit
12 Gilbertson Drive, P.O. Box 247
Simcoe, Ontario N3Y 4L1
Tel: (519) 426-6170
Fax: (519) 426-9974
Web: http://www.hnhu.org/
Acting MOH: Dr. Malcolm Lock
BOH Chair: Charlie Luke

Haliburton, Kawartha, Pine Ridge District Health Unit
200 Rose Glen Road
Port Hope, Ontario L1A 3V6
Tel: (905) 885-9100
Fax: (905) 885-9551
Web: http://www.hkpr.on.ca/
MOH: Dr. Lynn Noseworthy
BOH Chair: Mark Luvshin

City of Hamilton - Public Health & Social Services
1 Hughson Street North, 4th Floor
Hamilton, Ontario L8R 3L5
Tel: (905) 546-2424
Fax: (905) 546-4075
Web: http://www.hamilton.ca/phcs
MOH: Dr. Elizabeth Richardson
BOH Chair: Fred Eisenberger

Huron County Health Unit
Health & Library Complex, R.R #5
77722 London Road
Clinton, Ontario N0M 1L0
Tel: (519) 482-3416
Fax: (519) 482-7820
Web: www.huronhealthunit.com
Acting MOH: Dr. Maarten Bokout
BOH Chair: Tyler Hessel

County of Lambton
Community Health Services Dept.
160 Exmouth Street
Point Edward, Ontario N7T 7Z6
Tel: (519) 383-8331
Fax: (519) 383-7092
Web: http://www.lambtonhealth.on.ca/
MOH: Dr. Sudit Ranade
BOH Chair: Bev MacDougall

Halton Region Health Department
1151 Bronte Road
Oakville, Ontario L6M 3L1
Tel: (905) 825-6000
Fax: (905) 825-8588
Web: www.Halton.ca
MOH: Dr. Hamidah Meghani
BOH Chair: Gary Carr

Hastings & Prince Edward Counties Health Unit
179 North Park Street
Belleville, Ontario K8P 4P1
Tel: (613) 966-5500
Fax: (613) 966-9418
Web: http://www.hpechu.on.ca/
MOH: Dr. Richard Schabas
BOH Chair: Terry McGuigan

Kingston, Frontenac, Lennox & Addington Public Health
221 Portsmouth Avenue
Kingston, Ontario K7M 1V5
Tel: (613) 549-1232
Fax: (613) 549-7896
Web http://www.kflapublichealth.ca/
MOH & CEO: Dr. Ian Gemmill
BOH Chair: Charles Simmons

Leeds, Grenville and Lanark District Health Unit
458 Laurier Boulevard
Brockville, Ontario K6V 7A3
Tel: (613) 345-5685
Fax: (613) 345-2879
Web: http://www.healthunit.org/
MOH & CEO: Dr. Paula Stewart
BOH Chair: Anne Warren

Middlesex-London Health Unit
50 King Street
London, Ontario N6A 5L7
Tel: (519) 663-5317
Fax: (519) 663-9581
Web: http://www.healthunit.com/
MOH: Dr. Chris Mackie
BOH Chair: Ian Peer

North Bay Parry Sound District Health Unit
681 Commercial Street
North Bay, Ontario P1B 4E7
Tel: (705) 474-1400
Fax: (705) 474-8252
Web: http://www.myhealthunit.ca/en/index.asp
MOH & CEO: Dr. Jim Chirico
BOH Chair: Daryl Vaillancourt

Ottawa Public Health
100 Constellation Cres.
Ottawa, Ontario K2G 6J8
Tel: (613) 580-6744
Fax: (613) 580-9641
Web: http://Ottawa.ca/health
MOH: Dr. Isra Levy
BOH Chair : Shad Qadri

Peel Public Health
7120 Hurontario St.,
P.O. Box 667, RPO Streetsville
Mississauga, ON L5M 2C2 Tel: (905) 791-7800
Fax: (905) 789-1604
Web: http://www.region.peel.on.ca/health/index.
MOH: Dr. David Mowat
BOH Chair: Emil Kolb

Peterborough County-City Health Unit
10 Hospital Drive
Peterborough, Ontario K9J 8M1
Tel: (705) 743-1000
Fax: (705) 743-2897
Web: http://pcchu.peterborough.on.ca/
MOH: Dr. Rosana Pellizzari
BOH Chair: Leslie Parnell

Regional Niagara Public Health Department
2201 St. David's Road, Campbell East
P.O. Box 1052, Station Main
Thorold, ON L2V 0A2
Tel: (905) 688-3762
Fax: (905) 682-3901
Web: http://www.niagararegion.ca
MOH: Dr. Valerie Jaeger
BOH Chair: Alan Caslin

Northwestern Health Unit
210 First Street North
Kenora, ON P9N 2K4
Tel: (807) 468-3147
Fax: (807) 468-4970
Web: http://www.nwhu.on.ca/
MOH: Dr. Kit Yoing-Hoon
BOH Chair: Julie Roy

Oxford County - Public Health & Emergency Services
410 Buller Street
Woodstock, Ontario N4S 4N2
Tel: (519) 539-9800
Fax: (519) 539-6206
Web: http://www.oxfordcounty.ca/Healthy-you/Where-to-find-us
Acting MOH: Dr. Douglas Neal
BOH Chair: David Mayberry

Perth District Health Unit
653 West Gore Street
Stratford, Ontario N5A 1L4
Tel: (519) 271-7600
Fax: (519) 271-2195
Web: http://www.pdhu.on.ca/
MOH & CEO: Dr. Miriam Klassen
BOH Chair: Joan Facey

Porcupine Health Unit
169 Pine Street South
Timmins, Ontario P4N 8B7
Tel: (705) 267-1181
Fax: (705) 264-3980
Web: http://www.porcupinehu.on.ca/
Acting MOH: Denise Hong
BOH Chair: Steven Black

Renfrew County & District Health Unit
7 International Drive
Pembroke, Ontario K8A 6W5
Tel: (613) 732-3629
Fax: (613) 735-3067
Web: http://www.rcdhu.com/
MOH: Maureen Carew
BOH Chair: J. Michael du Manoir

Sudbury & District Health Unit
1300 Paris Street
Sudbury, Ontario P3E 3A3
Tel: (705) 522-9200
Fax: (705) 522-5182
Web: http://www.sdhu.com/
MOH & CEO: Dr. Penny Sutcliffe
BOH Chair: Ron Dupuis

Timiskaming Health Unit
247 Whitewood Avenue, Unit 43
PO Box 1090, New Liskeard, ON P0J 1P0
Tel: (705) 647-4305
Fax: (705) 647-5779
Web: http://www.timiskaminghu.com/
MOH (Acting) & CEO: Dr. Marlene Spruyt
BOH Chair: Carmen Kidd

Region of Waterloo, Public Health
P.O. Box 1633, 99 Regina Street South
Waterloo, Ontario N2J 4V3
Tel: (519) 883-2000
Fax: (519) 883-2241
Web: http://chd.region.waterloo.on.ca/
MOH: Dr. Liana Nolan
BOH Chair: Ken Seiling

Windsor-Essex County Health Unit
1005 Ouellette Avenue
Windsor, Ontario W9A 4J8
Tel: (519) 258-2146
Fax: (519) 258-6003
Web: http://www.wechealthunit.org/
MOH: Dr. Gary Kirk
BOH Chair: Gary McNamara

Simcoe Muskoka District Health Unit
15 Sperling Drive
Barrie, Ontario L4M 6K9
Tel: (705) 721-7330
Fax: (705) 721-1495
Web: http://www.simcoemuskokahealth.org/
MOH & CEO: Dr. Charles Gardner
BOH Chair: Barry Ward

Thunder Bay District Health Unit
999 Balmoral Street
Thunder Bay, Ontario P7B 6E7
Tel: (807) 625-5900
Fax: (807) 623-2369
Web: http://www.tbdhu.com/
MOH: Dr. David Williams
BOH Chair: Norm Gale

Toronto Public Health
277 Victoria Street, 5th Floor
Toronto, Ontario M5B 1W2
Tel: (416) 392-7401
Fax: (416) 392-0713
Web: http://www.toronto.ca/health
MOH: Dr. David McKeown
BOH Chair: Joe Mihevc

Wellington-Dufferin-Guelph Public Health
474 Wellington Road 18, Suite 100
RR #1
Fergus Ontario N1M 2W3
Tel: 519-846-2715
Fax: 519-846-0323
Web: http://www.wdghu.org/
MOH & CEO: Dr. Nicola Mercer
BOH Chair: Doug Auld

York Region Public Health Services
17250 Yonge Street, Box 147
Newmarket, Ontario L3Y 6Z1
Tel: (905) 895-4511
Fax: (905) 895-3166
Web:
http://www.region.york.on.ca/Departments/Health+Services/Public+Health/default+Public+Health+Services.htm
MOH: Dr. Karim Kurji
BOH Chair: Jack Heath

Appendix 5 - alPHa Board of Health Section Policies and Procedures

Name

1. The name of the organization shall be: "The Board of Health Section", hereinafter referred to as the Section.

Objectives

2. The objectives of the Section shall be:

   (a) To represent the views of boards of health as members of the Association of Local Public Health Agencies.

   (b) To promote and maintain a high standard of public health service in Ontario.

   (c) To work with other organizations which, from time to time, may exhibit similar objectives in the universal furtherance of a high standard of public health service in Ontario.

   (d) To promote the mutual helpfulness and procure harmonious action among the Boards of Health in the province.

   (e) To encourage legislation for the betterment of public health and to be available to cooperate with the Ministry of Health and Long-Term Care as consultants in the development of provincial policies and programs.

   (f) To endorse conferences and seminars to promote education and interaction amongst the membership.

Membership

3. (a) Active Membership in the Section shall be open to all active members of the boards of health, appointed or elected to serve a local, regional or municipal jurisdiction in Ontario. Active members shall have full voting privileges at Section general meetings and shall be eligible, under Article V of the constitution to vote at the annual meeting of the Association of Local Public Health Agencies.

   (b) Honourary Membership may be designated, at the discretion of the Section Executive, to any former Section Chair and/or Association of Boards of Health (AOBH) Past Presidents. They shall have no voting privileges.

Meetings and Procedures

4. (a) The general membership shall meet semi-annually: once at the Annual Conference of alPHa; and once in conjunction with the February All Members Meeting. Special general meetings may be held, at the call of the Chair, between meetings.

(b) A quorum for the transaction of business for the Section annual meeting shall consist of representatives from no fewer than fifty-one percent of member boards of health.

(c) The procedure for the order of business shall be those set forth in "Robert's Rules of Order" and shall prevail at all meetings.

(d) The Chair of the Section Executive shall preside over meetings and carry a vote. In the event of a tie vote on any motion or resolution the motion is defeated.

(e) Any board of health member of member agency shall qualify to be a voting delegate at large at any general meeting of the Section.

Executive Committee

5. (a) The Section will designate seven (7) members to make up one third of the Board of Directors of the Association of Local Public Health Agencies. These members will be elected for 2 year terms by the membership and constitute the Executive Committee of the Section. The Executive Committee of the Section will include:
   - a Chair
   - a Vice-Chair
   - and 5 members-at-large

(b) The Executive Committee shall meet at times and places as deemed necessary by the Chair to conduct the business of the Section. At other times the Executive Committee of the Section will maintain a continuity of effort through correspondence or directly through the alPHa Secretariat.

(c) The Section Executive may, from time to time, or upon direction from the alPHa Board, strike special committees or recruit from the membership special representatives to ad hoc committees.

(d) A quorum for the transaction of business at a Section Executive Committee meeting shall be four (4).

(e) No member of the Executive Committee of the Section shall receive any remuneration or honorarium from the Association of Local Public Health Agencies for acting as such.

(f) Attendance – It shall be the policy of the Section that any member who has two (2) absences in a row, or a total of three (3) during the same year, without giving prior notice of their absence, will be reminded by the Chair via official letter. After a total of four (4) absences, or three (3) in a row during the same year, without giving prior notice of their absence, the member will be deemed to have resigned from the Section unless exempted by a Section resolution.

Elections

6. (a) Elections for members of the Section Executive Committee shall be held each year during the alPHa Annual Conference.

(b) Elected or appointed members of a member board of health or health committee of a regional municipal council may be elected to the Section Executive. Termination of election or appointment at the local level will terminate membership of the Section and its Executive Committee.

(c) The Executive shall have the power to fill any vacancy within 60 days, if they so choose.

(d) The Board of Health Section Executive shall consist of seven (7) members, elected at the inaugural meeting of the Association, four (4) for two (2) year terms, the remaining three (3) for one (1) year terms. Thereafter, all newly-elected members of the Executive shall serve two (2) year terms. This shall promote continuity of experienced Executive members.

(e) Nominations will be accepted until five (5) business days prior to the commencement the Annual Conference of the Association of Local Public Health Agencies, at which time all Section Executive candidates will be allowed up to 2 minutes each for a brief statement of position.

(f) Board of Health voting delegates will be asked to elect from the slate of nominees the number of candidates to fill the number of Section Executive vacancies.

(g) Nominations must be submitted in writing from the respective Board of Health, bearing the signatures of two (2) Board of Health members from the sponsoring Board and that of the nominee. A nomination form that shall be supplied by the Association of Local Public Health Agencies. A biography of the nominee outlining their suitability for candidacy, as well as a motion passed by the sponsoring Board of Health are also required to be submitted with the nomination form. The future meeting expenses for directors will be paid by the sponsoring health unit.

(h) Representation on the Section Executive will include one (1) representative from each of the following regions of Ontario: North West, North East, South West,

Eastern, Central East, Central West, and Toronto, as defined by the Ministry of Health and Long-Term Care (see Appendix).

(i) The Executive Committee of the Section will endeavour to include at least one (1) representative from a Municipal Board of Health, meaning a Board that is separate from Council but where staff operations are integrated with the municipal administrative structures; at least one (1) representative from a Regional/Single-Tier Board of Health, meaning a Board where the Regional Council or a standing committee of Regional Council acts as the Board of Health; and at least one (1) member from an autonomous Board of Health, meaning a Board that is independent from local government.

(j) In general, candidates nominated by their Boards of Health must be present at the Annual General Meeting of the Association of Local Public Health Agencies to stand for election. However, absences may be permitted at the discretion of the existing Executive Committee in the case of emergency, catastrophic, or compulsory events that prevent a candidate from being present at an election.

(k) All Board of Health section members eligible to vote at the general meeting will participate in the election for each regional representative.

(l) Candidates shall be acclaimed to a position on the Section Executive where the candidate meets all of the nomination requirements and is the sole candidate in their region.

(m) The Executive Director of the Association of Local Public Health Agencies or designate shall preside over the election and shall not vote. In the case of a tie vote, the tied candidates will be allowed up to 2 minutes each for a brief statement of position. Immediately following the statements, eligible voters will be asked to vote for one of the tied candidates.

Chair

7. (a) Immediately following the election of the Section Executive Committee members, The new committee shall elect a Chair.

Note: The Chair also serves on the Executive Committee of the alPHa Board of Directors.

(b) It shall be the duty of the Section Chair (or designate) to preside over all Section meetings, to preserve order and, to enforce the Section Policies and Procedures. The Section Chair shall decide all questions of order subject to the appeal by a member to the meeting.

(c) It shall also be the duty of the Section Chair to provide a report of the Section's activities to the alPHa Board of Directors regularly.

Vice-Chair

8. It shall be the duty of the Vice-Chair, in the absence of the Chair, to preside and perform all duties pertaining to the office of the Chair.

Amendments and Alterations

9. (a) The Section Policies and Procedures may be amended at an annual or special General meeting of the Section with a quorum by a consensus vote.

(b) Notice of proposed amendments shall be circulated to each member board of health and health committee 60 days in advance of the meeting at which the proposed amendment will be presented.

Approved by the General Membership
Board of Health Section, ALOHA
June 7, 1988

Amended by the General Membership
Board Trustee Section, ALOHA
June 23, 1991 and June 15, 1992

Amended by the General Membership
Board of Health Section, alPHa
June 10, 2002

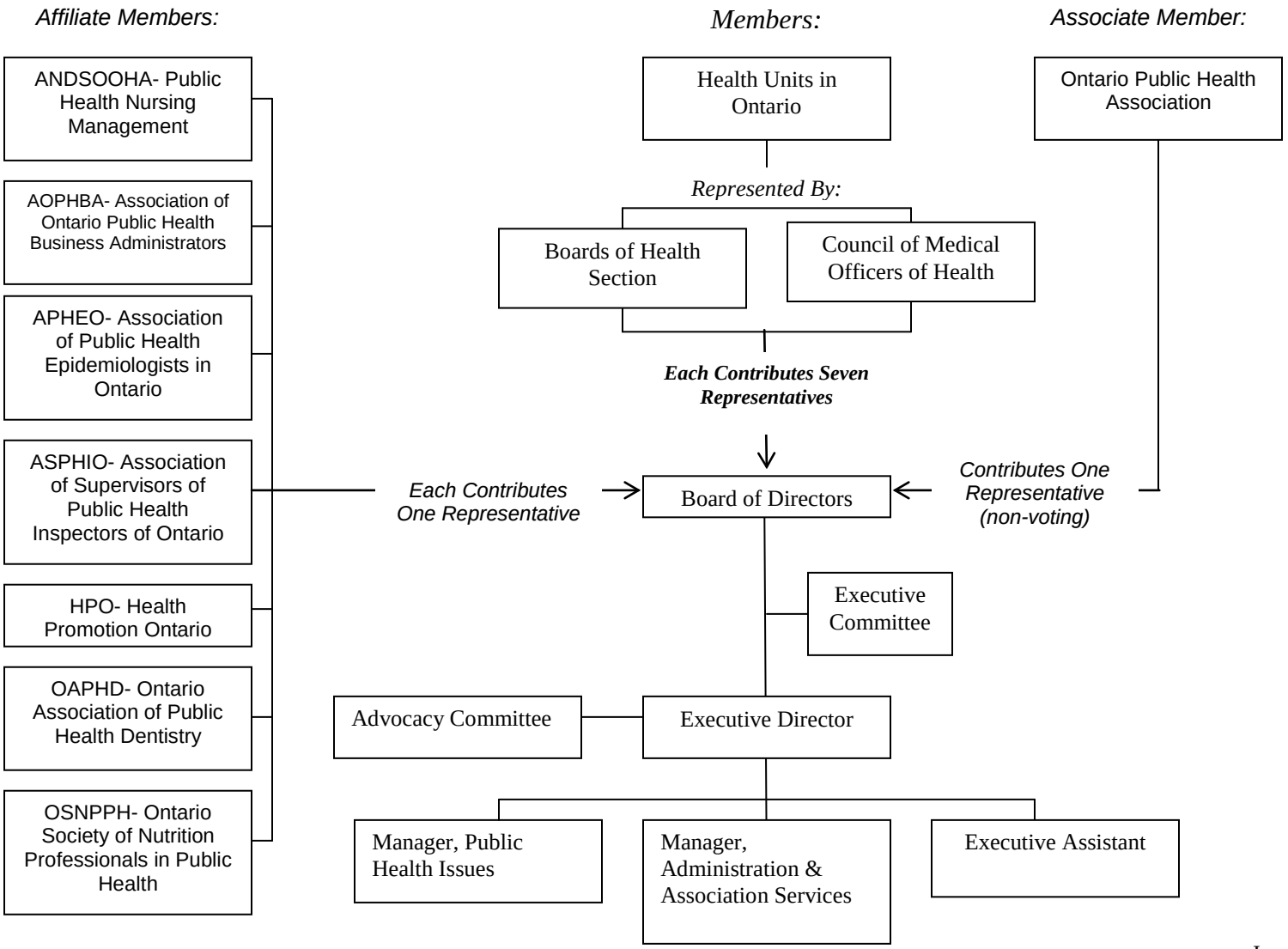
Amended by the General Membership
Board of Health Section, alPHa
January 29, 2004

Amended by the General Membership
Board of Health Section, alPHa
December 6, 2007

Appendix – Ontario Boards of Health by Region

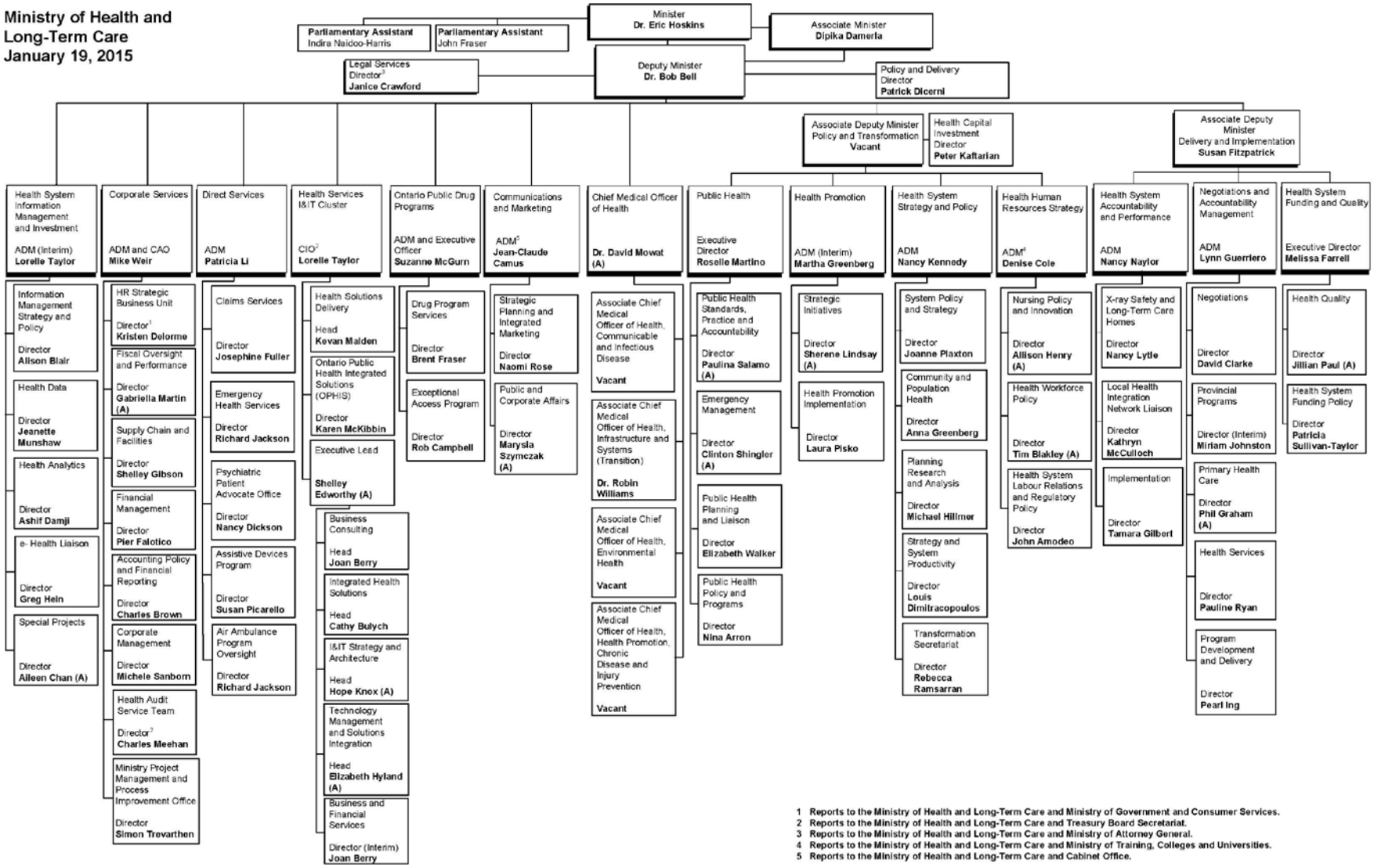
1	**North West Region**	NORTHWESTERN THUNDER BAY
2	**North East Region**	ALGOMA NORTH BAY PARRY SOUND PORCUPINE SUDBURY TIMISKAMING
3	**South West Region**	CHATHAM-KENT ELGIN ST THOMAS GREY BRUCE HURON LAMBTON MIDDLESEX LONDON OXFORD PERTH WINDSOR-ESSEX
4	**Central West Region**	BRANT HALDIMAND HALTON HAMILTON NIAGARA WATERLOO WELLINGTON DUFFERIN
5	**Central East Region**	DURHAM HKPR PEEL PETERBOROUGH SIMCOE MUSKOKA YORK REGION
6	**Toronto**	TORONTO
7	**Eastern Region**	EASTERN HASTINGS KINGSTON LEEDS OTTAWA RENFREW

Appendix 6 - alPHa Organizational Chart

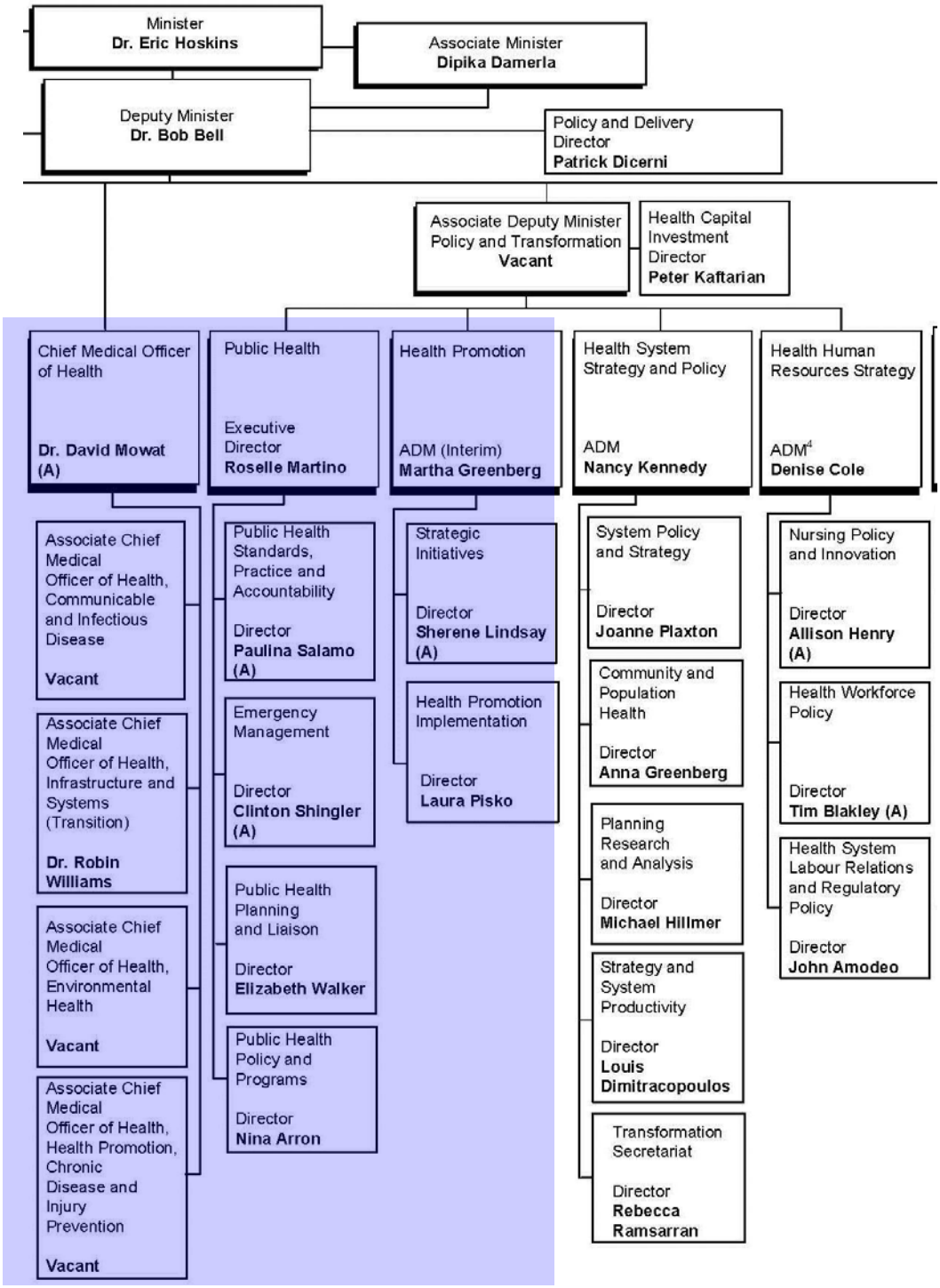


January 2015

Appendix 7 - Ministry of Health and Long-Term Care Organizational Chart



Appendix 8 – Public Health Division Organizational Chart



Appendix 9 - Board of Health Liability Review

A REVIEW OF BOARD OF HEALTH LIABILITY

For:

The Association of Local Public Health Agencies

James A. LeNoury
LeNoury Law
82 Scollard Street
Toronto, Ontario

T: (416) 926-1107
F: (416) 926-1108

Counsel to alPHa

Revised February 2011

Preface

This is a further update to a paper I originally presented in January 2004, [1]revised in November 2005 and updated again in 2006. My January 2004 presentation originated from a paper I had completed in November 2002 in which I was asked to review the liabilities of board members of Boards of Health in connection with carrying out their duties under the *Health Protection and Promotion Act.* In the January 2004 paper, I was asked to expand on the initial topic and include a

[1] I wish to thank my colleague John Middlebro who represents the Grey-Bruce-Owen Sound Health Unit for his comments in regard to the subject of this paper and my colleague Roderick Flynn who contributed to the 2006 and 2011 updates.

review of the general liabilities to which a board member of a Board of Health is subject to as a director[2]. I also included a section on the public health responsibilities and liabilities under the *Safe Drinking Water Act, 2002*.

In my subsequent revision in November 2005, I provided an update on changes which had occurred to the legislation affecting Boards of Health between 2004 and the November 2005.

In the 2006 version, I was asked to address still more developments in the applicable statutory regimes, outcomes from case law (including decisions involving a claim regarding West Nile virus[3] and another in which a municipality faced legal action arising from its public health aspect) and to address how public health was to potentially be shaped by the then-pending Bill 28 –the *Mandatory Blood Testing Act, 2006*[4].

In this latest update at the beginning of 2011, my intention is to provide a general update on the developments in the law and practice concerning the issue of liability as it relates to public health agencies.

Introduction

Public health is paradoxical. Public health attracts little attention when the system is functioning well. It is only in situations where the public's health is compromised that society turns its attention to the role of the public health system and the actions of public health providers. Sensational public health events such as the Walkerton Water Tragedy in May 2000, the SARS outbreak in 2003, West Nile virus and flu pandemic planning have prompted national and international attention to the role of public health and the actions of the public health providers.

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[2] For a helpful general overview of this topic, I recommend *Directors' Duties in Canada: Managing Risk, 2nd Edition* (2002), Margot Priest and Hartley R. Nathan, Q.C. CCH Canada Limited. I wish to thank Hartley Nathan for permission to use material from this book and to include the list of "Potential Questions for Board Self Evaluation" in Appendix A to this paper.

[3] *Eliopoulos Estate v. Ontario (Minister of Health and Long-Term Care* 2006 CanLII 37121 (Ont. C.A.), leave to appeal to the Supreme Court of Canada dismissed with costs, 2007 CanLII 19108 (S.C.C.)

[4] Bill 28 was referred to the Standing Committee on the Legislative Assembly which considered it on November 23 and 30, 2006. It received Third Reading in the Legislature on December 7, 2006 and got Royal Assent on December 20, 2006. It was proclaimed in force on August 10, 2007. In 2009, there was a minor amendment to the statute by virtue of the *Good Government Act*, S.O, 2009, c.33, Schedule 9, s.7.

In the course of the Walkerton Water Inquiry, other parties alleged fault on the part of the public health providers for decisions and actions taken in responding to the water crisis. Ultimately, the actions of the Bruce-Grey-Owen Sound Health Unit were exonerated and the steps taken by the Health Unit were in fact praised by Commissioner Dennis O'Connor in Part 1 of his Report of the Walkerton Inquiry. With respect to individual health concerns, , in 2006, the City of Toronto faced legal action arising from allegedly negligent administration of hepatitis B vaccine to a social worker with the Parkdale Community Health Centre who received 2 inoculations from "The Works", a Toronto outreach program."[5] This claim was dismissed by the Ontario Superior Court in reasons released on November 27, 2006[6] and later upheld on appeal. In a 2010 decision, Canada, Ontario and the City of Toronto faced a lawsuit by a citizen who had contracted HIV from his spouse who was an immigrant to Canada[7]. The action alleged that the three levels of government (including the City by means of its "Public Health Department") had failed to protect him from this consequence but the claim was struck out as against the Province and the City[8].

Further, an action against the Province of Ontario with respect to West Nile Virus (representative of approximately 40 actions against the Government of Ontario in this regard) was also struck out by the Ontario Court of Appeal in November 2006. Actions against the Province in connection with the SARS crisis resulted in similar holdings by the Courts[9].

Nonetheless, Walkerton, the SARS crisis and ongoing matters of public health (such as flu pandemic planning) have raised questions regarding the liability of boards of health and individuals for actions taken in the course of carrying out their duties on behalf of the public health system.

This paper addresses the topic of Board of Health liability in two main sections, each containing a number of interrelated topics:

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[5] See *Morgan v. Toronto* (2006), (Unreported: November 27, 2006) (Ont. S.C.J.) at para. 2; affirmed 2008 ONCA 603 (CanLII).
[6] *Ibid*.
[7] *Whiteman v. Iamakong* 2010 ONSC 1456 (CanLII)
[8] *Ibid.*
[9] See for example *Abarquez v. Ontario* 2009 ONCA 374 (CanLII); *Laroza Estate v. Ontario*, 2009 ONCA 373; *Williams v. Ontario* 2009 ONCA 378 (CanLII), leave to appeal to the Supreme Court of Canada dismissed 2009 CanLII 71462 (S.C.C); *Jamal v. Scarborough General Hospital* 2009 ONCA 376 (CanLII); *Henry Estate v. Scarborough General Hospital* 2009 ONCA 375 (ONCA).

I. GENERAL LIABILITIES OF DIRECTORS

1. **Prior to Accepting a Directorship**
2. **Statutory Liability**
3. **Determining Liability**
4. **Due Diligence**

II. SPECIFIC PUBLIC HEALTH LIABILITIES

1. **The Statutory Liability Exemption**
2. **Board Duties and Responsibilities**
3. **Board Governance**
4. **No Exemptions**
5. **Insurance**

Following a treatment of these main areas of interest, I will conclude by providing a brief update on the case law noted above and outline the significance of these decisions in the context of public health liability.

I. GENERAL LIABILITIES OF DIRECTORS

1. Prior to Accepting a Directorship

It is virtually impossible to be aware of every obligation and liability imposed upon a director. However, a board member can limit his or her own potential individual liability as a director by conducting his or her own process of "due diligence" prior to accepting and undertaking the obligations of being a director.

At a minimum, due diligence should involve:

- Requesting and receiving a written job description detailing the specific responsibilities expected of a director and what committees you may be expected to sit on;

- Request and take the opportunity to review board and committee minutes of the past 2 or 3 years to give you an understanding of the issues with which the board has been dealing;

- Attend the orientation program for new board members. If one does not exist, request an orientation;

- Request and receive a report on the current areas of concern and focus for the board of directors;

- Inquire whether the board has formal policies for compliance with its regulatory requirements, including the ones reviewed above; and

- Request and receive confirmation that the board has indemnification by-laws and insurance for its directors.

2. Statutory Liability

Corporations in Ontario and their directors are subject to statutory obligations and requirements under the *Ontario Corporations Act* and related statutes.

Section 52 of the *Health Protection and Promotion Act* ("*HPPA*") sets out that "…*every Board of Health is a corporation without share capital*". Because of their legislated status as corporations, Boards of Health ordinarily would be subject to the *Corporations Act*. However, section 52 of the *HPPA* specifically exempts Boards of Health from the provisions of these statutes applicable to ordinary non-share capital corporate legislation. This section provides that "the *Corporations Act* and *Corporation Information Act* **do not** apply to a Board of Health" [**emphasis added**]. As a result, board members of a Board of Health are not subject to directors' liabilities arising under the *Corporations Act*, including the personal liability to pay wages.

This does not end the matter. There are a number of other statutes (both federal and provincial) that hold directors personally liable for the failure of a corporation to comply with its obligations under the particular statute.

Income Tax, Employment Insurance, Workplace Safety

Directors can be found personally liable for failure of the Board of Health to deduct and remit amounts required under the:

- the *Income Tax Act;*
- the *Canada Pension Plan;*
- *Employment Insurance Act* (employment insurance premiums); *and*
- *Workplace Safety and Insurance Act, 1997* (Workplace Safety and Insurance Board premiums).

For your protection, you must ensure that these remittances are submitted in accordance with the requirements of the particular statute. In addition to liability for the outstanding remittances, directors may also be subject to additional penalties designated in the particular statute.

Employment Standards Act

The *Employment Standards Act*, 2000 ("*ESA"*) creates a director's personal liability for the payment of up to six months of employees' unpaid wages and vacation pay[10]. However, this provision does not apply to members of a Board of Health -as section 80 of the *ESA* sets out that the liability of directors under the *ESA* does not apply to directors of corporations "*…that are carried on* ***without*** *the purpose of gain*" [**emphasis added**]. Therefore, board members of a Board of Health are not liable under the *ESA* for employee unpaid wages and vacation pay.

Occupational Health and Safety

The Ontario *Occupational Health and Safety Act* ("*OHSA"*) establishes a comprehensive code of internal responsibility for health and safety within a workplace. This means that in addition to the employer as an entity, all individuals (from employees to directors) are responsible and liable for ensuring the health and safety of workers within a workplace, including a Public Health Unit.

Section 32 of the *OHSA* establishes the duties of directors and officers of a corporation. The section states that:

> Every director and every officer of a corporation shall take all reasonable care to ensure that the corporation complies with, (a) this Act and the

[10] See *ESA*, s.81.

> Regulations; (b) orders and requirements of inspectors and directors; and (c) orders of the Minister.

In relevant circumstances, the Ministry of Labour pursues charges and prosecutes individuals connected with workplace accidents. The penalties for an individual (including a Director) who is convicted of an offence under the *OHSA* are:

- a fine of not more than $25,000: or
- imprisonment for a term of not more than 12 months; or
- both a fine and imprisonment[11].

Amendments to the *Criminal Code of Canada* (Bill C-45) came into force on March 31, 2004 under which corporations and individuals can be charged with criminal negligence arising from a workplace accident. Such criminal charges would be in addition to a prosecution under the *OHSA*[12].

To comply with the duty to take reasonable care, directors must be found to have been involved with and to be overseeing the health and safety program in the Public Health Unit. At a minimum, this requires the Board of a Health Unit:

- to approve a health and safety policy;
- to ensure compliance with health and safety programs and training; and
- to receive information on a regular basis regarding the health and safety activities of the Health Unit.

Human Rights Code

Section 5 of the *Ontario Human Rights Code* (*"HRC")* establishes that:

> Every person has a right to equal treatment with respect to employment without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, record of offences, marital status, same sex partnership status, family status or disability.

[11] OHSA, s.66

[12] The first prosecution under the Bill C-45 amendments was initiated after a workplace fatality in April 2004 and resolved by way of a guilty plea to OHSA offences (with a withdrawal of the criminal charges) in March 2005. In 2010 individuals were charged in connection the death of four window washers on Christmas Eve 2009. A history of the prosecutions under the Bill C-45 amendments may be found at http://www.ccohs.ca/oshanswers/legisl/billc45.html

The *HRC* contains a specific provision that a person who is an employee has a right to freedom from harassment in the workplace by the employer or agent of the employer or by another employee.

Individuals (including directors of an employer) can be named as a Respondent to a complaint of discrimination or harassment in employment. To avoid being named as a Respondent to such a complaint, board members must ensure that their Health Unit:

- has a policy stating that the employer upholds the principles of the *HRC*;
- has established a process for dealing with human rights complaints; and
- complies with the established complaint process.

3. Determining Liability

At law, a director may be found individually liable when that person's conduct falls short of the established standard of care. In many situations the standard is that of, "…*a reasonably prudent person*". However, for some persons the standard of care can be higher than that of the "*reasonably prudent person*". For those directors with expertise, the standard of care can be that "…*which may reasonably expected from a person of such knowledge and experience*", as the identified director. For example, a health care professional, accountant or lawyer is considered to have expertise. Under this higher standard, it is important that a director exercise due diligence in accordance with his or her expertise to ensure that the Board and the organization is complying with its obligations.

4. Due Diligence

Most regulatory liability provisions allow a defence of "due diligence" for the corporation and for directors if potential liability extends to them. What constitutes "due diligence" depends on the regulatory statute, the corporation and the situation. However, some generalizations can be made. As a very general matter, "due diligence" involves:

- Putting in place a system for preventing non-compliance;
- Training employees in applying the system;
- Documentation;
- Monitoring and adjusting the system;
- Ensuring that adequate authority is given to the appropriate employees; and
- Planning remedial action in case the system fails at any point.

There is an increasing emphasis on the responsibility of directors to implement systems that provide them with the information they need to know to make decisions. Directors must ask questions and learn about the affairs and status of the corporation. They must monitor the workings of the corporation and make the decisions necessary to ensure that the corporation and its employees comply with the law.

To assist you in being able to comply with the due diligence required of a Board, I have included as Appendix "A" to this paper a questionnaire entitled, "*Potential Questions for Board Self-Evaluation*" This questionnaire will assist you in determining whether your Board is complying with its duties and obligations.

II. SPECIFIC PUBLIC HEALTH LIABILITIES

1. The Statutory Liability Exemption

The governmental responsibility for Public Health falls under the Ministry of Health and Long term Care. The *HPPA* sets out the statutory regime for the provision of public health duties, services, administration, and enforcement for the citizens of Ontario. The *HPPA* is divided into ten parts:

1. Interpretation
2. Health Programs and Services
3. Community Health Protection
4. Communicable Diseases
5. Rights of Entry and Appeals from Orders
6. Health Units and Boards of Health
7. Administration

8. Regulations
9. Enforcement
10. Transition

Section 95 of the *HPPA* deals with the issue of liability. The section provides for an exemption in regard to personal liability with respect to the carrying out of responsibilities under the *HPPA*. The section states:

> Protection from Personal Liability
>
> 95(1) No action or other proceeding for damages or otherwise shall be instituted against the Chief Medical Officer of Health or an Associate Chief Medical Officer of Health, a **member of a board of health**, a medical officer of health, an associate medical officer of health of a board of health, an acting medical officer of health of a board of health or a public health inspector or an employee of a board of health who is working under the direction of a medical officer of health for any act done in good faith in the execution or the intended execution of any duty or power under this Act or for any alleged neglect or default in the execution in good faith of any such duty or power. **[emphasis added]**

This section provides a broad exemption/protection to individual members of a Board of Health and the specified other individuals with respect to carrying out their responsibilities, **where their actions are done in good faith.**

It is noted that subsection 95(2) of the *HPPA* does state that the above-noted protection from personal liability does not apply to:

- prevent an application for judicial review of an action or an order;
- prevent a proceeding that is specifically provided for in the HPPA.

Subsection 95(4) provides for protection from liability for reports. It states:

> 95(4) No action or other proceeding shall be instituted against a person for making a report in good faith in respect of a communicable disease or a reportable disease in accordance with Part IV (Communicable Diseases).

However, these broad protections against individual liability under the *HPPA* do not end the matter. Subsection 95(3) reads:

> Board of Health not Relieved of Liability
>
> 95(3), subsection (1) does not relieve a Board of Health from liability for damage caused by **negligence** of **or action without authority** by a person referred to in subsection (1), and a

> Board of Health is liable for such damage in the same manner as if subsection (1) had not been enacted **[emphasis added].**

"*Negligence*" may be defined as follows:

> …the failure to do something or to use such care as a reasonably prudent and careful person would use under similar circumstances, or alternatively, it is the doing of some act which a person of ordinary prudence would not have done under similar circumstances, or the failure to do what a person of ordinary prudence would have done under similar circumstances.

While subsection 95(1) provides protection to board members from personal liability in regard to alleged negligence or fault in the carrying out of any duty or power in good faith, subsection (3) makes the Board of Health corporately liable for damage caused by negligence, or action without authority, by one of the persons referred to in subsection (1). It is noted that subsection 95(1) is limited to the public health professionals that are named and does **not** include other public health professionals such as public health nurses.

As well as the public health persons identified in section 95(1), other professionals of the Public Health Unit are protected by the 2-year time limitation for action stipulated in the *Limitations Act, 2002* (which came into force on January 1, 2004) ("*LA*"). Section 4 of the *LA* states:

> Unless this Act provides otherwise, a proceeding shall not be commenced in respect of a claim after the second anniversary of the day on which the claim was discovered.

While the statement of the 2-year limitation under section 4 of the *LA* seems relatively straightforward, the *LA* sets out fairly complicated rules for determining when a claim is "*discovered*" as a matter of practice (see section 5 thereof). The proclamation of the *LA* repealed the existing protection given to health units as "public authorities" under the limitation stated in section 7 of the *Public Authorities Protection Act* ("*PAPA*"). However, the *PAPA* limitation may still have application in very limited circumstances stated in the transition rules under s.24 of the *LA* [13].

[13] Section 24(5) of the LA allows a "former limitation" to apply where a plaintiff has a cause of action and no action has been commenced before the LA effective date of January 1, 2004 where a limitation did not expire before January 1, 2004 and the claim was discovered before January 1, 2004.

2. Knowledge of Duties and Responsibilities

Given the limited protection from liability provided to members of a Board of Health under section 95, it is recommended that the first step to be taken to avoid claims of negligence and a finding of liability is that members of a Board of Health take the time to become familiar with their duties and responsibilities under the *HPPA*.

Part VI of the *HPPA* deals with the formation and functioning of health units and boards of health.

Sections 48 to 59 deal with the composition, administrative issues and functions of the board.

Sections 62 to 71 deal with the board's responsibilities with respect to the Medical Officer of Health and other staff hired by the local Public Health Unit.

Sections 72 to 77 deal with the issues of funding of the Board of Health by the municipality and the provincial Government. The legislation requires the Board of Health to submit written notice of the estimated expenses expected to be incurred in carrying out the functions and duties of the *HPPA* and any other Act. It is the duty of the Board of Health to set a budget that allows the Board of Health to do what it is legally obligated to do. It is the obligation of the municipality to pay the expenses of the Board of Health.

Section 61 sets out the duty of a Board of Health in regard to the provision of public health services by the local Public Health Unit. This section states:

Duty of Board of Health

> 61. Every Board of Health **shall superintend and ensure the carrying out** of Parts II, III and IV and the Regulations relating to those parts in the health unit served by the Board of Health **[emphasis added]**.

Part II of the *HPPA* deals with Health Programs and Services.

The duties of the Board of Health with regards to health programs and services are set out in section 4. This section states:

Duty of Board of Health

4. Every Board of Health:

(a) shall superintend, provide or ensure the provision of the health programs and services required by this Act and the regulations to the persons who reside in the health unit served by the board; and

(b) shall perform such other functions as are required by or under this **or any other act** [**emphasis added**]

The use of the word "*shall*" in subsection 4(a) makes the duty of the Board of Health to provide programs and services mandatory. Subsection 4(b) extends the obligation to perform public health functions required under any other act. A general computer search found a reference to the words "*Board of Health*" in 66 provincial Acts or regulations.

Section 5 of the *HPPA* sets out that health programs and services must be provided in the areas of: (1) community sanitation; (2) control of infectious diseases; (3) health promotion and health protection; (4) family health; and (5) homecare services ensured under the *Health Insurance Act.*

Section 6 deals with providing public health services to school pupils.

Section 7 states that the Minister may publish guidelines for the provision of mandatory health programs and services and every Board of Health **shall comply** with the published guidelines.

Section 8 qualifies the obligation to provide programs and services in that it states that a Board of Health is not required to provide or ensure the provision of a mandatory health program or service set out in Part II **except to the extent** and under the conditions prescribed by the regulations and the guidelines.

Section 9 states that a Board of Health **may** provide any other health program or service in any area in the health units served by the Board of Health if, (a) the Board of Health is of the opinion that the health program or service is necessary or desirable, having regard to the needs of persons in the

area; and (b) the councils of the municipalities in the area approve the provision of the health program or service.

Part III of the *HPPA* deals with Community Health Protection. Part III establishes duties for the Medical Officer of Health and the professional staff of the local Public Health Unit with respect to conducting inspections for the purpose of preventing, eliminating and decreasing the effects of health hazards in the health unit; and dealing with complaints regarding a health hazard relating to occupational or environmental health.

Section 12 requires every Medical Officer of Health to keep him or herself informed in respect of matters related to occupational and environmental health.

Specific obligations are created in section 12(2) where it states that the Ministry of the Environment, the Ministry of Health, the Ministry of Labour or a municipality shall provide to a Medical Officer of Health such information in respect of any matter related to occupational or environmental health as is requested by the Medical Officer of Health, is in the possession of the Ministry or the municipality, and the Ministry or municipality is not prohibited by law from disclosing.

Part III also deals with the issuing of orders by the Medical Officer of Health or Public Health Inspector regarding a health hazard, specific obligations regarding food premises and food items, and the power of Medical Officer of Health or a Public Health Inspector when of the opinion upon reasonable and probable grounds that a health hazard exists to seize, examine, return and/or destroy a substance, thing, plant or animal.

Section 13 of the *HPPA* gives broad powers to a Medical Officer of Health or a Public Health Inspector in regard to issuing orders in respect of a health hazard. This section states:

> Order by MOH or Public Health Inspector re Health Hazard
>
> 13(1) A medical officer of health or a public health inspector, in the circumstances mentioned in subsection (2), by a written order may require a person to take or to refrain from taking any action that is specified in the order in respect of a health hazard.

Condition Precedent to Order

(2) A medical officer of health or a public health inspector may make an order under this section where he or she is of the opinion, upon reasonable and probable grounds,

(a) that a health hazard exists in the health unit served by him or her; and

(b) that the requirements specified in the order are necessary in order to decrease the effect of, or to eliminate the health hazard.

Given the broad powers that are designated under this section, it is recommended that members of a board of familiarize themselves with the entire section 13 of the *HPPA*.

As discussed above, under section 61, the Board of Health has the mandatory responsibility to superintend and ensure the carrying out of the obligations in Part III of the Act.

Part IV of the *HPPA* deals with communicable diseases. This part of the Act deals with the powers that are designated to the Medical Officer of Health and her or his staff in dealing with communicable diseases, many of which are defined in the Act. Part IV deals with the designated powers to a Medical Officer of Health to issue and seek the enforcement of orders and directions to prevent, respond to and control communicable diseases.

The *HPPA* formerly provided for a Medical Officer of Health to order blood samples in certain defined situations. Effective August 10, 2007, Section 22.1 of the *HPPA* was repealed and replaced by a freestanding statute called the *Mandatory Blood Testing Act, 2006***.** Bill 28, the *Mandatory Blood Testing Act, 2006*[14], made three significant changes from the procedure in place under section 22.1[15]. These are as follows:

- the period during which a voluntary sample from the person (from whom blood is sought) may be pursued was shortened to 5 days (from the former 7 day period prescribed in subsection 6(12) of Ontario Regulation 166/03 –"Orders under Section 22.1 of the Act");

[14] Bill 28 received third reading in the Legislature on December 7, 2006 and was given Royal Assent on December 22, 2006. It was proclaimed in force on August 10, 2007.
[15] In this respect, the author is indebted to Dr. Rita Shahin of alPHa who kindly shared with me her speaking notes with respect with respect to a speech she gave on November 23, 2006 concerning Bill 28.

- the application formerly made under s.22.1(2) of the *HPPA* will no longer be directed to the local Medical Officer of Health but instead will be directed to the Ontario Consent and Capacity Board[16];

- the right of both an applicant for such an order or the respondent "other person" to appeal any decision made under the section (as formerly provided in s.22.1 (9)) was removed by Bill 28.[17]

In essence, the *Mandatory Blood Testing Act, 2006* continues the involvement of the local Medical Officer of Health in the process of seeking voluntary provision of blood samples. However, in situations where a request for a voluntary sample is refused or ignored, under the *Mandatory Blood Testing Act, 2006,* a local Medical Officer of Health is not called upon to make an order for a blood sample: the Consent and Capacity Board (Ontario) is given jurisdiction over making such findings under the new regime[18].

It is recommended that members of Board of Health familiarize themselves with *the Mandatory Blood Testing Act*.[19]

Part IV of the HPPA also provides for appeals to the Health Services Appeal and Review Board and for applications to the courts in respect to orders and directions issued by the Medical Officer of Health.

Again, under section 61, the members of the Board of Health are responsible for superintending the actions of the Medical Officer of Health and staff of the local Public Health Unit under Part IV.

Safe Drinking Water Act

The *Safe Drinking Water Act, 2002*[20] ("*SDWA*") was introduced by the Ontario Government in response to the recommendations from the Walkerton Inquiry[21]. The *SDWA* establishes systems

[16] For information on the Consent and Capacity Board, see www.ccboard.on.ca
[17] *Ibid.*
[18] See s.4 of the *Mandatory Blood Testing Act*, S.O. 2006, c.26.
[19] The statute may be found at http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_06m26_e.htm
[20] S.O. 2002, c.32 (as amended).
[21] For background on the SDWA, see http://www.ene.gov.on.ca/envision/water/sdwa/index.htm

and obligations for the operators of water systems in the Province. The *SDWA* imposes a duty on persons:

- to report adverse water test results to the Ministry of the Environment and to the Medical Officer of Health;
- to consult with the local Medical Officer of Health in certain designated situations.

The *SDWA* also provides for the Medical Officer of Health to receive copies of orders from the Ministry of the Environment in regard to the operation and maintenance of water systems. The recipient Health Unit is obligated to respond to the communications in accordance with its mandate under the *HPPA*.

The *SDWA* has undergone several amendments since the January 2004 version of this paper[22]. The most significant of these changes is the recent transfer of direct oversight of five categories of systems to Public Health Units.

Under Ontario Regulation 252/05[23] (which came into effect on June 3, 2005), Public Health Units will be responsible for ensuring facilities such as churches, community halls, bed and breakfasts and tourist outfitters have safe drinking water. These provisions will regulate systems serving non-residential and seasonal residential uses. This will include a risk-based, site-specific approach for all drinking water systems serving non-residential and seasonal uses. Health Units will evaluate risks at individual systems and develop a system-specific water protection plan to ensure compliance with provincial drinking water quality standards.

The protection from liability under section 95 of the *HPPA* applies to the carrying out of duties under the *SDWA.* That is, liability only accrues in the event that the Health Unit or individuals were found to have been negligent in regard to the prescribed obligations. As set out in section 95, a Health Unit and the persons identified cannot be held liable if the duties were carried out in good faith.

[22] Amendments to s.14 and 19 (standard of care municipal drinking water system) of the Act are scheduled to come into force on January 1, 2013.

Clean Water Act, 2006

The *Clean Water Act, 2006* ("*CWA*") was passed by the Ontario Legislature and received Royal Assent on October 19, 2006 and came into force on July 3, 2007.

As described by the Government of Ontario Backgrounder on the legislation[24], under the *CWA*:

> For the first time, communities will be required to create and carry out a plan to protect the sources of their municipal drinking water supplies. The Clean Water Act will:
>
> - Require local communities to look at the existing and potential threats to their water and set out and implement the actions necessary to reduce or eliminate significant threats.
> - Empower communities to take action to prevent threats from becoming significant.
> - Require public participation on every local source protection plan. This means everyone in the community gets a chance to contribute to the planning process.
> - Require that all plans and actions are based on sound science.[25]

Local boards of health (as "local boards" as defined in the *Municipal Affairs Act*[26]) may be called upon under the *CWA* to "*comply with any obligation that is imposed on it…*" pursuant to certain protection policies developed under the statute (see section 38). Boards of health may also be required to provide documents which relate "*…to the quality or quantity of any water that is or may be used as a source of drinking water*" including:

> (a) any technical or scientific studies undertaken by or on behalf of the person or body; and
>
> (b) any document or other record relating to a drinking water threat;

upon the request of a municipality, a provincial ministry or water protection authorities or committees which are to be created/authorized under the statute.[27]

Section 98(1) (c) of the *CWA* contains a provision protecting against liability for local boards such as Boards of Health. It reads:

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[23] The rather unwieldy title of this Regulation is "Non-residential and non-municipal seasonal residential systems that do not serve designated facilities."
[24] http://news.ontario.ca/ene/en/2010/06/backgrounder-strong-protection-for-ontarios-drinking-water.html
[25] See http://www.ene.gov.on.ca/envision/news/2006/101801mb.htm
[26] Section 2 of the *CWA* imports the definition of "local board" from the *Municipal Affairs Act* which definition includes a "board of health" in section 1.

No cause of action arises as a direct or indirect result of:

(c) anything done or not done by…a local board in accordance with Parts I, II or III.

Subsections (2) and (3) go further and preclude any remedy to any claimant with respect to anything done under section 98(1). Subsection (3) clarifies that any such proceeding is barred.

While a Board of Health's obligations under section 87 of the *CWA* fall in Part V (rather than Parts I through III which are protected under s.98), the ordinary protections of s.95 of the *HPPA* would apply to any duty under section 87 of the *CWA*. Nonetheless, section 99 of the *CWA* provides similar protections to "*employees or agents*….of local boards". Section 99(2) states that:

> "No action or other proceeding shall be instituted against a person referred to in subsection (1) for any act done in good faith in the execution or intended execution of any power or duty to which this section applies or for any alleged neglect or default in the execution in good faith of that power or duty."

The omission of statutory protection to local boards (and their members) seems to be a significant oversight in the *CWA*, particularly given that presumably the local board would authorize the disclosure of any document under s.87 by an employee or agent, yet the shield from liability in the statute (as currently drafted) applies only to the actor and presumably not to the board which would authorize such steps.

3. Board Governance

Given the obligations and responsibilities of the Board of Health, it is clear that in order to carry out its responsibilities and to avoid liability, members of the Board of Health must take an active role in assuring themselves that the Medical Officer of Health and staff are carrying out their duties in compliance with the *HPPA* and its regulations. This may call for a review of a Board of Health's governance policies, procedures and practices.

The Board of Health must be assured that the Medical Officer of Health and staff are providing the health programs and services prescribed in Part II of the *HPPA*. In regard to Parts III and IV, the

[27] See section 87.

Board of Health must be satisfied that the duties under these parts are being carried out in compliance with the *HPPA* and its regulations. This means being satisfied that proper policies and procedures for carrying out the responsibilities under the *HPPA* and creating records have been put into place by the Medical Officer of Health and have been communicated to the staff. A protocol should be in place that establishes the expectation that the Medical Officer of Health will advise the Board of Health or the Chair of the Board of Health of crisis situations and of situations where there has not been compliance with the Act and regulations.

At the Walkerton Inquiry, one of the issues that arose was in regard to the Health Unit's receipt and follow-up with respect to communications with the Ministry of the Environment. The Board of Health must be assured that procedures are in place to ensure that its staff receives pertinent information from outside sources and that follow-up information is provided, or received in order to complete the communications loop.

Under section 67 of the HPPA, a Medical Officer of Health is responsible for the employees and reporting to the Board of Health in relation to the delivery of public health programs or services and issues relating to public health concerns programs and services.

It is recommended that if a Board of Health has not already done so, that a standing item on the board's agenda should be the receipt of a report from the Medical Officer of Health on the status of compliance with required obligations under the HPPA.

At Appendix "B" is a sample "*Board of Director Duty of Care Report*". The report provided is from alPHa's executive director to the alpha Board. The report states that the statutory obligations of the organization have been met.

In Boards of Health where public health and administration duties are under the direction of separate individuals, a report from both of these persons regarding compliance in their areas of responsibility would be in order.

4. No Exceptions

It is posited that persons serving in public health, whether as staff or as a board member, have one of the most important and challenging roles in our society. Anyone who is aware of the history of the Province of Ontario knows that it is the contribution of public health that is responsible for the quality of health and standard of living that the citizens in our province enjoy.

I suggest that it is a particularly challenging responsibility to be a member of a Board of Health for municipal politicians. This is because municipal politicians are faced with many competing demands.

The political challenges faced by a Board of Health were described in an article commenting on the Krever Inquiry into the Blood Tragedy. In a section on politics and public health funding, the author writes:

> The final report states that public health has been chronically under funded, which contributed to the blood tragedy. I believe that public health has two characteristics that make its funding problematic.
>
> First, public health is least visible when it is working best. In the competition for public dollars and political priority, what is not visible may receive little attention. Preventative or protective functions are noticed most when they fail - as with Canada's blood supply.
>
> Public health is often in the position of justifying resource needs on the basis of problems successfully avoided, or of hypothetical future problems. Politicians rarely respond well to this kind of argument, particularly when faced with the public and professional pressure to put more money into the curative side of health. In many provinces, public health is less visible than ever as regionalization has pushed its operating side away from where major policy and resource decisions are made.
>
> Second, public health often has its highest political visibility when raising issues that politicians would just as soon avoid. Food and water safety, occupational and environmental health, alcohol and drugs, for example, provide many issues with significant political consequences that public health professionals champion. Often in the face of pressure from those with a vested interest in the status quo. Politicians rarely warm to those they believe are causing political problems, even when they are public health professionals simply doing their jobs.
>
> A concerted effort must be made to explain public health to the public, especially the preventative and protective functions that are seen only when they fail. At the same time, public health advocates must be careful not to generate a negative reaction in politicians and senior decision makers by how they approach their responsibilities. Politicians do listen to

> those with an understanding of the irresolvable dilemmas of modern politics, and to those who have a track record of not 'crying wolf', unless there really is one! [28]

These comments are also applicable to the Walkerton tragedy, SARS and to the challenges faced by Boards of Health in the last number of years, including planning for a flu pandemic.

The author quoted above was writing about the political challenges for public health *vis-à-vis* politicians who are not members of a local Board of Health. I suggest that the political challenges relating to public health are heightened for councilors who are also members of the local Board of Health. The Walkerton tragedy in 2000 and the SARS epidemic in 2003 have served as stark reminders of the consequences if the public health system is weakened. These challenges are currently before members of Boards of Health in planning for a flu pandemic. Therefore, aside from the desire to avoid liability, the first duty of a member of a Board of Health is to ensure the integrity of the public health system. This is achieved by ensuring that the obligations under the *HPPA* are complied with, in order to protect the health of the citizens in the local health Unit.

Section 42 of the *HPPA* prohibits anyone from the obstruction of a public health professional from carrying out his or her duties. The section states:

> Obstruction
>
> 42.(1) No person shall hinder or obstruct an inspector appointed by the Minister, a Medical Officer of Health, a Public Health Inspector or a person acting under a direction of a Medical Officer of Health lawfully carrying out a power, duty or direction under this Act.

Notwithstanding the protection from liability under section 95 of the HPPA, an individual (including a board member) who is in violation of section 42 could be subject to being charged under the HPPA. While it is perhaps unlikely that a board member might face a charge under s.42 (as most, if not all, of a board member's actions in this regard would be official acts of the board itself as part of the directorship of the body corporate i.e. supporting or opposing the board acting by way of motion or by-law), it is conceivable that an individual's actions in his or her personal capacity to hinder or obstruct the actions of the board or its employees might attract such a charge in appropriate circumstances.

[28] Jan Skirrow: "Lessons from Krever - A Personal Perspective", Canadian HIV/AIDS Policy and Law Newsletter, Vol.

Section 101(1) provides that every person who is guilty of an offence under this Act is liable on conviction to a fine of not more than $5,000 for every day or part of a day on which the offence occurs or continues.

A member of a Board of Health cannot let competing interests override the duty to protect the public's health.

5. Insurance

This paper has reviewed the responsibilities of a Board of Health and the ways in which a Board of Health can avoid being found liable for breaches of the duties and responsibilities under the HPPA. Nevertheless, despite this review, your Board of Health could still find itself one day subject to a claim for negligence.

As a final practical matter, your Board of Health should review its liability insurance coverage on a regular basis to ensure that its coverage is adequate.

CASELAW

In the 2006 decision in the case of *Morgan v. Toronto*[29] ("Morgan"), the defendant was the City of Toronto. The City faced a claim for damages from a social worker with Parkdale Community Health Centre ("Parkdale"), who received 2 inoculations in 1994 from "The Works", a social and medical assistance program operated by Toronto arising from allegedly negligent administrations of a hepatitis B vaccine. After she had started with Parkdale, the Plaintiff's supervisor suggested that because of her work with intravenous drug users, she should receive hepatitis B vaccinations. When Morgan objected to the $150 cost of the vaccinations, her supervisor arranged to have them administrated for free by "The Works". Morgan received 2 hepatitis B inoculations, which she claimed were done without her signing a consent form with respect to either administration. Morgan was later diagnosed with Chronic Fatigue Syndrome ("CFS") (which she attributed to the

4, No. 2/3, Spring 1999.

Hepatitis B vaccinations in view of her symptoms after both inoculations), which rendered her unable to work. She claimed damages against Toronto for, *inter alia*, loss of future earnings and loss of enjoyment of life arising from her CFS which she alleged were caused by these injections.

In the result, the Court dismissed the Plaintiff's claim. At the same time, the Court was not unsympathetic to the Plaintiff's claim and essentially made a finding that the hepatitis B vaccinations she had received were the cause of her CFS[30]. However, the reasoning of the decision turned upon the Court's finding with respect to the limited medical knowledge about the risks from the inoculations at the time the hepatitis B vaccinations were given in 1994. The Court found that given that in 1994, the administrations of the particular hepatitis B vaccine were presumed to be safe and were not suspected to be associated with long-term neurological damage, the City (through the Works) could not be found to have breached its standard of care to the Plaintiff in failing to warn her about possible serious side-effects in taking the vaccinations.[31] Given the increased medical knowledge concerning these inoculations in the years after 1994, the Court added:

> Given the developments since 1994…and the recurring expressions of concern in the medical literature, had [the Plaintiff's] inoculation taken place in 2006, and obviously dependent upon the specific evidence adduced, it might well be open to a Court to conclude [despite the lack of proof to scientific certainty] that inoculees should be advised of continuing expressions of concern in the medical literature about a possible link between the vaccine and serious sequelae, including serious neurological sequelae/CFS/demylination. It might be well open for a Court to find that these are known, "material" risks about which a reasonable patient would want to know before making a decision to undergo a vaccination….It might well be open for a Court to hold that failing to disclose that information would breach the requisite standard of care.[32]

In addition to the insight the decision provides with respect to how courts may handle allegations of negligence against public authorities (including Boards of Health), the *Morgan* decision is of interest to public health units because in the course of the trial, broader allegations were raised

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[29] *Supra*, note 4.
[30] *Ibid*. at para.392.
[31] *Ibid* at para. 343.
[32] *Ibid*. at para. 353.

against, among others, public health authorities with respect to alleged suppression or concealment of hepatitis B vaccinations. The Court documented this at paragraph 4 of the decision as follows:

> "At trial, [the Plaintiff's] counsel alleged that the pharmaceutical companies, Health Canada, and other public health agencies have withheld and/or suppressed information concerning known dangers of the hepatitis B vaccine in order to promote widespread and therefore effective inoculation."[33]

Despite these allegations, the Court confined its ruling to the issues between the parties, leaving these broader aspects largely unresolved, saying:

> While I agree that these broader issues are deserving of further consideration, and I have made some general observations at the end of these reasons, I have not made and would not make findings about the conduct of unrepresented persons. I have focused, as I must, on the issues between the parties.[34]

Toward the end of its reasons, the Court added comments which underscored the importance of public health activities (from a societal perspective) while acknowledging that the protection of the public from ongoing or emergent threats to public health often occurs in a context of scientific and factual uncertainty and debate, calling upon the Legislature to be proactive to create funds for compensation of those who may be injured in these circumstances.[35]

The *Morgan* decision demonstrates, in an individual context, the difficult challenge facing public health boards and officials: while allegations of negligence (and widespread attention) may follow compromises in public health (either on an individual or broader basis), public health endeavours to operate within the parameters of the specific medical and scientific context of its time and resources. This recognition by a court is somewhat comforting, but at the same time, highlights again the ongoing paradox of public health.

The difficult job faced by those who work in public health was also underscored by the Ontario Court of Appeal's decision (released on November 3, 2006) in the case of *Eliopolous Estate v.*

[33] *Ibid*., para. 4.
[34] *Ibid*. para. 10.
[35] *Ibid*. para. 417-446.

Ontario (Ministry of Health and Long Term Care)[36]. The matter involved a claim brought by the estate of a man who had been bitten by an infected mosquito and had contracted West Nile Virus ("WNV") in 2002[37]. He was treated in hospital and released. In 2003, however, he suffered a fall and died from the complications which ensued. His estate sued the Province of Ontario, claiming that it "*could have*" and "*should have*" prevented the outbreak of WNV.

Faced with the claim, Ontario sought to strike the plaintiff's lawsuit on the grounds it disclosed no cause of action. Unsuccessful in both the motions Court and at the Ontario Divisional Court with this position, Ontario made a further appeal to the Ontario Court of Appeal. In the second paragraph of its decision in the case, the Court of Appeal summarized the central issue before it:

> "The central issue is whether, on the facts that have been pleaded, Ontario owed [the plaintiff] a private law duty of care [so as to provide the plaintiff] with the necessary legal basis for a negligence action for damages." [38]

The plaintiff's contention was that Ontario owed a duty of care "*…to take reasonable steps to prevent the spread of WNV and that Ontario failed at the operational level to implement a plan it developed for the expected outbreak of WNV.*" Ontario countered by denying that it owed any private law duty of care to the plaintiff. However, it was the Province's secondary position on this appeal which had primary significance for Ontario boards of health:

> "Ontario further submits that any liability for failure to implement measures to prevent WNV rests with local boards of health."

The Court of Appeal concluded (reciting the legal test used on a motion to strike a claim) that it was "*plain and obvious*" that the plaintiff's claim would not succeed. It allowed the appeal and struck the plaintiff's statement of claim. In so doing, however, it made somewhat startling and somewhat disconcerting statements concerning the responsibility of public boards of health for health crises such as WNV.

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[36] *Supra*, note 3. While not specified to be a "class action" in the decision, the Court of Appeal mentions in paragraph 1 of its reasons that "*This action is one of approximately forty similar actions brought by Ontario residents who contracted WNV in 2002.*" An application for leave to appeal to the Supreme Court of Canada was filed by the plaintiff on December 29, 2006.

[37] As noted in the reasons, Mr. Eliopoulos was one of forty claimants re: WNV. All of the actions were at the same stage in litigation.

[38] *Supra*, para. 2.

As noted above, the Court determined that the primary question before it was the proximity of the relationship between the plaintiff and defendant and whether under the circumstances, "*…it is just and fair having regard to that relationship to impose a duty of care on the defendant*."[39] In embarking upon its analysis of this question, the Court of Appeal held that this was a legal question which could be resolved, primarily by reference to the HPPA.[40] After reviewing the role of the Minister and Ministry of Health under the HPPA, the Court of Appeal found that the Ministry/Minister of Health accrues "*discretionary powers*" under the HPPA which were insufficient to create a "*private duty*" of care to the plaintiff.[41]

Next, the Court of Appeal dealt with the plaintiff's argument that its issuance of "West Nile Virus: Surveillance and Prevention in Ontario 2001" ("the Plan") amounted to a policy decision "*…of the kind that would engage Ontario at the operational level*".[42] The Court rejected this argument for reasons including:

> "…to the extent that the Plan amounted to a policy decision to act and created a duty of care, it is clear from the terms of the Plan itself and from the relevant legislation to which I will refer that any operational duties under the Plan resided with the local boards of health."[43]

On the issue of whether promulgation of the Plan by Ontario amounted to "*the adoption of a policy at the operational level*", the Court ruled that the Plan's impact was primarily informational and not practical, with the latter aspect falling to public health units:

> "…the Plan represented an attempt by the Ministry to encourage and coordinate appropriate measures to reduce the risk of WNV by providing information to local authorities and the public. The Ministry undertook to do very little, if anything at all, beyond providing information and encouraging coordination. The implementation of specific measures was essentially left to the discretion of members of the public, local authorities and local boards of health."[44]

Finding that the operational aspects of the Plan (including the collection and reporting of dead birds; necessary liaison with hospitals and testing of mosquito pools) were "*left to local*

[39] *Supra*, para. 11.
[40] Supra, para. 14-15.
[41] *Supra*, para. 17.
[42] *Supra*, para 21.
[43] *Supra*, para. 22
[44] *Supra*, para. 23

authorities"[45], the Court of Appeal determined that the Plan fell "*…well short of the sort of policy decisions to do something about a particular risk that triggers a private law duty of care*."[46]

The Court of Appeal returned to this aspect again, identifying that like the HPPA, the Plan outlines general duties of the Province, but by contrast delineates a specific, practical role for local health agencies:

> "To the extent that the Plan may be read as identifying specific operations to be performed, those tasks are left to local health authorities and local boards of health. In this regard, the Plan mirrors the scheme of the HPPA, ss.4 and 5: responsibility for implementation of health policy, including superintending and carrying out health promotion, health protection, disease prevention, community health protection and control of infectious diseases and reportable diseases, rests with local boards of Health, not the Ministry."[47]

The Court did acknowledge however, that local boards could be directed by the Ministry:

> "Local boards of health are subject to direction from the Minister (s.83 (1)), and in the event the local board of health fails to follow such direction, the Minister can act in its stead (s.84 (1)). However, this serves only to emphasize that under the HPPA, local boards of health, constituted as independent non-share capital corporations, bear primary operational responsibility for the implementation of health promotion and disease prevention policies."[48]

In concluding that it would "*…create an unreasonable and undesirable burden on Ontario that would interfere with sound decision-making in the realm of public health*" to impose a private law duty of care on Ontario with respect to the plaintiff, the Court of Appeal finished its reasons with some perhaps more comforting words for those working in the public health sector:

> "Public health priorities should be based upon the general public interest. Public health authorities should be left to decide where to focus their attention and resources without the fear or threat of lawsuits."[49]

The plaintiff filed a notice of appeal with the Supreme Court of Canada on December 29, 2006. However, this appeal was dismissed with costs on May 24, 2007.

The thrust of the Court of Appeal's decision in *Eliopoulos* was that Ontario did not owe the plaintiff a duty of care with respect to WNV, the breach of which could give rise to an action for damages.

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[45] *Supra*, para. 24
[46] *Supra*, para. 25.
[47] *Supra*, para. 27.
[48] *Supra*, para. 27.

The main rationale for this finding was that with respect to WNV specifically (and as a general matter under the HPPA), the Province has primarily an advisory rather than operational role with respect to matters of public health.

Unfortunately, the reasons of the Court of Appeal in *Eliopoulos*, in emphasizing the lack of proximity between Ontario and individual citizens with respect to operational matters of public health, perhaps overplays the legal responsibility of local public boards during any crisis in public health (such as WNV). It must be remembered that there is a difference between the existence of statutory duties to the public in this context and the breach of such duties: the case should not be misread as suggesting that losses attributable to crises in public health are necessarily recoverable from one or more local public boards of health (or their members). While certainly underplaying the importance of the Province's coordination of public health initiatives and operations in the face of public health crises, *Eliopoulos* does highlight that much of the hard work in responding to such health crises falls to the local units. It also acknowledges that under the structure of the HPPA, local units do have legal duties to citizens within their respective jurisdictions. At the same time, it must be remembered the fact that the Court of Appeal in *Eliopoulos* has identified that local units do have duties to members of the public with respect to public health crises (such as WNV) pursuant to the HPPA regime, it does not necessarily follow that any harm to a member of the public from such a crisis amounts to negligence on the part of a local public health unit (or any of its members) or to reasonably foreseeable damage.

In my view, the mere existence of duties of local health units to the citizens within their jurisdictions does not necessarily predicate that any loss from a public health crisis will be give rise to a finding of liability against the unit (or indeed any of its members). To show negligence, in addition to showing the existence of a duty, a plaintiff has to show:

- a breach of the duty of care by the defendant (i.e. less than the required standard of care);
- the breach of duty caused damages to the plaintiff which were reasonably foreseeable.

In these respects, individual members of local boards of health will still have the protection of s.95 of the HPPA for acts done in good faith in the "*execution or intended execution of any duty or*

[49] *Supra*, para. 33.

power" under the HPPA. Further, under the law of negligence, defendants are only responsible for reasonably foreseeable damages. The fact that loss occurs by virtue of a public health crisis does not mean that such damage was caused by a breach of duty by a local public health authority or any of its members. In this context, it is submitted that the Court of Appeal's decision in *Eliopoulos* recognizes that, like so much in the public health realm, compromises of public health are reviewed retrospectively with the benefit of hindsight illuminating how the system could have worked better.

Courts considering the *Eliopoulos* decision have not seemed to focus on the responsibility of local public health agencies (or their members) in analyzing issues about duties to members of the public. The focus of the post- *Eliopoulos* decisions (particularly in respect to the SARS crisis) appear to have returned to a recognition of the inherent difficulty in making decisions in the context of emergencies –as the Court of Appeal stated, decisions about "….*where to focus their attention and resources*"[50] –and provide at least some deference to judgments made by local boards of health and their members in these trying contexts.

Decisions of Ontario courts subsequent to *Eliopoulos* (made in the context of the aftermath of the SARS crisis), appear to show a similar reluctance to impose a private law duty of care on health authorities as a result of a public health crisis. While there were many decisions arising out of the SARS crisis[51] (primarily seeking to strike out statements of claim at an early stage on the basis that they show no reasonable cause of action against public authorities), the Ontario Court of Appeal's decision in the case of *Williams v. Ontario*[52] ("Williams"), is perhaps the most expansive in its analysis of this issue.

Williams was heard along with 4 similar appeals which raised the issue of whether "….*Ontario can be held liable for damages by individuals who contracted SARS during the outbreak of that illness in 2003*."[53] In addressing a motion to strike by Ontario, the motions court had struck out portions of the claim, but not all of it, relying upon the Divisional Court's decision in *Eliopoulos* (which itself was later overruled by the Ontario Court of Appeal).

[50] *Supra*, note 44.
[51] *Supra*, note 9.
[52] *Ibid.*
[53] *Ibid*, para. 1.

Ontario appealed the decision with respect to the portions of the claim which survived the motion. In turn, the plaintiff appealed the motions court ruling in respect to those which had been struck out. The matter evolved into a proposed class action which came before the Ontario Court of Appeal. As in *Eliopoulos*, the Court of Appeal stated the issue in the matter plainly:

> "The central issue on this appeal is whether, on the facts pleaded in the claim, it is arguable that Ontario owes a private law duty of care to the plaintiff sufficient to ground an action in negligence for damages."

The plaintiff tried to distinguish *Eliopoulos* on its facts, noting that the Directives issued by the Ontario Government during the SARS crisis created a relationship of proximity far closer than the situation than when the Province was facing the West Nile virus. In so arguing, the plaintiff was attempting to fit the facts before the Court within the test for the imposition of a legal duty of care.[54] In this analysis, the Court is first to look at whether the duty of care asserted by the plaintiff already exists in the law. If the facts do not fit within an existing situation where a duty of care has been recognized, the Court must do a two-step analysis involving two components:

- a consideration of whether the two parties are sufficiently proximate to justify the imposition of a duty of care; and
- whether there are residual policy considerations which militate against the imposition of a novel duty of care.

The plaintiff argued that the case fit squarely into an existing category: negligence causing physical harm to persons or property. The Court rejected this argument, focusing on the fact that the alleged negligence did not arise from creating the risk which caused the harm, but failing to adequately address it:

> "…the proximity analysis cannot be short-circuited by focusing simply on the fact that the plaintiff has alleged that the defendant's negligence has resulted in

[54] *Anns v. Merton London Borough Council*, [1977] 2 All E.R. 492 as adopted by the Supreme Court of Canada in the case of n *Kamloops v. Nielsen*, 1984 CanLII 21 (S.C.C.), [1984] 2 S.C.R. 2, and *Cooper v. Hobart*, 2001 SCC 79 (CanLII), [2001] 3 S.C.R. 537

> physical harm to a plaintiff's person or property. This is especially so in cases where the defendant did not create the risk that actually caused the harm, and the alleged negligence consists of a failure to take adequate steps to prevent physical harm arising from the external or existing risk…"

In moving to an analysis of the proximity between the plaintiff and Ontario, the Court looked at the statutory scheme under which SARS directives were made by Ontario's Chief Officer of Health ("COH"): the HPPA. In so doing, the Court summarized the finding in *Eliopoulos* that the powers given to the COH and MOH to take measures to protect the public in respect to outbreaks were to be exercised in the "*general public interest*" rather than being "*…aimed at or geared to the protection of the private interests of specific individuals*." In referencing *Eliopoulos*, the Court alluded to a similar finding by the Ontario Court of Appeal in the context of products liability, where individuals alleged negligence against the Federal Government in failing to test ban or recall certain breast implant products[55].

Despite the plaintiff's attempts to distinguish *Eliopoulos* by maintaining that the risk of exposure to SARS through a visit to a certain hospital was far more specific –and therefore proximate -than the risk of being bitten by a mosquito circulating among the public at large, the Court refused to distinguish the facts in *Eliopoulos* and declined to impose a duty of care on the Province to the plaintiff. In making this finding, the Court appeared to emphasize the highly "macro" nature of public health policy decision-making:

> " When assessing how best to deal with the SARS outbreak, Ontario was required to address the interests of the public at large rather than focus on the particular interests of the plaintiff or other individuals in her situation. Decisions relating to the imposition, lifting or re-introduction of measures to combat SARS are clear examples of decisions that must be made on the basis of the general public interest rather than on the basis of the interests of a narrow class of individuals. Restrictions limiting access to hospitals or parts of hospitals may help combat the spread of disease, but such restrictions will also have an impact upon the interests

> of those who require access to the hospital for other heath care needs or those of relatives and friends. Similarly, a decision to lift restrictions may increase the risk of the disease spreading but may offer other advantages to the public at large including enhanced access to heath care facilities. The public officials charged with the responsibility for imposing and lifting such measures must weigh and balance the advantages and disadvantages and strive to act in a manner that best meets the overall interests of the public at large."

In its analysis of the second part of the test –whether there were any policy concerns which argued against the imposition of a duty of care on the Province to the Plaintiff re: SARS, the Court quoted *Eliopoulos* in saying that public health officials were called upon to "…*weigh and balance the many competing claims for the scarce resources available to promote and protect the health of its citizens.*" The Court agreed with its own earlier finding that to impose a duty on the Province to the Plaintiff re: SARS would impose "…*an unreasonable and undesirable burden on Ontario that would interfere with sound decision-making in the realm of public health*." In conclusion, the Court in *Williams* noted that the plaintiff was not without defendants to pursue: "*local health care facilities*" and "*health care professionals*" (without reference to local public health entities).

The *Williams* decision, while focusing on the duties of the Province, re: public health (and finding no liability against this level of health authority with respect to injuries suffered by citizens), essentially repeats the reasoning stated in *Eliopoulos* that there is both insufficient proximity and policy considerations which militate against imposing a private law duty of care on provincial health authorities for injuries suffered by citizens through outbreaks.

Apart from the many actions dealing with issues of liability in respect to the SARS outbreak, as noted above, a 2010 decision specifically addresses the legal distinction between an incorporated municipality and a local board of health operating within such jurisdiction.

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[55] *Drady v. Canada (Minister of Health)* 2008 ONCA 659 (CanLII) leave to appeal to Supreme Court of Canada refused [2008 S.C.C.A. 492)

In the matter of *Whiteman v. Iamekhong*[56] (from 2010), the plaintiff had contracted HIV from his spouse, who had immigrated to Canada from Thailand while HIV positive. The plaintiff brought an action against his former spouse, Canada (alleging among other things, negligence arising from a medical examination when the spouse sought permanent resident status), Ontario and the City of Toronto via its "Public Health Department". The lawsuit alleged that his former spouse had failed to disclose her HIV positive status to him. Against the three levels of government, the plaintiff alleged they had failed in their duty to protect him.

In his claim, the plaintiff had pleaded that "Toronto Public Health" was "*….the municipal entity responsible for educating, monitoring and investigating residents with reportable diseases pursuant to the Health Protection and Promotion Act."* The government defendants brought a motion to strike the plaintiff's claim as disclosing no reasonable cause of action among other reasons. The Court struck out the claim against Ontario based upon the reasoning in *Eliopoulos.*

In considering the motion by the City of Toronto, the Court made clear that the municipality was not the appropriate defendant to the action. Rather, the Court pointed to the independent corporate entity of Toronto's board of health, established pursuant to the *City of Toronto Act, 1997*. The Court similarly struck out the claim against the City observing that the municipality was not "*…the local "board of health" which may be held liable in some individual cases and, finally, any broad systemic failures alleged against Toronto in the public health field are not a proper basis for private law duties*".

The decision in Whiteman simply highlights that at the local level, it is the Board of Health, rather than the municipality itself, which is the independent entity responsible for health promotion and protection. The fact that the Court opined that perhaps a board of health might be held liable in certain circumstances (as more extensively described above) does not appear to detract from the *Eliopoulos* principle which resisted the imposition of duties on public health entities to individuals in public health emergencies.

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CONCLUSION

Although there is statutory protection from liability for individuals and the Board of Health when carrying out responsibilities under the statute in good faith, the Board of Health remains potentially liable for harm caused by the negligence of an individual. Members of a Board of Health in order to avoid liability must be aware of the duties and activities of the employees of the Local Public Health Unit and be satisfied that the activities of health unit employees are being carried out in accordance with statutory requirements and in a professionally recognized manner. Board of Health members cannot allow for any exemptions from their public health obligations. Sufficient liability insurance should be purchased to ensure adequate coverage in the event a lawsuit is brought against the Board of Health.

APPENDIX A

Potential Questions for Board Self-Evaluation

1. Does the Board get enough information of the right kinds, at the right time, from the right members of management?

2. Does the Board have an effective orientation and training program, both for new directors and for current directors?

3. Does the Board have active committees, composed of an effective number of directors to deal with such matters as audit, governance, nominations, environmental issues, human resource, program and other matters?

4. Are the committee members and chairs rotated at appropriate intervals?

5. Are the Board meetings conducted effectively, with appropriate frequency and according to well-thought-out agendas and circulated in advance?

6. Do Board members receive the necessary briefing material for Board meetings in sufficient time to prepare?

7. Are Board meetings characterized by open communication and diligent questions on the points discussed in a collegial manner?

8. Does the Board meet regularly in private, apart from the CEO or other senior managers?

9. Are the Board's actions motivated by the furtherance of the objectives of the corporation and enhancing the ultimate value to shareholders?

10. Does the Board communicate regularly with its shareholders and other stakeholders?

11. Does the Board establish goals for management and review their effectiveness and performance on at least an annual basis?

12. Does the Board establish guidelines for managers that clearly specify their authority?

13. Does the Board micromanage operations or, at the other extreme, does it ignore them and let management handle everything with little Board oversight?

14. Has the Board reviewed legal exposures and assessed legal compliance processes and records?

15. Does the Board receive regular reports on compliance with applicable legislation, including compliance with the Income Tax Act and the Employment Standards Act and environmental statutes?

16. Does the Board have an effective audit and financial oversight process?

17. Does the Board have effective standards and procedures to minimize and disclose potential conflicts of interest by members or officers?

APPENDIX "B"

alPHa Board of Director Duty of Care Report

The following actions are being completed on behalf of the Board of Directors of the Association of Local Public Health Agencies:

1. The payroll functions are being completed by the Haliburton, Kawartha, and Pine Ridge District Health Unit (HKPR). Included in this is the payment of Canada Pension Plan contributions, Employment Insurance contributions, Ontario Municipal Employees Retirement Plan contributions to the appropriate sources and timely remuneration of Association staff. The current contract with HKPR expires March 31, 2003.

2. The Non-Profit Information Return (R1044) is filed within six months of March 31, (year end) of each year. Activities such as trades or business are not completed ensuring the Association maintains its non-profit status. The Association is exempt from Income Tax.

3. The General Sales Tax (GST) is reconciled and filed every three months. The Association is Provincial Sales Tax (PST) exempt.

4. Adequate Board of Directors' Liability Insurance is being maintained through the timely payment of its premiums.

5. All staff are operating under the alPHa Personnel Policies at all times when performing work for the Association.

6. No other information material to the financial operation of the Association has been withheld.

NOTES

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Briefing Note

To: The Board of Health of Algoma

From: Tony Hanlon, Chief Executive Officer

Date: September 22, 2015

Re: Prenatal & Postnatal Nurse Practitioner Program (PPNP)

☒ For Information ☒ For Discussion ☒ For a Decision

ISSUE:

In June 2014, Algoma Public Health's Prenatal and Postnatal Nurse Practitioner (PPNP) services were discontinued as the nurse practitioner at the time resigned. The position remains unfilled to this date, due to paucity of applicants and very little community demand.

RECOMMENDED ACTION:

To discontinue the PPNP program offered at Algoma Public Health in Sault Ste. Marie.

BACKGROUND:

The Prenatal and Postnatal Nurse Practitioner (PPNP) program was first established in 2001 to support the provision of primary health care by a nurse practitioner (NP) through public health units in under serviced areas where there were barriers to accessing primary care services for pregnant women and parents/caregivers and families with children under the age of 6.

In 2003, Algoma Public Health secured program funding through the Ministry of Children and Youth Services (MCYS) to implement a local PPNP program in Sault Ste. Marie.

Until June 2014, when the nurse practitioner resigned, APH provided full time NP services to pregnant women and those women with children under the age of 6. After the

NP's resignation, a recruitment phase was undertaken. No viable applications were received.

In November 2014, an inquiry was made about the position. At that point, a scan of calls received on the Parent Child Information Line (PCIL) and anecdotal information received from both the hospital liaison and 48hr home visiting public health nurses indicated that there was little to no community demand for primary care from pregnant women and women with children under the age of 5. Additionally, contact was made with the Group Health Centre who confirmed that there were "many" family practitioners within our community accepting newborn patients.

An application was received in February 2015, however during the month of February and March 2015 conversations with the MCYS and APH representatives, including Director of Community Services occurred to discuss the status of Sault Ste. Marie's PPNP program. Expansion of the program was mentioned however it was not an option at that time. It was agreed upon that we would collaborate with our internal epidemiologist to evaluate available client data, consider anecdotal information and develop a client survey to best inform the next steps.

In June 2015 a survey using convenience sampling was administered by APH staff working in program areas where women who were currently accessing services were likely to be pregnant or have children under the age of 5. Of the 66 respondents, 81% of women confirmed having a primary care provider for both themselves and their children, 4.8% confirmed having a primary care provider for their children but not themselves, and 14.3% pregnant women reported not having access to a primary care provider.

Reports were generated using our internal electronic health records for clients accessing NP services from April 2012 to March 2014. These showed a decrease in client visits, new clients, and unique clients, and an increase in prenatal client visits. However, prenatal client visits were almost exclusively for the purposed of obtaining a referral to an OB/GYN.

On September 10, 2015 APH engaged in a second conversation with MCYS to review current data and discuss options to explore expansion of current services. At this time MCYS indicated that they are not in a position to change the policy of this program.

ASSESSMENT OF RISKS AND MITIGATION:

Some of the potential risks associated with discontinuing the PPNP program:

- A small percentage of potential clients that fit the PPNP criteria will need to access other options for primary health care.
- Staff reduction will not need to be addressed as APH does not currently have a nurse practitioner in this position. However, this will be a loss of a specific ONA position.

FINANCIAL IMPLICATIONS:

No financial implications exist for APH as this is a program that is 100% funded through the Ministry of Children and Youth Services.

STRATEGIC DIRECTION:

The recommendations cited in this briefing note align to the Improve Health Equity and Collaborate Effectively strategic directions.

CONTACT:

Laurie Zeppa, Director of Community Services and Chief Nursing Officer