2. Local Governance

Introduction

Ontario's 36 local health units are the front line of protection against infectious disease. That chain of protection is only as strong as its weakest link. Some health units are well governed, some poorly. Because viruses respect no boundaries, it is little comfort that some are well governed. It takes only one dysfunctional health unit out of 36 to incubate an epidemic that brings the province to its knees within weeks.

These weak links often result from the system of two governments, provincial and municipal, being involved in the operation of local health units.

Problems caused by split provincial-municipal governance run deep in our public health system. So many members of the public health community have expressed frustration, and have presented evidence of dysfunctionality in the present arrangement, that something must be said about it in this interim report.

Dr. Sheela Basrur, Ontario's Chief Medical Officer of Health, appointed after SARS, has initiated measures to address these problems. Only time will tell whether this fresh leadership, together with the measures recommended in this report, can fix the deep systemic problems caused by split governance.

It is only fair that those Ontarians who live in health units with good governance have the opportunity to see whether the present system can be fixed within a reasonable time frame.

But there is too much at stake to let the present problems continue indefinitely. The cost of waiting will be the risk of disease and deaths, so a clear decision point is required. The government must decide whether to continue the present system of split governance, or to upload public health funding and control 100 per cent from the municipalities to the province. That decision needs to be made by the end of 2007, the deadline having been chosen for reasons noted below.

The public health community is deeply divided into those who think the present system of split governance is satisfactory, or at least salvagable, and those convinced by their experience that 100 per cent uploading of funding and control to the province is now the only solution. It will take time to resolve that debate. There is a strong consensus that immediate steps are necessary to strengthen the present system, whatever future direction it might take.

This chapter will:

- Expand on the problems, described in the Commission's first interim report,[69] of split provincial-municipal governance;
- Canvass the arguments for retaining the present system and the arguments for 100 per cent provincial control and funding;
- Note the need for a clear decision on this issue by the end of the year 2007; and
- Note the initiatives undertaken under the fresh leadership of the new Chief Medical Officer of Health to improve the present system.

Pending that decision, five measures are urgently required to improve the existing governance system:

1. Protect the local medical officer of health from bureaucratic encroachment;
2. Require by law the regular monitoring and auditing of local health units;
3. Change the public health programme guidelines to legally enforceable standards;
4. Increase provincial representation on local boards of health and set qualifications for board membership; and
5. Introduce a package of governance standards for local boards of health.

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69. The Commission's first interim report. See in particular Chapter 10 "The Public Health Ping-Pong Game," Chapter 11 "One Local Funding Problem," Chapter 12 "The Municipalities' Funding Dilemma," Chapter 13 "One Local Story: Parry Sound," and Chapter 16 "Greater Priority for Infectious Disease Control."

Much of the attention since SARS has been directed towards the provincial level, the Public Health Division of the Ministry of Health and the office of the Chief Medical Officer of Health. While the work and reform that is occurring at the provincial level is vital, it must always be remembered that the first line of defence against disease is in the hands of local health units and medical officers of health. It was they who struggled against SARS in the front lines. It was they who were hampered by the deficiencies in public health resources and infrastructure. As one medical officer of health told the Commission:

> I'm worried that the public health system at municipal level may not be reformed to extent it should be; I think it's being lost in the shuffle. The primary focus for change and reform seems to be at the provincial level. The backbone of the public health system is the local boards of health and they are not getting the proper focus or attention.

One thing though is clear: The underlying problems must be fixed or the current system of governance must be radically reorganized. The current state of affairs is unacceptable and cannot continue. Great strides to improve the present system are being taken under the leadership of Dr. Sheela Basrur, appointed since SARS. The first question is whether the province will provide the necessary resourcesavailable to effect the major changes now planned. The second question is whether local bureaucratic and political resistance will prove too strong. If the province cannot dedicate enough resources and leadership to make the present system work and if the current problems cannot be fixed within the existing system, drastic reorganization is required. Although there may be intermediate solutions, the only solution seriously advanced as an alternative to the present system is to upload the funding and control of public health 100 per cent to the province and to get municipalities out of the public health business.

It would be premature to make such a recommendation, however, without providing some time to see if the system can be fixed within the present framework of governance.

That is why the Commission recommends that the province at the conclusion of the year 2007, which is after the pending public health capacity review,[70] decide whether

70. The Public Health Capacity Review Committee will present interim recommendations to the Ministry of Health and Long-Term Care in June of 2005 and a final report in December 2005. The time for the implementation of its recommendations under Operation Health Protection, is one year from then, the end of 2006. The end of 2007 gives enough time to see whether the reforms are working and to decide whether or not to upload public health 100 per cent to the province.

the present system can be fixed with a reasonable outlay of resources or whether control of public health should be uploaded 100 per cent to the province. This will require an amendment to the "Operation Health Protection" plan to include a firm decision point to upload completely or to leave the present system in place.

The burden of persuasion is on those who want to preserve the present system of split provincial-municipal governance. A clear timeline for that decision is required.

A decision to upload 100 per cent control to the province would in one sense be regrettable because a number of local health units function, under the present system of dual governance, as well as could be expected given current levels of resources. The problem is that viruses do not respect health unit boundaries. The fact that some units function well is no comfort when it just takes one dysfunctional unit to spark a province-wide outbreak of infection. Public health is a provincial programme and every citizen is entitled to an equal measure of protection from infectious disease no matter where they live.

Ontario cannot go back and forth like a squirrel on a road, vacillating between the desire for some measure of local control and the need for uniformly high standards of infectious disease protection throughout the entire province. A clear decision point is required before some deadly infectious disease rolls over the province.

Unfortunately there is no clear consensus, among municipal politicians or public health officials, on the solution to the problems of split governance. The different views will be canvassed below.

Whatever the ultimate solution to those problems, the following areas clearly require immediate reform and need not await long-range policy decisions on governance:

- First, amend, strengthen and enforce the *Health Protection and Promotion Act* to ensure the protection of the medical officer of health from bureaucratic and political encroachment in the administration of public health resources and to ensure the administrative integrity of public health machinery under the executive direction of the medical officers of health.

- Second, amend s. 7 of the *Health Protection and Promotion Act* to provide that the Minister, on the advice of the Chief Medical Officer of Health shall publish standards for the provision of Mandatory Health Programs and Services and every board of health shall comply with the published standards which shall have the force of regulations.

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

- Fourth, amend the *Health Protection and Promotion Act* to ensure that the greater funding and influence of the province in health protection and promotion is reflected in provincial appointments to local boards of health. Also to ensure that the qualifications required of members of boards of health include experience or interest in the goals of public health.

- Fifth, introduce a package of governance standards for local boards of health.

These measures are in addition to those recommended in the previous chapter of this report to protect the independence of the local medical officer of health and to ensure the direct accountability to that office of those who provide public health services.

Fundamental Governance Problems

The local medical officer of health leading each of the 36 local health units is the backbone of public health in Ontario. However, as was noted in the Commission's first interim report, many medical officers of health report that a considerable amount of their time and energy is spent in turf wars with the municipal bureaucracy and in fighting against budget constraints that prevent the attainment of a proper standard of public health protection.

Since the Commission's first interim report, the Commission has heard additional reports of:

- Municipal officials unilaterally removing or transferring public health staff to other departments within the municipality;

- Municipal officials unilaterally reducing the public health budget, without input from the medical officer of health or the board of health;

- Boards of health with members whose sole objective is to the reduce the budget;

- Boards of health determined to micromanage the health unit instead of performing their role of overall stewardship;

- The inability of the medical officer of health and public health staff to get confidential information technology support and legal advice within the structure of municipal services; and

- The diversion to other municipal departments of funding intended for public health.

This is not to suggest that the above problems occur in each health unit across the province. The Commission has been told of jurisdictions where the board of health works well and has a good relationship with the local medical officer of health. Similarly, not all municipal officials or members of boards of health are against public health funding. Many are in fact very supportive of public health, advocate on behalf of the public and generally take their duties and responsibilities to protect the public's health very seriously.

Unfortunately, experienced and dedicated medical officers of health in other units continue to be demoralized and exhausted by these ongoing struggles. Some of them see little light at the end of the tunnel. As one local medical officer of health described the current state of affairs:

> At a recent meeting of our colleagues, I heard a lot more grief, anger, it was very emotional. People who are close to leaving the profession, who've had it with municipal interference, with the provincial bullying. You need to know, you've got a very shaky public health system, at least with respect to public health physicians.

This local medical officer of health worried about the ability of public health to attract and retain qualified physicians, if they are going to have to face the problems that exist in relation to public health governance:

> I think that on governance and on powers and duties of medical officers of health alone, unless you correct some of these problems, you're going to have a heck of a time trying to attract new medical officers of health when they're put in positions of executive authority but they have to second guess the administration, business affairs part of it. And, in fact, they have to deal with boards of health that are not terribly interested in what they're doing.

And the problem may not lie only in attracting new medical officers of health. It also lies in retaining experienced medical officers of health whose frustration is reaching the point of no return:

> I'm absolutely disgusted, I loathe coming to work. I'm hanging on by my fingertips, waiting to see if the system will get fixed soon and if it doesn't, I'm getting out of the public health business.

The deterioration of public health at the local level in some parts of the province is epitomized by the problems recently evidenced in the Scott Report on the dysfunctional Muskoka-Parry Sound Health Unit, discussed below, which led to a decision to abolish the unit and amalgamate it with neighbouring units.

The difficulties of the Muskoka-Parry Sound Health Unit serve as a cautionary illustration of the deep structural problems in our public health system caused by divided provincial and municipal governance. They show how a dysfunctional board of health can impair the effective delivery of public health services. The Commission in the first interim report identified these problems as examples of the weaknesses in Ontario's public health system disclosed by SARS.

On July 12, 2004, Dr. Sheela Basrur, appointed Mr. Graham Scott, Q.C, a former deputy Minister of Health, to conduct an assessment of the Muskoka-Parry Sound Health Unit, pursuant to s. 82(3) of the *Health Protection and Promotion Act*. Although the power to appoint an assessor is assigned by statute to the Minister, he wisely delegated that power to the Chief Medical Officer of Health.[71]

Mr. Scott released his report on October 20, 2004 and on October 21, 2004, Dr. Basrur assumed the powers of the Muskoka-Parry Sound Board of Health.[72]

The Scott Report demonstrated that the local board of health had not functioned properly for years;

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71. For the reasons given earlier in this report, the Commission has recommended that this power be reassigned by statute directly to the Chief Medical Officer of Health
72. The Minister of Health and Long-Term Care granted authority to the Chief Medical Officer of Health to assume the powers of the board of health under s. 86 of the *Health Protection and Promotion Act*. Ministry of Health and Long-Term Care News Release, "Chief Medical Officer of Health takes action to protect health of Muskoka-Parry Sound residents," October 21, 2004. As discussed below, the powers in s. 86 are now given to the Chief Medical Officer of Health.

> The problems plaguing MPSHU are deeply rooted. The fault lies not with any one individual but with an entrenched governance culture that is focused, not on the delivery of public health programs and their adequacy, but on the cost of public health. Efficient and effective management of the costs of public health is obviously important, but the primary responsibility for the Board is the delivery of public health programs and services to ensure the protection of the residents of the two Districts.
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> The failure of the Board in not engaging fully in the public health role is overwhelmingly evidenced by the lack of strategic consideration to public health issues and the low regard for the role of the MOH within the MPSHU. Further, the Board, in its attempts to address costs has become a micro-manager of the MPSHU. The Board has no role in management of the MPSHU. Even if it were appropriate for a Board to engage in management, it is an assignment that they are not capable of discharging given their limited experience in public health administration, as well as the other demanding responsibilities that require their time in meeting their responsibilities, particularly those serving as councillors and Mayors.
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> Indeed the evidence is clear that they failed to bring either sound organization or stability to the MPSHU. This is true even on the administrative and cost side that has been their declared area of priority. On the health side, notwithstanding a previous assessor report, a SARS case in 2003 and the interim report of Justice Campbell, they have not carried out any serious health program or performance review at the Board level, which as a minimum would seem an essential response to critical external reviews.[73]

Mr. Scott summarized what he found in Muskoka-Parry Sound that constituted a dysfunctional board performance:

- The Board had no strategic plan;
- The Board had no process for establishing expectations and monitoring them for either the MOH or themselves;

73. Assessors Report on the Muskoka-Parry Sound Health Unit, Graham W.S. Scott, Q.C., Assessor, October 20, 2004. (Subsequently referred to as the Scott Report.)

- The Board did not fully debate or engage on health issues;
- There was no permanent MOH and the Board chose to exercise some of the duties of the MOH;
- The MOH was not invited to and did not report to every Board meeting;
- There was Board micro-management of the Health Unit;
- The Muskoka-Parry Sound Board was focused on expenses and costs not on health policy matters;
- Most Board members paid little attention to the mission of the Health Unit between meetings.[74]

Regrettably, many of the problems identified in the Scott report are not confined to the Muskoka-Parry Sound Health Unit. As one experienced medical officer of health told the Commission:

> . . . in fact there are shades of Muskoka-Parry Sound in all 37 health units.

Many local medical officers of health who spoke to the Commission reported that post-SARS the battle for independence and resources at the local level has gotten worse.

For example in one public health unit at the end of the first phase of SARS, the local medical officer of health was told by the Chief Administrative Officer that a significant number of staff, currently situated in the health unit and instrumental in the SARS response, were being transferred out of the health unit for consolidation into the municipal bureaucracy. This transfer not only threatened the ability of the medical officer of health to resource the health unit and fulfill the obligations under the *Health Protection and Promotion Act*, but also represented an apparent contravention of s. 67(2) the *Health Protection and Promotion Act*, which gives the local medical officer of health responsibility over employees of boards of health and those whose services are engaged by a board of health if their duties relate to the delivery of public health programmes and services.

74. *Ibid.*

Nothing in the *Health Protection and Promotion Act* or the *Municipal Act* authorizes a board of health to delegate its administrative authority to a municipal administrator. Neither the Chief Municipal Administrative Officer nor any other municipal official has any authority to control and manage the staff of a health unit. These are the responsibilities of the medical officer of health. One medical officer of health described the day to day struggle to fight off municipal encroachment:

> Our corporate communications function largely acts as a press secretary for the regional chair. So what if they take over that? What if they take over epidemiology because in fact it is needed in social services and they have not deemed it to be a high priority? I mean how can you fulfill your duties when you do not have the tools at your disposal to make it happen and what can I do as a MOH? I mean I have to go on the QT to outside legal counsel to get this advice because I cannot go to my legal department; they represent two masters . . .
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> . . . I have come to the conclusion that you need to fix governance. I mean that you can strengthen section 67 as much as you want. If you have a counsel or a CAO that just completely ignores it and I am not given any tools or resources to deal with it, then what is the point in having it in the legislation to begin with?

Other medical officers of health cite examples of regional officials making unilateral budget decisions which directly impact on the ability of the medical officer of health to deliver programmes and services legally required under the *Health Protection and Promotion Act*. One medical officer of health described to the Commission how the Chief Administrative Officer for the municipality unilaterally reduced the public health budget, without consultation with the medical officer of health or the chair of the board of health. They simply advised the medical officer of health's staff to reduce the money from the budget.

Other medical officers of health cite examples of board of health members whose priority is budget cutting, rather than health protection and promotion. One expressed the demoralizing effect of that attitude:

> And as a medical officer of health, reporting directly to a board, and I'm speaking now on behalf of medical officers of health, I think the job would be far more appealing if you did have a board that was interested in public health, rather than cutting your budget, freezing your budget, making you beg for all the scraps under the table before they'll give you

> an increase. It's just demeaning and it's totally dysfunctional. And I can't think of any other setting where you'd be governed by a governing body that's really not interested in what your objects are.

One seasoned medical officer of health thought that the difficulties experienced by many medical officers of health with their local boards and municipalities reflected a cynical municipal political view: if the municipalities made things sufficiently hard for the local medical officers of health, they would encourage the province to take over public health completely and thus free the municipalities from the burden of public health stewardship and expense, and from having to deal with a local medical officer of health who was independent of the municipality.

These difficulties suggest to many that public health in some parts of the province would be better served by removing muncipalities from public health funding and public health delivery. These difficulties have been recognized by the Association of Municipalities of Ontario which advised the Commission before its first interim report:

> The impact and speed at which SARS and West Nile virus spread across jurisdictions points to the vulnerability of the current structures, responsibility, authority and responsiveness of the system – both from a policy perspective and certainly the inappropriateness of subsidizing provincial health programs by the property tax base.

A medical officer of health described a constellation of problems caused by the present governance structure including the difficulty of giving public health its proper priority in a system where those charged with its stewardship may be more interested in diverting money to other municipal purposes than in protecting public health:

> The kinds of individuals that are attracted to, have themselves elected on regional boards are not particularly interested in either health issues or in human infrastructure components. And so where there are police boards that are marching in, for example, in our jurisdiction with an enhancement this year, and the regional tax base is looking to absorb that enhancement, if you're in a cross-boarder situation where public security is high on the corporate agenda, it squeezes out services like ours, public health services and really our affinity and alignment is much more with other sectors in our community than the regional corporation. . . The particular fiscal challenges that we're facing with this year's budget speak, in my mind, to a whole variety of other issues around values, why someone puts themselves forward to be elected, what their passions are. My

> chair is a good example of a regional corporate thinker who's interested in transit and good infrastructure and the reason he's chair of the public health services board is to get money out of the public health budget. It's not about the protection of the health of the public.

This chapter comes with two warnings.

The first warning is that the Commission attempted no scientific analysis of the opinions of those engaged in public health. The Commission is grateful to the many medical officers of health and others in the public health community who devoted so much time and energy to written submsisions and confidential interviews. The information acquired by the Commission in response to its general request to the public health community was however, because of the nature of the open process of soliciting views, necessarily anecdotal. As noted below, however, even those who want to retain the present system agreed on the need for corrective measures within the present system. And as noted above, it takes only one dysfunctional health unit to bring down the entire province.

The second warning is that the Commission's mandate is SARS and that this report focuses on infectious disease as opposed to other public health concerns such as childhood obesity, heart disease, and other aspects of health promotion.

Whatever might be disclosed by a scientific analysis of public health opinion, the fact remains that there are serious problems in the present system. As noted above, the fact that some health units work as well as is possible is no comfort when it just takes one dysfunctional unit to spark a province-wide outbreak of infection. Public health is a provincial programme and every citizen is entitled to an equal measure of protection from infectious disease no matter where they live.

As noted above and below, pending the resolution of the deep structural problems caused by divided governance, measures must be taken to ensure that the financial priority given to public health, and accountability and authority of the medical officer of health are not diluted by difficulties with municipal bureaucracies.

Should Municipalities Get Out of Public Health?

Should split governance between the municipalities and the province be maintained? Should public health be uploaded 100 per cent to the province with no local stewardship? Should some other path of reform be attempted?

The Commission consulted extensively with members of the public health community.[75] There is a clear division of opinion on stewardship. Some feel that public health should be uploaded 100 per cent and controlled by the province. Others feel it is essential to retain the current system or at least some strong aspect of local control and some local funding.

Out of the many possible models for public health governance in Ontario, three basic models[76] have been proposed to the Commission:

- Give the present system another try and see whether a greater measure of central control and guidance, accompanied by the increase in funding from the province can overcome the serious structural problems that flow from divided provincial and municipal stewardship over public health;

- Upload the funding entirely to the province but leave the local municipalities and boards of health some say in local programme delivery;

- Upload the funding entirely to the province, give the province direct control, remove the municipalities from public health stewardship, and abolish the local boards of health.

So long as some measure of local governance remains it is essential to strengthen the present system by the five measures mentioned above:

1. Protect the local medical officer of health from bureaucratic encroachment;

2. Require by law the regular monitoring and auditing of local health units;

3. Change the public health programme guidelines to legally enforceable standards;

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75. The interviews were conducted on the understanding they were confidential and the participants would not be named in the report although what they said might be reported without personal attribution.

76. The idea earlier canvassed, of uploading infection control funding and stewardship entirely to the province and leaving the rest of public health under some form of split governance, was not recommended to the Commission during this phase of consultation. The problem with that model is that it maintains all the problems of split governance that flow from the housing of the health unit in a municipal system. In one or two consultations it was suggested that the worst problems arise in the eight or ten regional municipalities under s. 55 of the *Health Protection and Promotion Act* where municipal politicians have more ways to cut public health budgets than exist with independent boards. This view was not unanimous. No one suggested that a model which replaced regional boards with "independent" boards would solve the underlying problems.

4. Increase provincial representation on local boards of health and set qualifications for board membership; and

5. Introduce a package of governance standards for local health boards.

Give the Present System Another Try – Increased Pay for Increased Say

Some argue that the pending increase in the proportion of provincial funding to 75 per cent will make a notable difference. They argue that this, combined with a greater enforcement presence by the Chief Medical Officer of Health, should result in greater central control and less problems around municipal governance.

Others have suggested that the solution may lie in uploading the cost of infectious disease protection 100 per cent to the province and continue with split municipal governance. This would do nothing to fix the difficulties of split governance. This suggestion is not a solution to the underlying structural problem.

While the notion of say for pay should result in the Chief Medical Officer of Health having more input and control over local public health and increasing the proportion of provincial control will go some of the distance to ensuring uniform standards of public health protection across the province, it will not solve all the problems identified above.

The recent difficulties in the Muskoka-Parry Sound Health Unit, described above, serve as a paradigm for many of the problems caused by split governance. While Dr. Basrur's intervention in the Muskoka-Parry Sound Health Unit, and the action in response to Mr. Scott's report, are a good sign that the will is there to address the problems of split governance, the question remains whether there is the will and resources centrally to monitor and control the local systems throughout the entire province and to mediate governance disputes on an ongoing basis.

Since the release of the Walker Report and the release of the Commission's first interim report, the proportion of provincial funding for public health services and programmes has increased.[77] Yet, as noted above, some local medical officers of health

77. The provincial share of local public health funding rose to 55 per cent on January 1, 2005. It is scheduled to increase to 65 per cent on January 1, 2006, and to 75 per cent on January 1, 2007. (Source: December 9, 2004 memorandum from Chief Medical Officer of Health to medical officers of health and acting medical officers of health)

continue to report that they face the same problems now that they faced when the municipality paid an equal share of the funding.

As for the recent increase in provincial funding, many local medical officers of health understood that this provincial funding was not to result in a decrease in local funding and not to be used as a form of municipal tax relief. This understanding was based on a memorandum from Dr. Basrur to the medical officers of health, dated December 9, 2004, in which she stated:

> As you are aware, the provincial government has made several recent announcements of increased funding for public health programmes and services. This letter is intended to clarify these changes and provincial expectations associated with these increased funds.
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> New provincial funding is intended to enhance the total funding available for public health in order to improve local public health capacity, and the Province expects municipalities to contribute their full share to this important area of public service. While these provincial initiatives may offer limited financial relief to some local municipalities, the government's primary purpose is providing these funds it to protect and promote the health of the public.

One local medical officer of health described their interpretation of that memorandum, an interpretation that was shared by others:

> The intent of that, which was explained by Dr. Sheela Basrur in the memorandum dated December 9th of this year to MOHs and to chairs of boards of health, was to increase public health capacity across the province. And only in some sort of dire financial situations would it provide some property tax relief for an obligated municipality, that's the sense of her letter.

Some municipalities, however, did not share this view. For example, the City of Toronto considered a plan that would see half of the additional funding go to Parks and Recreation.[78] Councillor John Filion, chair of Toronto's Board of Health, at a budget meeting where the issue was raised, tried to persuade the City to use the money as it was intended: for public health. He was reported as stating:

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78. Toronto Star, "Toronto Could Divert Aid From Province," January 21, 2005

> I think we're shooting ourselves in the foot if we don't use this money for public health.[79]

Toronto was not alone in its eagerness to use public health money for other programmes. As another medical officer of health reported to the Commission:

> … the base budget has been reduced arbitrarily by the Chief Administrative Officer, without any consultation with me, which will result in a net decrease, or a total decrease in my public health budget for 2005, based on this new funding formula. It will of course mean that we cannot access those cost-sharing funds that would be due to us from the province. So he has arbitrarily reduced, with in fact not even anything in writing to me, it's simply appeared this way after I'd had my initial budget meeting with him, as a reduction in our base budget and the municipal contribution, which of course goes against the intent of the new funding formula.

Some see the municipal attitude, notwithstanding the provincial attempts to upgrade public health, as a continuing source of opposition to improvement. Said one medical officer of health:

> Things have not improved since SARS notwithstanding the provincial rhetoric of improving public health services because municipal politicians, particularly in regional governments, still see public health as a lower priority than other municipal services such as roads.

The problem is not solely one of funding. The problem is also one of governance. Even if the provincial government uploaded the percentage of provincial funding to 90 per cent, in some municipalities the battle over the remaining 10 per cent and the remaining involvement of the municipality in governance would still lend itself to governance problems and local fights over staff direction, public health communication, and the spending of provincial funds. The problem is not who pays, but who says. Some medical officers of health are convinced that this problem will continue so long as the medical officer of health and local boards of health are embedded in municipal bureaucracies. According to this view, no amount of distant correction, no amendments to the *Health Protection and Promotion Act* can correct the underlying problems facing public health in some municipalities around the province.

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79. *Ibid.*

Some, however, argue that the combination of increased funding and greater enforcement by the Chief Medical Officer of Health may address the systemic problems. They point to Muskoka-Parry Sound as an example of how the system can work. The situation in Muskoka-Parry Sound cuts both ways. On the one hand, it shows how dysfunctional a public health unit can remain before someone fixes it. On this view it shows that the system is broken. On the other hand, it also shows that the province under new public health leadership has finally taken steps to cure the problem. On this view it shows that the system works. Does one say the system is broken because of the problems or does one say the system works because the province eventually decided to fix Muskoka-Parry Sound Health Unit?

Those who argue that Muskoka-Parry Sound is an example of how the system can work, argue that the province has the tools to ensure compliance with the Act and to ensure a uniform standard of programmes and services across the province. But the system only worked after years of dysfunction, and then only because of the leadership of the new Chief Medical Officer of Health and the Minister of Health. The steps taken in Muskoka-Parry Sound, while admirable, took energy, attention and resources. It cannot be easy for the Chief Medical Officer of Health, amidst all the concern about disease, including pandemic influenza, with myriad pressing daily responsibilities, to confront and wrestle to the ground the local problems caused by the divided stewardship of public health. And Muskoka-Parry Sound was not alone in its problems. It was only the worst and the most obvious. To confront governance problems in a local health unit is to invite political controversy and dispute. Do the Chief Medical Officer of Health and the Public Health Division have enough time, energy and resources to monitor and control local systems, and to mediate governance disputes on an ongoing basis? Is this the best way to use this time, energy and resources? Or is the energy of Ontario's public health leadership best directed to protecting us from disease?

The Argument for Local Control

Those medical officers of health for whom the current system works argue that you should not change the whole system just because some parts are not working. As one medical officer of health stated:

> I don't think you blow up the entire structure because of instances where it didn't work. You put in appropriate checks and balances and carrots and sticks to make the system work.

Some local medical officers of health, concerned about uploading public health entirely to the province, fear that the result will be worse. They fear that the loss of local municipal involvement and contribution will impact their independence and autonomy. They also fear that by relying on an entirely provincial system, you put all your eggs in one basket, and if that system fails to devote the resources to make things work, they will have no other partner to whom they may turn for help. One local medical officer of health said:

> I think there's a concern about too much power being invested in the province. I think the strength, for SARS, Walkerton, whichever, was in the local public health unit response, despite the province. And so, if we centralize too much direction, and then lower the independence of the medical officer of health as well, by uploading it to the province, I have great concerns of that model as well. There's this balance that we have to try and strike between the strength of the local system and ensuring a system overall.
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> What's going through my mind is, if you didn't have a board of health, then how could you preserve local autonomy and independence without your actions being unduly politicized? If what you mean is a provincial agency, you'd be an employee of that provincial agency. You'd run into the same interference.

Those medical officers of health who oppose provincial uploading position their argument for local stewardship largely in the nature of health promotion work, which depends on local community partnerships with non-governmental organizations, school boards and other local institutions. The argument is that local stewardship strengthens these partnerships, which would be lost or diminished if the province took over public health. As one medical officer of health said:

> … I think it does need to be embedded in the local community boards of health, because public health issues really are at the local level and we're only able to move agendas like the smoking by-laws etc. forward through critical mass at local grass roots level so it does need to be part of that milieu but strengthening it is a piece of it and the question is how … I mean police commissions do very well when you look at how they're resourced over time and if you're looking at the public health agenda, you don't do well at the regional corporate table.

But even those who argue for the preservation of local governance, like the medical

officer of health quoted above, find it hard to see how public health can get a proper priority within a system of municipal governance.

The problem with 100 per cent provincial control is that in some municipalities the present split governance relationship is welcomed by the medical officer of health. One local medical officer of health, who did not want to see public health uploaded 100 per cent to the province, and clearly had a positive relationship with their board of health and with their municipal councillors, stated:

> I think the local councillors have a voice and people do listen when they speak in the local area. Municipalities and provinces have a link. There is a cross germination that is helpful. When you pay, you pay more attention. Without pay it would be more difficult to get municipal councillors actively involved. When you think about board of health, public health has a history of being local and it is not without good reason. We do need to make sure that we are interacting with local political situations in terms of getting changes made that are supportive and conducive to public health. We need to make sure that we are in step with what is happening locally. Whatever we do, there needs to be a local flavour … I would argue that municipalities are important partners as well.

Another public health official noted the difference between a health issue that impacts all health units in the province, such as infectious disease, and issues unique to the local area such as community based health promotion programmes. The former attracts a greater provincial influence but the latter, it is argued, benefits greatly from local influence:

> I think public health as you know is extremely broad and you know what makes sense perhaps for something like communicable disease control and health protection may have a different balancing in terms of local versus provincial input that is required if you are looking at things that are more community based health promotion. The board of health of course is responsible for the programmes in public health.

One local medical officer of health described the importance of maintaining local boards if balanced by the effective exercise by the province of central control and accountability mechanisms:

> I would favour local boards … but I think that in terms of the makeup of the board of health, you could provide provincial direction in terms of the

> ideal candidates. Maybe the objects of the board of health, whatever. I think that you can design the makeup of the board of health that reflects the community and gives clear direction as to what their role is. I think there needs to be, as I say, a return to the powers and duties of the medical officer of health, certainly at the time that it was downloaded, with a view towards independence at the local level. And in terms of the interfacing with the province, there are lots of instruments there that ensure accountability. You've got programmes, plans and budgets, you've got the mandatory health programmes and services guidelines. You have financial and operating audits. And this happens all the time anyway. And on specific issues, you can deal with the Chief Medical Officer of Health directly. So, I don't worry about sufficient provincial oversight, because I think the instruments are in place now. If you actually look at downloading, though, in terms of compliance with the Mandatory Health Programs and Services Guidelines, I think there has been a trend towards greater compliance, but, for example, the tools that the Province gave themselves with respect to assessment, I think that only kicked in last year. We don't know anything about the results. We don't know if it led to any changes. So, not only are there instruments in place in terms of accountability, quite frankly, the province hasn't exercised the tools that it has at its disposal already to ensure compliance and the carrying out of provincial policy and so forth.

There is no easy solution. For those medical officers of health who enjoy supportive and proactive boards of health, the upload of control to the province may make things worse. For those mired deeply in municipal bureaucracy and day to day struggles with local politicians, the status quo does nothing to address the serious problems they face. One medical officer of health accurately summarized the dilemma:

> One of the challenges I think that you face is the diversity that is out there right now and if you come up with a formula, it is going to make many situations better and some situations worse. For example, [Municipality X] is one of those regional municipalities in which the regional council has elected municipal politicians to serve at the board of health and I think that [Municipality X] would be much better served by an independent board of health with a majority of provincial appointees. In the case of the [Municipality Y], there has been a long history of an extremely progressive group of local politicians. Some members of the board are citizens who are appointed by the municipality but nonetheless are not elected officials themselves and that board has been a leader in

> terms of public health policy programmes and services. At the time a number of years ago when the board did have provincial appointees, most of them did not distinguish themselves if I can say so there is … so in different jurisdictions, it is going to work better or worse depending on where they are now.

For those whose boards work well it will be difficult to embrace change when that change is accompanied by the fear it will make their local system worse. As one local medical officer of health noted:

> Local medical officers of health are leery of 100 per cent provincial funding. Although they complain about their local boards, the existence of the local board means the medical officer of health is not entirely dependent on the province; they think it's better to stick with the devil they know.

Upload Public Health Funding and Control 100 Per cent to the Province

There has always been a measure of support for the proposition that municipalities should simply get out of the public health business and leave it entirely to the province. Some municipal politicians involved in the "Who Does What" consultations in the mid 1990's were confident that Mr. Crombie would recommend that public health and social services be uploaded 100 per cent to the province. One prominent mayor went so far as to say, of local public health boards, "Don't worry, they'll be gone" only to be jolted by the government decision in 1997 to download public health funding 100 per cent to the municipalities.

It was the unanimous view of all the municipal councillors at a recent regional seminar on public health governance that they should get out of public health altogether. Because the programme direction came so strongly from the province, and the local medical officer of health was independent of the municipality, the municipal politicians felt that municipal influence was just too small having regard to the proportional municipal tax contribution.

While this regional consensus is not a provincial consensus, some observers suggest that it reflects a deep current of municipal opinion in many parts of Ontario.

Even some outside of public health argue the need for uploading public health and ensuring central control under a single governance structure. Mr. Tom Clossen,

President and Chief Executive Officer of the University Health Network in Toronto, said this at the Commission's public hearings:

> I think it's a big weakness in the Ontario health care system that public health is under the municipalities. As you might know, public health was put under municipalities as a tax issue, because taxation for education was moved out of the municipalities and into the province was a tax balancing effort. It had nothing to do with what would be the best way to run a health care system.
>
> Again, if you look at other provinces, you'll see that public health is part of the regional health organizations and hospitals, community health, public health, are all under a single governance structure.

Some medical officers of health see a measure of consensus in the public health community for 100 per cent provincial uploading and control. One medical officer of health had no doubt that the greatest consensus was for 100 per cent uploading:

> Q. What is the greatest consensus?
>
> A. For those of us who have been around it is no doubt upload to the province.

One medical officer of health responded to a suggestion that the public health community was generally against a 100 per cent upload of provincial control because of the fear that it would result in the loss of local uniqueness and the ability to deal with local problems:

> I totally disagree. I have never had a local person interested in local health issues. I think it should be uploaded 100 per cent … Medical officers of health do like to be independent but some want to have their cake and eat it too … I would much rather have a functioning provincial system with accountability. It used to be done that the province would come and say you are not doing this well or not focusing on this – or they would say we think your demographics are changing and you need to adjust your programmes. There are mandatory programmes for a reason.

Some observers fail to see how community partnerships depend on municipal funding and the involvement of municipal politicians in health board stewardship:

> The thrust of their [those who oppose full provincial control] argument is that the grass roots of health promotion are at the municipal level. But the partnership isn't with the municipal councillors, it's with the community partners, schools, school boards, long-term care facilities, and so forth. I don't know why they think that 100 per cent provincial funding would mean no local community partnerships … It's not the councillors with whom we have partnerships but the staff at the municipal level. For many boards, the only role of municipal councillors is to have input into health to control funding.

Those who favoured full provincial uploading agreed that local health promotion programmes require strong community links. But they thought the continuation of community links had nothing to do with the question of municipal governance. They noted that the important community involvement was not with municipal councils or politicians, but with schools, school boards, long-term care facilities, and other community partners. In their view the strength of these community relationships came not from the political link with the municipalities, but from the work of the medical officer of health and health unit staff in the development of community links.

One public health observer struck a chord with the suggestion that the local municipal link was a political wild card without any consistent benefit throughout the province:

> There's a disconnect here, between the importance of the role of the medical officer of health and bringing in a group of political appointments, Order in Council this, Order in Council that, depends on who the government is, to be your governing body in some way or to give you advice, when in fact, if you get the right person in as the medical officer of health, and you do that across the province, you have direct access to the people who make the decisions about where the money goes. And, to my mind, I can't see taking the chance that with those in power in your jurisdiction, you're going to have enough people that are favourable with the government in power, to give you clout when it comes to negotiating, as opposed to the next jurisdiction or somebody in another part of the province who has the real ace card when it comes to this. It seems to me, you can be the local medical officer of health, but you can also be part of a provincial system and derive great benefits from that, without having to rely on this questionable system that brings you only advocacy, depending on whether you've got the right group of people or not, and maybe some outreach, which I imagine you could get in other ways.

There are many ways to retain local decision-making and community participation without the existing structure of municipal funding and political involvement. The public partnerships so vital to local health promotion, as noted above, are not with municipal councillors or politicians. They are with schools, school boards, health care institutions, and voluntary organizations. Full tax uploading and full provincial control is perfectly consistent with the continuation of such partnerships. Many Ontario ministries maintain strong local links through advisory groups and community outreach. Local community participation in provincial programmes does not require split provincial-municipal governance.

If one accepts the principle of "say for pay", a principle the Commission notes is endorsed by the Association of Municipalities of Ontario,[80] then the government that pays for the programme says how it will be run. Many who advocate 100 per cent provincial pay see the result as 100 per cent provincial say with no municipal governance and no problems from the municipal level.

Others want it both ways. Some who strongly favour local decision-making argue that it is possible to upload the funding 100 per cent to the province yet retain the present municipal stewardship through local boards of health. On this highly political question the Commission can do no more than point out the difficulties of any such departure from the principle of political accountability for the expenditure of public funds, and agree with the observation of the experienced public health observer, quoted above, that

> Say will be hard without pay.

Because public health is a provincial programme and because the divided accountability between the province and the municipalities works very poorly in some parts of the province, a strong argument can be made for 100 per cent provincial uploading and control. It would be premature to recommend this permanent change in governance in this interim report. Full provincial uploading would have significant tax implications, as shown by the tortured history of provincial and municipal cost sharing[81] and big human resource issues caused by the change of employer. Transition to full provincial funding and control would require enormous administrative adjust-

80. AMO Report to Members: Recent MOU Meeting with Province, February 18, 2005, Alert 05/016.
81. Described in the Commission's first interim report under the heading "The Public Health Ping-Pong Game."

ments even beyond those within the present scope of the Public Health Capacity Review Committee.[82]

Full provincial uploading would also require a long-term commitment to refrain from further downloading. Unfortunately, as noted in the Commission's first interim report, Chapter 10, The Public Health Ping-Pong Game, the local public health units have long suffered the impact of consistent provincial downloading to the municipalities that occurred in the late 1990's. A public health scholar noted recently that the funding crisis has not so much been a ping-pong game, but rather a series of pings, followed by a big pong, then further pings.[83]

> The history of provincial funding of local public health is not a ping pong game, unless the focus is on a very short period (e.g., 1997 - 1999). The secular trend is one of increasing provincial financial support, both to

82. Chaired by Dr. Susan Tamblyn, former medical officer of health for the Perth District Health Unit, the Capacity Review Committee is to advise the Chief Medical Officer of Health on the following:

    - Core capacities required (such as infrastructure, staff, etc.) at the local level to meet communities' specific needs (based on geography, health status, health need, cultural mix, health determinants, etc.) and to effectively provide public health services (including specific services such as applied research and knowledge transfer);
    - Issues related to recruitment, retention education and professional development of public health professionals in key disciplines (medicine, nursing, nutrition, dentistry, inspection, epidemiology, communications, health promotion, etc.);
    - Identifying operational, governance and systemic issues that may impede the delivery of public health programmes and services;
    - Mechanisms to improve systems and programmatic and financial accountability;
    - Strengthening compliance with the *Health Protection and Promotion Act*, associated Regulations and the Mandatory Health Programs and Services Guidelines;
    - Organizational models for Public Health Units that optimize alignment with the configuration and functions of the Local Health Integration Networks, primary care reform and municipal funding partners; and staffing requirements and potential operating and transitional costs.

83. Ping reflecting an uploading of funds to the province, a pong indicating a download of funds to the local level. See: "Comparative Historical Perspective, Mr. Justice Archie Campbell's Ping Pong Game," Mary Powell, PhD, Visiting Scholar, Comparative Program in Health and Society, Munk Centre, University of Toronto.

> more local units and to a larger local units at a higher level of support, beginning in 1940 and continuing consistently until the 1997 decision (effective Jan 1 1998) to download 100% of public health costs to the local level … Mr. Justice Archie Campbell identified 23 problems that contributed to or exacerbated the 2003 SARS crisis in Toronto. Many of them have to do with public health, particularly the dismal state of public health at the provincial level. If we take a historical view, dismal has been the norm for public health.[84]

The question raised above as to whether the Public Health Division has the resources and appetite to oversee the local health units and boards of health so as to ensure compliance with the Act, and to enforce the Act in the face of a recalcitrant or ineffective board of health or where a municipality or municipal council interferes with the delivery of public health services, is an important one. Equally important, however, is whether the provincial government has the commitment to upload public health funding for the long term, or will it be a ping followed years from now with another great pong? And will the provincial government dedicate the resources to ensuring that the Public Health Division is capable for assuming the governance of 36 boards of health across the province.

Association Of Municipalities' Position

The Commission's first interim report noted the Association of Municipalities of Ontario's position in respect of municipal funding of public health. During the preparation of this second interim report the Commission repeatedly asked the Association of Municipalities of Ontario for its assistance and position on a number of the issues addressed in this report, including the continuation of local public health governance. The Association of Municipalities of Ontario unfortunately found itself unable to take a position.

Local Health Integrated Networks

Before leaving the question of public health governance, a word should be said about the proposed Local Health Integration Networks (LHINs). Announced on July 14, 2004, LHINs are intended to re-align the planning and delivery of health services across Ontario through 14 geographically based networks.

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84. *Ibid.*

Whatever promise the Local Health Integrated Networks may hold for the hospital system and the health system in general, the Local Health Integrated Networks proposals to date make little if any reference to the alignment between LHINs and public health units.

It is difficult to find anyone who says that LHINs will be good for public health. One hospital administrator at a recent conference on Local Health Integrated Networks said:

> There's nothing for public health in the LHIN's.

The Ministry of Health and Long-Term Care describes their purpose in the following terms:

> LHINs are organized geographically to bring health services closer to where people live. Accordingly, geography is a central organizing principle underlying the LHINs. The 14 Local Health Integration Network areas were created to reflect local areas where people naturally seek health care. They were determined by using an evidence-based methodology in collaboration with the Institute for Clinical Evaluative Science (ICES). The boundaries are permeable and do not restrict patient choice of physician and medical or acute services.
>
> Local Health Integration Networks will integrate health care at a local level and consolidate the following functions: planning, system integration and service coordination, funding allocation, and evaluation of performance through accountability agreements. The first function that the LHINs will be expected to take on is integrated health services planning, which will help inform and shape the design and execution of the other functions.[85]

Governance of LHINs will be through an appointed Board of Directors and through performance agreements with the Ministry:

> The Boards will be appointed by an Order in Council. Board members will be selected using a merit-based process, with all candidates assessed for fit between skills and abilities of the prospective appointee and the

85. Ministry of Health and Long-Term Care, "Taking Stock: Setting Integration Priorities – A tool to guide the initial LHIN transformation process," p. 2.

> needs of each individual LHIN. The appointment process will be transparent and consistent – with clear and understandable guidelines applied consistently to all Board appointments.
>
> Board members will be expected to possess relevant expertise, experience, leadership skills, and have an understanding of local health issues, needs and priorities.[86]

Some close observers of the public health scene speculate that health unit boundaries will eventually be aligned with Local Health Integrated Network boundaries,[87] especially given the terms of reference of the Capacity Review Committee, chaired by Dr. Susan Tamblyn, former medical officer of health of the Perth District Health Unit. Among other issues, the Capacity Review Committee will examine:

> Organizational models for Public Health Units that optimize alignment with the configuration and functions of the Local Health Integration Networks, primary care reform and municipal funding partners; and staffing requirements and potential operating and transitional costs.[88]

However it is undertaken, any decision to align public health units with LHINs will prove to be complex. The City of Toronto, for example, will have four of the 14 LHINs within its geographic boundaries, although only one will be entirely in the City. A report to City Council stated:

> The only one that falls entirely within the City of Toronto municipal boundaries is Toronto Central. This LHIN encompasses seven high volume hospitals, namely Mount Sinai, Hospital for Sick Children, University Health Network, Sunnybrook, St. Joseph's, St. Michael's and Toronto East General. The Central East LHIN includes Rouge Valley and Scarborough General. The Central LHIN includes North York

86. Local Health Integration Networks, "Bulletin No. 5 / December 15, 2004."
87. It is worth noting that, in the midst of implementing LHINS, the issue of reducing the number of local units appears to have fallen off the radar screen. As stated in the Commission's first interim report (see pages 190-191), the Walker Interim Report had recommended that the existing number of public health units should be reviewed and, within two years, reduced from 36 units to 20 to 25 units. Some observers questioned whether it is necessary to reduce the number of local units instead of providing the necessary critical mass of expertise to serve a number of individual units, on the argument that the problem is not the number of local units, but the lack of support and resources made available to the local units.
88. Public Health Capacity Review Committee, Terms of Reference.

> General and Humber River. Last, the Central West LHIN will include both William Osler sites, including Etobicoke.[89]

Thus, three of the four LHINs in the City will be jointly served by Toronto Public Health and by neighbouring public health units, each of which may do some things differently. As Dr. Bonnie Henry told the Justice Policy Committee, boundaries are already creating coordination problems among some Toronto area public health units:

> . . . we have 22 hospital corporations in the City of Toronto. Many of them have sites outside the City of Toronto. The Rouge Valley Health System has two in Toronto and three outside of Toronto. If we are doing things differently in two different health units, that can be very difficult for a hospital. It's the same if we look at our mental health system, our community care access centres, our district health councils, our long-term-care facilities. They are all, if you want, regionalized or organized on different geographical and jurisdictional boundaries. That can create massive difficulties in dealing with an emergency, and it's not limited to the health sector. It's similar in many other parts of our organization as well. For example, one health unit may actually involve several different municipal police services plus the OPP.[90]

Having regard to the absence of information on public health and LHINS, it is beyond the ability of this report to review and assess the plusses and minuses of transferring local public health into regional networks like LHINS. Nevertheless it is clear that such a transformation would by its very nature be complex and unsettling.

Significantly, it also may generate important stresses and pressures on public health. Were this transformation to occur in the near term before measures to strengthen public health have taken hold, a process that may take years,[91] it would likely add to

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89. City of Toronto Council, "Consolidated Clause in Community Services Committee Report 8, which was considered by City Council on November 30, December 1 and 2, 2004," p. 3.
90. Justice Policy Committee, Public Hearings, August 18, 2004, p. 153.
91. The U.S. General Accounting Office, the equivalent of the Auditor General of Canada, in underlining the challenge of making fundamental, long-term change, has stated: "Experience shows that successful major change management initiatives in large private and public sector organizations can often take at least 5 to 7 years. This length of time and the frequent turnover of political leadership in the federal government have often made it difficult to obtain the sustained and inspired attention to make needed changes." (Source: U.S. General Accounting Office, *Centres for Disease Control and Prevention: Agency Leadership Taking Steps to Improve Management and Planning, but Challenges Remain* (Washington, D.C.: January 2004), pp. 2-3.)

the considerable strain already felt by a public health system struggling to cope with the deep-seated problems caused by years of government inattention and neglect.

It is too early to tell what LHIN's mean for public health. The LHIN documentation and literature makes little if any reference to public health. The significant questions have not been answered: will the LHIN boundaries affect public health boundaries? If so, how? How will LHIN's governance mesh, if at all, with public health governance? Will LHIN financial and resource planning affect the delivery of public health services? If so, how? These questions far from being answered, do not appear even to have been addressed. The proposed LHIN system, announced as a major transfiguration of Ontario's health system, appears to ignore public health. The LHIN proposals, from the public health point of view, are a complete wild card.

Conclusion on Uploading

As noted above, Ontario's protection against infectious disease is only as strong as the weakest public health unit in the province. An outbreak of disease that spins out of control in a dysfunctional health unit can spread to other units and bring the province to its knees within days. Although machinery does exist for provincial oversight of individual health units, the process is unnecessarily cumbersome. The complex procedures for statutory oversight of local health boards take time and energy, distracting the Chief Medical Officer of Health from the more vital task of protecting the public health rather than dealing with intransigent local boards. It is hoped that the recommendations set out below will overcome some of these difficulties.

As for the workability of the present municipal stewardship system, there will be as many different points of view as there are health units. In well functioning local health units people will argue for the virtues of local stewardship. In dysfunctional local health units, or those where the only apparent municipal interest is to cut cost at the expense of public health, those who care about public health will argue that the present system is broken and cannot be fixed.

The province has powers under the *Health Protection and Promotion Act* which enable it to monitor and correct deficiencies in local health units. Although these powers may need to be fine-tuned, the bigger question is whether the province has an appetite to take hold of the local public health system and confront those who need to be confronted in order to make the system work. It may be that the powers of provincial oversight have been exercised unevenly over the years and that some local medical officers of health have felt unsupported by the province in the struggle to maintain

the integrity and political independence of the office of medical officer of health in the face of unfriendly local power structures. The key question at this time is, does the province have the appetite and the resources to oversee municipal stewardship?

It is too early to say the system is hopeless. But the burden of persuasion has fallen to those who want to make the present system work. Is the government prepared to pour into the present system the resources necessary to make it work? Is it prepared to devote the energy, leadership and political will necessary to make it work? If the province does not commit the necessary resources, and develop the will to wrestle the present system of split stewardship into a consistently excellent province wide system of governance, then it should withdraw municipalities from the field. It is infinitely more efficient, and saves infinite time, energy, and resources to administer a unitary stewardship system. It takes enormous work to make a mixed stewardship system work and the question must be asked, is it worth it?

The important question that must be resolved is whether the present system can be fixed and at what cost in resources and focus. The cost of failing to fix it is risk of disease and death … should an infectious outbreak strike a health unit that is poorly resourced, poorly prepared, and struggling to breathe within the municipal bureaucracy.

There is no doubt that municipal stewardship works well in some areas and poorly in others. The challenge is to identify the conditions that make the difference between the good and the bad, and to fix the latter.

Although it may be that the conditions that drive the difference have to do with size and demography, the anecdotal evidence examined by the Commission suggests otherwise. It appears, anecdotally, that large urban health units and small rural health units can be equally successful or unsuccessful depending on a host of factors other than size and demography. The conditions that make a difference are many, including local history and tradition, the organizational culture of the local board and health unit, the personality of the local medical officer of health, board members and politicians, and the cyclical determination and ability of the province, waxing and waning over the years, to do what is necessary to make the local systems work.

One condition that makes for good governance is the adoption of governance standards of the kind recommended below.

The fact that many public health units work in an admirable fashion is a credit to the individuals involved, not to any wisdom in the institutional arrangment that leaves a

provincial function like public health in the hands of local municipalities. In some local units the management of the difficult relationship between the medical officer of health and the board and municipal authorities diverts precious time and energy from the real task of protecting the public against disease. In some cases the difficulty of ensuring local municipal compliance diverts more time and energy from the first priority of the Chief Medical Officer of Health and the province, which should be public health protection rather than mediation with local governments and boards.

All the fine public health initiatives taken since SARS, all the fine initiatives planned and considered for the future, are at risk from the deep problems that attend the municipal role in the delivery of provincial public health services. One dysfunctional health unit can break the chain of protection.

The issues surrounding the municipal governance of public health are complex. As set out above, there is no easy answer and there is no common solution. However, as one local medical officer of health aptly noted, there is plenty of fuel for the discussion. The discussion has to occur now, and a timeline for decision-making and change must be set.

To this end, as noted in the introduction to this chapter, the Commission recommends that the province, by the end of the year 2007, after the implementation of the recommendations of the pending public health capacity review,[92] decide whether the present system can be fixed with a reasonable outlay of resources. If not, funding and control of public health should be uploaded 100 per cent to the province. This will require an amendment to the Operation Health Protection plan to include a firm decision point to upload completely or to leave the present system in place. The take-home message here is that the burden of persuasion is on those who want to preserve the present system of split provincial-municipal governance. A clear timeline for that decision is required.

The underlying problems of municipal funding and municipal governance are the Achilles heel of public health in Ontario. Ontario's only choice, if these problems cannot be fixed within a reasonable time, is to assume full funding and direct control of public health in Ontario.

This recommendation might be resisted on the grounds that the system is going through enough changes right now without the further distraction of a fundamental

92. As noted above, the Capacity Review Committee is to present its final report in December 2005.

review. But if a timetable is not set now to resolve this fundamental issue it will continue to fester for years as it has in the past, to the detriment of the morale of those who serve the system with such dedication and to the detriment of the public interest in public health protection. The risk of inaction is simply too high.

Recommendation

The Commission therefore recommends that:

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

Municipal Bureaucracies

In some municipalities, public health faces a constant flow of problems that impact their ability to deliver health services and to protect the public. These problems include:

- Local health units with unfilled full-time medical officer of health positions;[93]
- Local health units without adequate staff;
- Medical officers of health without operational control over what staff they do have;
- Constant warfare and turf disputes between the municipal authorities and the medical officer of health; and
- Municipal reluctance to authorize payments required by law to meet minimum health protection standards laid down in the Mandatory Guidelines.

93. As of October 21, 2004, there were two full-time vacancies in the province: Hastings County and Peel. Additionally, six medical officers of health positions were filled on an acting basis (information provided by the Association of Local Public Health Agencies).

These problems have led to uneven levels of functionality in health units around the province, some strong and others weak. In those areas plagued by these problems, the local medical officer of health and public health staff have done an admirable job trying to protect the public, while struggling daily for operational and administrative control, and to secure appropriate levels of funding. It is a testament to their professionalism and dedication that in the face of these problems they remain in the service of the public, committed to protecting the public.

On the other hand, not every board of health is dysfunctional. Some, as noted above, function quite well. Not every municipal official or board of health member is against public health. Some, as noted above, are very proactive and they provide a supportive voice and, indeed, advocacy on behalf of the public's health.

Although there is no consensus on the ultimate solution to the problem of the dual system of governance, there is some common ground. The common ground is that so long as the governance of public health remains at the local level, the province, through auditing, enforcement and amendments to strengthen the *Health Protection and Promotion Act*, must ensure that local medical officers of health are free to do the important job of protecting the public.

Too much energy goes into the conflict between municipal funding concerns and the needs of public health. Too much energy goes into the mediation of disputes arising from the municipal role. A medical officer of health in one of Ontario's largest cities described the problem to the Commission:

> Most of us are lost deep down in municipal bureaucracies. This needs to be corrected. The medical officer of health should be the Chief Executive Officer of a distinct service unit with accountability to a Board.

Despite the existence of s. 67(2), which should provide the medical officer of health with clear authority over and responsibility for public health employees as noted above, in some municipalities local medical officers of health are struggling to keep their staff, much less direct them.

Subsection 67(2) provides:

> The employees of and the persons whose services are engaged by a board of health are subject to the direction of and are responsible to the medical officer of health of the board if their duties relate to the delivery of public health programmes or services under this or any other Act.

This provision is designed to ensure that the Chief Medical Officer of Health has the necessary authority and accountability in respect of staff and resources of the board of health.[94] Section 67 looks on its face like a common sense provision with which every sensible person would agree. It has, however, become in some health units a battleground between local medical officers of health, who attempt to preserve the administrative integrity of public health resources, and muncipal authorities determined to extend their control at the expense of public health. More will be said below about this problem in the context of s. 67.

As noted above, in Muskoka-Parry Sound, Mr. Scott observed that:

> … the Board, in its attempts to address costs has become a micro-manager of the MPSHU. The Board has no role in management of the MPSHU.

The problems faced by some local medical officers of health and the situation in Muskoka-Parry Sound Health Unit suggest that s. 67 has not prevented the apprehended danger that public health administration would become lost within the municipal bureaucracies.

The Commission in its first interim report analyzed serious problems at the local level and recommended:

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94. The entire section provides as follows:

> Medical officer of health
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> 67 (1) The medical officer of health of a board of health reports directly to the board of health on issues relating to public health concerns and to public health programmes and services under this or any other Act.
>
> Direction of staff
>
> (2) The employees of and the persons whose services are engaged by a board of health are subject to the direction of and are responsible to the medical officer of health of the board if their duties relate to the delivery of public health programmes or services under this or any other Act.
>
> Management
>
> (3) The medical officer of health of a board of health is responsible to the board for the management of the public health programmes and services under this or any other Act.

> Whatever is done by way of structural revision, two adjustments are clearly needed to the role of the local medical officer of health. The first is to ensure, as noted above, that the local medical officer of health enjoys the same degree of political independence from the local power structure that the Chief Medical Officer of Health enjoys from the province. Both the local medical officer of health and the Chief Medical Officer of Health require the ability to speak out on public health issues without going through a political filter, and need to manage outbreaks free from politically motivated interference. The second is to ensure that the local medical officer of health is not buried in the municipal bureaucracy. It has been suggested that some local medical officers of health, as municipalities moved to consolidate, have been sucked into the corporate municipal entity instead of retaining the executive authority over their own operations that is necessary to ensure their accountability for the administrative machinery that makes public health work on the ground.

The first recommendation, ensuring the independence of the local medical officer of health, is discussed in the previous chapter, Medical Independence and Leadership.

Following the above passage in the first interim report, the Commission recommended that s. 67 be enforced, or if necessary, amended:

> Because of the overall provincial interest in public health protection and because of the statutory obligations of the local medical officer of health to ensure public health protection, the provisions of s. 67 should be enforced or if necessary amended to ensure that the medical officer of health has direct administrative control over the personnel and administrative machinery required to deliver public health protection.

Mr. Scott, in a presentation to the Grey-Bruce Board of Health, set out the important distinction between the CEO/Board relationship in most corporations, and the medical officer of health/board relationship in the *Health Protection and Promotion Act*:

> While the Board is ultimately responsible for the quality and success of the mandatory health programs and in the execution of the above duties, the relationship with the Medical Officer of Health ("MOH") is central to the success of the health unit.
>
> The foregoing makes it plain that there is a marked difference between

> CEO/Board relationship in most corporations and the MOH/Board relationship under the HPPA.
>
> The Board, subject to the approval of the Minister, has the responsibility to hire and fire the MOH, assess the MOH, and hold the MOH accountable for the effective operation of the health unit. This on the surface is similar to the Board/CEO relationship in other corporations. However, in other corporations the Board can interfere with the CEO and remove the CEO at will and even take over the operation of the corporation. This is not an option under the HPPA.
>
> In addition to the substantial medical powers carried by the MOH, the MOH must also ensure the development of a budget that is sufficient to meet the public health needs while administering a health unit that is efficient, and cost effective. The board must approve the budget. This leadership by the MOH in both medical and administrative matters and the policy and approval oversight by the Board should provide assurance that the public health is protected and that public health programs are delivered at a reasonable cost to their taxpayers.
>
> The failure to understand these dynamics and the central role of the MOH was at the root of most of the problems in Muskoka-Parry Sound. The board seemed to believe it could act as it saw fit with the office of the MOH. They were wrong in policy and wrong in law![95]

In some areas there is a clear lack of understanding of the role of the board of health. This is evidenced by the numerous examples of municipal officials, both those who sit on boards of health and those who aren't members of the board of health, virtually ignoring s. 67. Those examples, along with the Muskoka-Parry Sound experience, demonstrate that s. 67 as it now stands is powerless against any municipality or local board that chooses to ignore or defy it.[96] Section 67 in its present form has proved

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95. Graham W.S. Scott, Q.C., Presentation to the Grey-Bruce Board of Health: Critical Elements for Effective Governance of Boards of Health in Ontario, January 21, 2005. (Subsequently referred to as the Scott Presentation.)
96. This is clear from the Scott Report findings:

> … I am satisfied that the Board has shown little interest in meeting the requirements of the legislation where it is inconvenient. For example:

inadequate to prevent the mischief it was designed to prevent.

The overall provincial interest in public health protection, and the statutory obligations of the local medical officer of health to ensure public health protection, require the amendment of s. 67 to ensure that the medical officer of health has direct administrative control over the personnel and administrative machinery required to deliver public health protection.

The Commission therefore again recommends that s. 67 be amended and strengthened to ensure that those whose duties relate to the delivery of public health services are directly accountable to, and under the authority of, the medical officers of health, and that their management cannot be delegated to municipal officials. More importantly, however, as will be discussed below, so long as public health governance remains at the local level, the provincial government must be vigilant in auditing and taking decisive action where violations of s. 67 occur.

A parallel amendment is required to provide that the local medical officer of health is the chief executive officer of the local board of health. It must be made abundantly clear that the local medical officer of health has exclusive authority over the direction of employees whose duties relate to the delivery of public health programmes and services. It must be clear that the local medical officer of health is responsible to the board for the management and administration of public health programmes and services, and the business affairs of the board of health.

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1) The Board has been without a full-time MOH for most of the time since 2000 and consequently has not met the requirements of Section 62(1) of the HPPA, which require it to appoint a full-time MOH.

2) The last time an MOH reported regularly to the Board was during the tenure of Dr. Pfaff. The Board has, at best, been passive about the presence of the MOH at Board meetings and is clearly outside the intent of Section 67(1) of the HPPA.

3) The Board's actions with regard to personnel matters have circumvented and frustrated the intent of Section 67(2) and (3) which provide that employees are subject to the direction of, and responsible to, the MOH.

4) The Board has, by procedural means, made it difficult for the MOH to exercise the right in Section 70 to attend each meeting of the Board and every committee meeting.

5) The Board has appointed Co-Chairs of the Board notwithstanding that they were aware that the HPPA has no provision that permits the appointment of Co-Chairs.

This measure, among others, is necessary to ensure that local medical officers of health have the clear authority to manage the health unit and that appropriate public health standards are met across the province. So long as municipally governed local boards remain in place, the local medical officer of health requires both full authority, as chief executive officer in respect of local public health services, and direct accountability to the local board free from any municipal intervention.

As noted in the previous section, the medical officer of health requires a degree of independence parallel to that now provided to the Chief Medical Officer of Health. Medical officers of health should have the duty and the authority to speak out publically about local public health concerns. This must include the power to bring to the attention of the public a local board's failure or refusal to comply with their obligations under the Act. The local medical officer of health must be able to do so without fear of recrimination, reprisal, dismissal, or other adverse employment consqequences. The Commission reiterates its recommendation in the previous section that the *Health Protection and Promotion Act* must be amended to provide every local medical officer of health with a degree of independence parallel to that recommended for the Chief Medical Officer of Health, including the duty and authority to speak out publicly about local public health concerns without fear of adverse employment consequences.

Recommendations

The Commission therefore recommends that:

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

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

    - **Take enforcement actions in respect of violations of s. 67;**

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

- **Amend the *Health Protection and Promotion Act* to provide local medical officers of health a degree of independence parallel to that of the Chief Medical Officer of Health, as set out in Chapter 1 of this Report.**

Strengthening Accountability

SARS showed that provincial control over public health protection needs more teeth.

The present regime depends on compliance by local public health boards with the Mandatory Health Programs and Services Guidelines (the Guidelines). First published in 1984, and then revised in 1997, the Guidelines set out minimum requirements for public health programmes and services delivered by public health units across Ontario.

Although the statute requires local boards to comply with the Guidelines, a guideline is no more than a suggestion, making the Guidelines a weaker form of direction than standards. A uniform standard of health protection throughout the province requires more than a series of suggestions that are inadequately monitored, audited and enforced.

Under the *Health Protection and Promotion Act*, every board of health is responsible for ensuring the provision of health programmes and services required under the Act and its regulations. Section 4 of the *Health Protection and Promotion Act* provides:

> 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.

Section 5 of the Act sets out the types of health programmes and services that every board of health must provide:

5. 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.

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.

5. Home care services that are insured services under the *Health Insurance Act*, including services to the acutely ill and the chronically ill.

While s. 5 sets out the general areas, it does not establish a baseline standard of serv-

ice that must be provided in each area. Rather, this is set out in the Guidelines established by the Minister under the authority of s. 7 of the *Health Protection and Promotion Act,* which provides:

> 7. The Minister may publish guidelines for the provision of mandatory health program and services and every board of health shall comply with the published guidelines.

As the opening paragraph (see below) of the Guidelines demonstrates, the words "guideline" and "standard" are used interchangeably, as if they had the same meaning and same mandatory vigor:

> The standards contained in this document obtain their legal authority under provisions of the *Health Protection and Promotion Act*. Part II, Section 5, of the *Health Protection and Promotion Act* specifies that boards of health (as defined in the *Health Protection and Promotion Act*) must provide or ensure the provision of a minimum level of public health programs and services in specified areas. Section 7 of the *Health Protection and Promotion Act* authorizes the Minister of Health to develop and publish guidelines that represent minimum standards for these programs and services.

However, guidelines are weaker than standards.

The Canadian Oxford Dictionary defines "guideline" as:

> A principle or criterion guiding or directing action.

But it defines "standard" as prescriptive in nature:

> An object or quality or measure serving as a basis or example or principle to which others conform or should conform or by which the accuracy or quality of others is judged.

Merriam-Webster's Dictionary of Law defines "standard" as:

> Something established by authority, custom, or general consent as a model, example, or point of reference.

Stedman's Online Medical Dictionary defines "standard" as:

> Something that serves as a basis for comparison; a technical specification or written report by experts.

Although to some the difference between the words "guideline" and "standard" may be a matter of linguistics, to others the term "standard" more appropriately reflects their significance and mandatory nature. As one experienced medical officer of health told the Commission:

> It would be very helpful even if you just changed the name because in fact they are … if you read the details they are legally enforceable but you would not think so from the description.

Although this observer thought the Guidelines were legally enforceable, it is difficult to identify any quick and effective legal machinery for their enforcement under the present system.

The term "guideline" connotes discretion and suggests that a particular level of performance is desired but not required. A guideline is simply an indication or outline of policy or conduct; a mere suggestion. Mere suggestions are not enough to ensure a reasonable level of public health protection across the province. It is not enough to require boards of health to meet guidelines. Standards are stronger, requiring a particular level of performance. The measures required to protect public health should be laid down as binding standards across the province, having the force of law and with consequences for noncompliance.

The Commission welcomes the decision of Dr. Basrur to review the Mandatory Health Programs and Services Guidelines, a process that,

> … will incorporate emerging health issues, best practices, new science, as well as lessons learned from Ontario's experiences with Walkerton, West Nile virus and SARS.[97]

Many public health advocates have recommended to the Commission that the standards be included as part of the regulations to the *Health Protection and Promotion Act*, to give them the strength of law. This makes good sense in order to ensure that the standards have the force of law. As one medical officer of health told the Commission:

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97. Public Health Division, "2005 Financial Planning and Accountability Guide for Provincial Grants for Mandatory and Related Public Health Programs," (Toronto: February 2005), p. 3

> I recommend that the guidelines be replaced as a standard. I recommend that they be given the weight and laws of regulations …

Recommendation

The Commission therefore recommends that:

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

Monitoring, Auditing and Enforcement

Compliance is weak in any system when standards are considered to be mere suggestions whose observance is discretionary. Compliance declines gravely in any system when standards are perceived to lack the weight of mandatory direction and are not effectively monitored, audited or enforced. Under such conditions, even the best-crafted standard can fall short of its intended goal.

Effective monitoring, auditing and enforcement can help to root out organizational problems before they spin out of control and require drastic measures. They can raise the level of performance among weaker health units. And they can ensure the provision of a uniform level of public health services throughout Ontario.

Ineffective monitoring, auditing and enforcement, as demonstrated by SARS, can allow problems of capacity, resources and leadership to fester and worsen. Weak health units are permitted to decline even further. Ineffective central control deprives Ontarians of their right to expect similar levels of public health protection no matter where they live.

Prior to SARS, the Ministry had a poor track record of monitoring local health unit compliance with the Guidelines. The Provincial Auditor (now the Auditor General) stated in his 2003 report:

> Ministry staff informed us that, since 1998, only one assessment of a local health unit had been undertaken and that in March 2003, the

Ministry began limited assessments of mandatory programme areas at five local health units.

When the Guidelines were revised in 1997, the Ministry estimated that it would take three years to achieve full compliance. In 1998, the Ministry initiated an annual Mandatory Programs Indicator Questionnaire (MPIQ), whereby local health units answered a series of questions related to the Guidelines. The Ministry uses their answers to assess whether programme requirements are being met. At the time of our audit, the Ministry was in the process of reviewing the MPIQs covering the year 2001.

We questioned the Ministry's full reliance on the MPIQ as a basis for its assessment, as the MPIQ data consisted solely of local health units' self-reported answers and the Ministry did not have any procedures in place for verifying the reliability of the information reported. In this regard, in 2000, the Mandatory Programs Measurement Working Group, comprising representatives from the Public Health Branch and Ontario's Association of Local Public Health Agencies, recommended that the MPIQ be evaluated for its validity as a tool for assessing compliance with the mandatory programs. At the time of our audit, the recommended evaluation had not been conducted.

Based on its review of the completed MPIQs for the year 2000, the Ministry concluded that local health units were 78 per cent compliant with the Guidelines. This was calculated by averaging the overall compliance rate for each of the MPIQ areas across the 37 local health units. However, we noted that this calculation was not a meaningful measure of compliance and was therefore not an indicator of the Actual performance and overall effectiveness of public health programmes across the province. Specifically, we noted the following weaknesses in the compliance calculation and the MPIQ itself.

- The Ministry calculated overall compliance without considering the relative size of individual health units (the population served by the largest local health unit is over 60 times that of the smallest health unit).

- Compliance was assessed in absolute, "either/or" terms, rather than taking into account degrees of compliance. For instance, one health

> unit was about 10 per cent compliant in a mandatory programme area while another was 70 per cent compliant, yet both were rated equally non-compliant.
>
> • The MPIQ did not elicit compliance data for all of the mandatory programmes and services. For example, the Guidelines include an objective for a coverage rate of 95 per cent for vaccinating children for hepatitis B by the end of grade 7, but the MPIQ did not address hepatitis B vaccination coverage rates.[98]

A compliance monitoring system that does not adequately measure compliance is of little help. Improved monitoring through random assessments was recommended by Mr. Justice O'Connor in the Walkerton Inquiry and also in the 2003 report of the Provincial Auditor;

> Under the Act, the Minister of Health and Long-Term Care may assess whether local health units are providing or ensuring the provision of health programmes and services in accordance with the Guidelines. In addition, Part One of the Walkerton Report, released in January 2002 (the report was the result of the Walkerton Inquiry, established in June 2000 to investigate the water-borne E. Coli outbreak in Walkerton, Ontario), recommended that the Ministry conduct random assessments on a regular basis to ensure local health units are complying with the Guidelines. The report also stated that the Ministry should annually track trends in noncompliance in order to assess whether changes are required to the mandatory programmes and whether resources require adjustment to ensure full compliance.[99]

Since SARS the Public Health Division under Dr. Basrur's leadership has made important strides in addressing this problem, sending a clear signal that the Guidelines are to be treated as mandatory standards – not suggestions. The Public Health Division's recently released "2005 Financial Planning and Accountability Guide for Provincial Grants for Mandatory and Related Public Health Programs" advises boards of health and health units:

98. 2003 Annual Report of the Office of the Provincial Auditor of Ontario, pp. 223-4.
99. *Ibid,* p. 223.

> To ensure that services provided by health units respond effectively to the needs of Ontarians, the Ministry will actively enforce compliance with the Mandatory Health Programs and Services Guidelines.[100]

Indeed, a heightened level of accountability is a constant theme of the "2005 Financial Planning and Accountability Guide for Provincial Grants for Mandatory and Related Public Health Programs." It advises boards of health and health units:

> In 2005 the Ministry will implement a performance measurement system. This, along with the Program-Based Grant Request and related reporting requirements, will enable the Ministry to strengthen its review of eligible expenditures in order to effectively monitor programme funding and service delivery. These initiatives will build on the public health system's demonstrated interest in working towards increased accountability. The continuing cooperation of all public health providers will be essential to our success in demonstrating accountability and "value for money" as we move forward to revitalize Ontario's public health system.
>
> In addition to improving accountability, the information obtained through the above noted mechanisms will assist us in planning future programme changes and enhancements and will inform the Mandatory Program Review and the Local Public Health Capacity Review committees.[101]

The Guide, for example, provides clear direction on how funds for infection control should be allocated and monitored. It states:

> The Ministry has clarified the requirements for the Infection Control program (formerly the SARS Short-Term Action Plan) initiated in 2003 . . .
>
> - For the Infection Control program, health units are required to stay within both the funding levels and the number of full-time equivalent positions identified in the Ministry's allocation letter of

100. Public Health Division, "2005 Financial Planning and Accountability Guide for Provincial Grants for Mandatory and Related Public Health Programs," (Toronto: February 2005), p. 3
101. *Ibid.*

> December 19, 2003 (supercedes and replaces original allocation letter of September 25, 2003).
>
> - Funding for this initiative must be used solely for the purpose of hiring and supporting staff that will increase the health unit's ability to monitor and control infectious diseases and enhance its ability to deal with surges of activity related to outbreaks of diseases.
>
> - Effective with the 3rd Quarter Report due October 30, 2005, health units will be required to submit the "Staffing and Related Costs" report for the Infection Control Program as part of their quarterly reports.
>
> - Staff funded through this initiative are required to be available to be re-deployed when requested by the Province to assist with large-scale outbreaks in the event that they threaten to overwhelm another local health unit's capacity to respond. This is part of the provincial commitment to improve the capacity of all Ontario public health units to control and respond to infectious diseases.[102]

Meeting the minimum requirements set out in the Guidelines is also an explicit feature of transfer payment agreements between the Province and the local health unit. The recently released Guide states:

> Transfer payments involve an agreement between the Province and the applicable health unit. The Ministry must ensure that prior to advancing any provincial funds to health units, signed agreements are in place that:
>
> - Bind the health unit to achieve specific, measurable results per the Mandatory Health Programs and Services Guidelines;
>
> - Require health units, as a condition of funding to have in place governance and administrative structures and processes necessary to ensure prudent and effective management of public funds;
>
> - Require health units to provide periodic reports on financial status and relevant financial and program results achieved;

102. *Ibid,* pp. 6-7.

- Clearly establish the province's right to require independent verification of reported information by independent professionals;

- Limit the obligations of the province according to the terms of programs approved by Cabinet; and

- Permit the recovery of provincial funds and/or the discontinuance of ongoing funds in the event of health unit non-performance.[103]

Monitoring and reporting is also an explicit feature of the transfer payment agreements. The Guide states:

> Monitoring and Reporting
>
> The Ministry is required to obtain and review information on the status of health unit eligibility and performance and identify noncompliance with agreements and the failure of health units to demonstrate continued eligibility.[104]

The Guide also outlines the consequences of failing to meet the terms of the funding agreements:

> Corrective Action
>
> The Ministry must initiate corrective action where a health unit has failed to comply with any of the terms of the agreement or where ineligibility is identified. Where appropriate corrective action is outside its direct authority, the Ministry must bring the situation to the attention of officials with the necessary authority.
>
> The nature of corrective action will depend on the type and extent of noncompliance, but in all cases the objective of corrective action is to ensure that provincial funds are used as specified in agreements or returned to the provincial treasury.[105]

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103. *Ibid,* pp. 16-17.
104. *Ibid,* p. 17.
105. *Ibid,* p. 17.

Complimenting these initiatives is an innovative change in the role of the Auditor General (formerly called the Provincial Auditor.) The Guide advises boards of health and health unit staff that Bill 18, *An Act Respecting the Provincial Auditor,* which received Royal Assent in November 2004, expands the mandate of the Auditor General to conduct discretionary value-for-money[106] audits of local boards of health.

Section 9.1 of the Act states:

> 9.1 (1) On or after April 1, 2005, the Auditor General may conduct a special audit of a grant recipient with respect to a reviewable grant received by the grant recipient directly or indirectly on or after the date on which the Audit Statute Law Amendment Act, 2004 receives Royal Assent.
>
> Exception
>
> (2) Subsection (1) does not apply with respect to a grant recipient that is a municipality.

However, while the Auditor General does not have the mandate to audit municipalities, s. 9.2 of the *Auditor General Act* does provide the following authority with regards to municipal grants:

106. According to the web site of the Auditor General: "An extremely important part of the Auditor General's mandate is the value-for-money component. Value-for-money audits are assessments of whether or not money was spent with due regard for economy and efficiency and whether appropriate procedures were in place to measure and report on the effectiveness of government programs. Under the Auditor General Act, the Office is required to report to the Legislature significant instances where it is observed that the government is not fulfilling its responsibilities in these areas. To fulfill its value-for-money mandate, the Office annually conducts audits of selected ministry or agency programmes and activities. Major programmes and activities are generally audited every five years or so. Every year, senior management of the Office consider a number of risk factors when selecting which programmes to audit in the coming audit period. These factors include: the results of previous audits, the total revenues or expenditures at risk, the impact of the programme or activity on the public, the inherent risk due to the complexity and diversity of operations, the significance of possible issues that may be identified by an audit, and the costs of performing the audit in relation to the perceived benefits. The results of value-for-money audits are reported on in the Auditor General's Annual Report and constitute a large portion of that document. As well, of all the observations that the Auditor General reports on, value-for-money findings tend to attract the largest proportion of media coverage and interest from the public and from the Standing Committee on Public Accounts." (See http://www.auditor.on.ca/english/aboutus/whatwedo_frame.htm)

> 9.2 (1) The Auditor General may examine accounting records relating to a reviewable grant received directly or indirectly by a municipality.
>
> (2) The Auditor General may require a municipality to prepare and submit a financial statement setting the details of its disposition of the reviewable grant.

The Ministry of Health advises that spot audits have been conducted since SARS to determine whether local health units are meeting mandatory infection control guidelines. This sensible initiative needs to become part of the regular accountability and monitoring process authorized and required by law to serve not only as an accountability measure to encourage compliance and identify problems at an early stage, but also as a management tool to identify and correct general trends in noncompliance.

That's why the Commission recommends that the *Health Protection and Promotion Act* be amended to require, by law, the regular monitoring and auditing, including random spot auditing, of local health units to ensure compliance with provincial standards. The public should be able to see any such audits so that they can judge the level of performance of their local health unit.

Effective monitoring, auditing and enforcement require sufficient allocation of resources – to the Provincial Health Division, to the local health units, and to the Auditor General. Too often in the past, the importance of monitoring compliance with public health standards has been given short-shrift – both as a strategic imperative and a funding priority. And yet, as suggested by Mr. Justice Horace Krever in the Commission of Inquiry on the Blood System, by Mr. Justice O'Connor in the Walkerton Inquiry, and by the Provincial Auditor in his 2003 report, monitoring and audits are essential to ensuring that public health standards are maintained so that emergencies are either prevented from developing or can be more effectively contained.[107]

The enactment of a new statutory duty to monitor and audit, together with an increased emphasis on active enforcement, are vital to ensure that problems are found and fixed before they get so big that they require heavy and expensive interventions.

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107. Mr. Justice Horance Krever, *Final Report, Commission of Inquiry on the Blood System in Canada* (Ottawa: 1997), Volume 3, p. 1054; Mr. Justice Dennis O'Connor, *Part One: Report of the Walkerton Inquiry* (Toronto: January 14, 2002), pp. 263-4; Provincial Auditor of Ontario, *2003 Annual Report* (Toronto; December 2, 2003), pp. 217-44.

With this increased responsibility must come increased resources to fund the monitoring, the audits and the enforcement. As noted below in the section on public health resources, it is idle to enact improvements to the public health system without funding those improvements. Publicly announced initiatives, without adequate funding, mislead the public.

Recommendation

The Commission therefore recommends that:

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

Composition & Qualification of Boards of Health

Acting on recommendations set out by the Commission in its first interim report[108] and the recommendations in the Walker Report,[109] the provincial government has begun to upload a greater proportion of public health funding. The goal is for the province, by January 2007, to be responsible for 75 per cent of public health funding.[110]

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108. The Commission in its first interim report recommended the following:

> There is no scientific way to determine the appropriate degree of provincial funding upload for infectious disease surveillance and control. Although a case can be made for 100 per cent funding upload, the persuasive views of a number of local medical officers of health suggest that it would be sensible to upload infectious disease control to a provincial contribution of at least 75 per cent.
>
> It may be that the provincial acceptance of that recommendation, the initiatives taken by Dr. Basrur since her appointment, and the recommendations in this second interim report will fix the underlying governance problems. It is the Commission's further position in this report that if these measures do not fix the problems, a clear decision must be made by the end of 2007 whether or not to upload funding and control 100%100 per cent to the province (p. 175).

109. The Walker Final Report, p. 74.
110. Ministry of Health and Long-Term Care Press Release, "New provincial commitment to public health a positive change," May 28, 2004.

On the principle of say for pay, it follows that the province should assume a greater representation on local boards of health. If the provincial government is paying for three-quarters of the funding, then it should clearly have a greater say than it does now – less than 50 per cent[111] – in its representation on local boards of health.

As for the proportion of municipal and provincial appointees on boards of health, it is anomalous that the province, which now pays over 50 per cent of the overall cost, is restricted by statute to less than 50 per cent of board appointees. It is not just a question of money. Public health is a provincial programme. As noted above, the nature of infectious disease requires stronger central control of the machinery that detects and prevents its spread throughout the province. Should the recommendations in this report be implemented, the degree of provincial control will increase. The governance of a provincial programme, funded mostly by the province, requiring a strong measure of provincial control, should attract a majority of provincial appointees on the local governing boards.

The Commission therefore recommends that the province appoint a majority of the members of each local board of health.

A significant practical difficulty attends this recommendation. There has been from time to time a significant delay in the cabinet appointment (by Order in Council) of provincial representatives on local boards, including boards of health. Long standing vacancies interrupt continuity and impair the full functioning of local board. As one medical officer of health noted:

> The other problem with provincial appointees that has been experienced, especially with district health councils, is if the provincial government delays in appointing it can really paralyze governance bodies, so that's another piece that attention needs to be paid to. If you happen to get a government that wasn't supportive of public health, a way to make it very difficult to move forward is to not to fill the empty seats.

The Commission therefore recommends that if cabinet has not by Order in Council

111. Subsection 49(3) of the *Health Protection and Promotion Act* provides that the provincial representation should always be less than half:

> The Lieutenant Governor in Council may appoint one or more persons as members of a board of health, but the number of members so appointed shall be less than the number of municipal members of the board of health.

filled a board of health vacancy within six weeks, the vacancy shall be filled by an appointment made directly by the Chief Medical Officer of Health.

When asked about increasing the proportion of provincial representation on boards of health, some members of the public health community met this suggestion with caution. They thought that in many cases the quality of provincial appointments did not reflect the degree of commitment to public health required of those in a stewardship role. One medical officer of health observed:

> … from my previous experience, when we had provincial appointees they were not that distinguished or helpful, so I guess it has not been a great experience.

Widespread concern was expressed not only about provincial representatives on health boards, but about the general need for board members to have some qualifications based on experience, interest, and commitment in respect of public health.

Some local medical officers of health have to contend with board of health members whose sole focus is on cutting the budget. As one local medical officer of health described their situation:

> … one of the board member's key agendas is to cut our budget. My budget meeting is next week. [They] have been actively voting against, and trying to undermine what we're doing since the day [they] walked in the door. And it depends on who's at the table, whether or not the more reasonable people at a particular meeting, [are] able to carry the discussion around the table. And frankly, it's very disheartening for me as a medical officer of health and my staff, when they're just trying to do their jobs, to see how the board behaves.

Whether a board of health member is appointed by the province or the municipality, the member has a duty of stewardship not only for the expenditure of public funds but also for the delivery of public health services that adequately protect the public. They should, as members of a board of health, share a public health agenda, interest, and commitment. Unfortunately this is not always the case.

Mr. Scott, the assessor in Muskoka-Parry Sound referred to above, summarized the conflict faced by many municipal officials who also sit on boards of health:

> One central question that needs to be addressed is: Does a conflict of

interest exist between a municipal councilor's duty to the taxpayer and his or her duty to the community as a steward of the public health system?

I encountered these issues directly in carrying out the Muskoka-Parry Sound assessment. There was a very serious disconnect between the way the Board interpreted its role and what constituted specific requirements of the HPPA and many of the established principles of good governance.

I believe many of those problems originated from a fundamental misunderstanding of how their duties as Board members differed from their duties as elected municipal representatives. Clearly elected municipal representatives are expected by their electorate to manage the affairs of their jurisdiction in an efficient and effective manner; and of obvious importance, is the need to manage them in accordance with the resources available. This puts pressure on the elected municipal representatives to deliver as much as they can for as little tax demand as possible. It further creates an incentive to pick and choose among priorities to keep taxes down and to focus on priorities that may get the most positive reception from the electorate. An elected municipal representative, when wrestling with difficult municipal budgetary demands, is obviously tempted to consider the heath unit as just another essential service that must play its part in the management of the municipal cost structure.

Unfortunately that is not how it works if the law is to be respected!

I believe that there is a potential conflict most notably arising around what was termed the municipal funding dilemma by Justice Campbell. There is a deep structure problem that drives much of the trouble on boards of health. The municipal funding dilemma is that the municipalities fund public health, a provincial program, from a limited local property tax base. Even though the province underwrites more than 50 per cent of the costs of the program, provincial program growth drives municipal costs. This puts the municipalities in a tough spot, a spot that many municipal councilors feel is unjust and unfair. This is covered succinctly in Justice Campbell's Interim report, *SARS and Public Health in Ontario*.

A municipal councilor who also sits on a board of health has two hats, the municipal politician hat: *keep taxes down* and the public health hat: *fight disease*. When the councilor is sitting on the board of health he or

> she cannot perform their statutory duty by simply saying *"no increases because I made a political promise to hold taxes."* The councilor on health board cannot say *"all I care about is the money; no tax increases; public health will have to be cut like everything else."* Those statements would constitute a derogation of his or her duty to the Board of Health. Only one hat can be worn on the Board of Health.
>
> Clearly those who control public funds have a stewardship to ensure value for money. But the councilor on the board of health is bound by legal duty under HPPA which is where his or her first loyalty must lie.
>
> It is not at the option of the Board to avoid their statutory duty to meet the budget requirements of the health unit. The mandatory health programmes and services to be delivered are a statutory requirement. Further, the standards expected for programme delivery are clearly laid out, so there is little room for Board members to adjust the Health Unit budget.
>
> This can make it very awkward for elected municipal representatives who are on the Board as they are open to suggestions from their colleagues that they are not applying the same standards of restraint to the Board that they are applying to other municipal responsibilities. While an unfair shot in the circumstances, it is in fact true, due to the lack of flexibility to suspend or cut back on most programs.
>
> This reality does not at all diminish the importance of the Board or the job of ensuring that the budget is well managed and appropriate for the services delivered, but it does very much limit budgetary discretion.[112]

This is a conflict that is not shared by unelected representatives on the board of health. One local medical officer of health described the important role that the public member of the board of health, an unelected official, played in their board of health:

> We have a citizen who is knowledgeable and interested in public health and they sit on the board. Having them provides for healthy

112. The Scott Presentation.

> checks and balances between the public members who are much more concerned about public health and the business of public health. They have less of an issue with the hats they wear at the table.

Mr. Scott also noted the value of municipally appointed, non-elected public representatives on a board of health:

> One final thought on municipal representation. Section 49(2) of the HPPA refers to municipal members. The Act defines municipal member as "… a person appointed to the Board of Health by the Council of the Municipality." Consequently, the municipality may appoint members who are not elected members of municipal councils. This could have the advantage of removing any conflict an elected representative may experience while providing an experienced individual in the community with an interest in public health the opportunity to serve the interests of public health.

The Commission recommends that the *Health Protection and Promotion Act* be amended to require that those appointed to boards of health possess demonstrated experience or interest in the goals of public health – to prevent the spread of disease and to protect the health of the people of Ontario – and that they be broadly representative of the community to be served.[113]

The Commission recommends that consideration be given to a *Health Protection and Promotion Act* amendment to clarify the role and priorities of health board members, the first priority being compliance with the *Health Protection and Promotion Act* and the mandatory public health standards.

One local medical officer of health described their vision for a board whose goal is health protection and promotion supported by links with the new proposed Ontario Health Protection and Promotion Agency:

> I've thought about this, and I thought why do we need a Board. And if

113. Section 2 of the *Health Promotion and Protection Act* provides:

> The purpose of this Act is to provide for the organization and delivery of public health programmes and services, the prevention of the spread of disease and the promotion and protection of the health of the people of Ontario.

> you were going to change things, who would you put on your Board? I can imagine there being a Board, and it could be governing, could be advisory, with a senior person from the Boards of Education, so that we could in fact work collaterally with and gain entry to the school boards. We don't have that now. We could have somebody from the business community. Worksites are a venue for public health programmes and services. What a great way of getting a sounding as to whether a service delivery strategy will work, as well as an entrée into the business community. If we did have a successor Board, that's how I would go about structuring it. It would be very strategic, and it would be serving at least two roles. One as a kind of a sounding board type of function, as well as kind of a conduit if you will, into specific sectors that perhaps are not well represented now. So that's how I would do it. It would certainly be far different than it is now, which as you know depends on the whim of the municipal council approval who gets on it, and for many boards of health, it changes yearly. So you make a few gains in terms of their understanding, appreciation and guidance with respect to public health, and just like that, they change. The other thing I would say is, I could imagine a model like CCO, Cancer Care Ontario, if Walker recommends and the government sets up a provincial health protection and promotion agency, that is independent of government, presumably it will be governed by a board of directors, and I could imagine that a local board perhaps could nominate one or two members to the directorship of the Provincial agency, and at a government's level, that could provide the tie-in there, as it does with the Board of Cancer Care Ontario, and regional cancer advisory committees that are set up at the regional level. I could imagine that as well. And that would be another way of ensuring communication between the province and local authorities, in addition to the Chief Medical Officer of Health.

Whatever the ultimate structure and composition of boards it will, as Mr. Scott points out, be in the best interest of members of boards of health to become proactive and ensure they are complying with their obligations under the *Health Protection and Promotion Act* and that their sole focus is the protection of the public:

> It is not only Justice Campbell who is putting the heat on Boards of Health, the Walkerton Report that you are very familiar with, and the new national and provincial emphasis on public health will necessarily

place a bigger and bigger spotlight on Health Board affairs. Board members will be locally front and centre for the next SARS-type event; growing health information reporting will put you on the spot if you are not meeting provincial or national performance expectations and statutory requirements.

The simple message is – expectations are changing and changing fast with regard to governance and accountability practices and it will not be good news for Boards of Health that have not fully met expectations if things go awry. Things will go awry! Pandemics happen, and with some of the flu and other infectious disease strains that are developing and society's difficulty in keeping pace with vaccinations and potential cures, the local performance may have a big impact on the spread and/or management of the event. The ability of terrorists to impact public health is real and management and operational incompetence can still have a devastating effect.

When disaster strikes will the Health Board be able to say it met the governance standards expected and did its best when the inevitable questions are asked? That will be the minimum test to protect the community and the Board.

In the event of a public health crisis the Board may not only be under intense public scrutiny but may also be subject to legal action. The issue of whether you met your duties under the law may be subjected to prolonged legal proceedings. This is of little comfort unless you enjoy the spectre of unending legal fees and spending long periods under a potential cloud. A more practical way of assessing whether you are living up to your obligations and hopefully avoid legal proceedings is to apply some simple tests. Given your understanding of your obligations as a board member how would you explain your action as a witness at an inquest or to a Royal Commission or how do you think your position would be portrayed in the media?

Recommendation

The Commission therefore recommends that:

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

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

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

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

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

Good Governance Best Practices

No matter how the relationship between the province and local public health units takes shape, local oversight of public health should reflect the best practices of good governance.

For many years, the word "governance" had a simple meaning. The Canadian Oxford Dictionary defines it as:

> The act or manner of governing.

In recent years, as demonstrated by its usage in this chapter, "governance" has taken on a wider meaning to include structures, processes and systems to whose goal is,

> . . . a robust, well-run organization that achieves peak performance and is accountable to the public it serves.[114]

Many studies in recent years have compiled best practices of good public sector governance including the final report of the Broadbent Panel on Accountability and Governance in the Voluntary Sector,[115] the work of American health care consultants Dennis D. Pointer and James E. Orlikoff,[116] and the recently released guidelines issued by the Office of the Premier of the Province of British Columbia.[117]

In Ontario, the best framework for health organizations may be the one developed by Mr. Scott and Ms. Maureen A. Quigley for the Ontario Hospital Association and funded by the Ministry of Health and Long-Term Care.[118] The following key principles for good governance have been derived from the work of Mr. Scott and Ms. Quigley and adapted to the public health environment:

- Boards of local public health units are accountable to the communities they serve: to effectively deliver services; make appropriate use of community resources; and consider their communities' particular needs and requirements.

- Boards of local public health units also are accountable to the province for: utilizing grants in a manner consistent with provincial directions; ensuring compliance with mandatory health guidelines, regulations and legislation; and measuring performance against accepted standards and best practices.

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114. Office of the Premier of British Columbia, "Best Practice Guidelines: Governance and Disclosure Guidelines for Governing Boards of British Columbia Public Sector Organizations," (Victoria: February 2005), p. 1.
115. Panel on Accountability and Governance in the Voluntary Sector, "Building on Strength: Improving Governance and Accountability in Canada's Voluntary Sector," (Ottawa: February 1999)
116. Orlikoff, James E. and Dennis D. Pointer, "Getting to Great: Principles of Health Care Organization Governance," (San Francisco: 2002).
117. Office of the Premier of British Columbia, "Best Practice Guidelines: Governance and Disclosure Guidelines for Governing Boards of British Columbia Public Sector Organizations," (Victoria: February 2005)
118. Quigley, Maureen A. and Scott, Graham W.S., "Hospital Governance and Accountability in Ontario," (Toronto: April 2004)

- There must be a clear distinction between the roles of management and the roles of boards. While boards delegate authority to management, they must also monitor, assess and evaluate the actions of management. Management oversees the day to day operations of the health unit within the parameters of mandatory health guidelines, regulations and legislation and in the context of their boards' accountability to the communities they serve and the province.

- In making board appointments, the province and the municipality should select a percentage of members equal to their respective financial contributions. In most cases, this requirement would be satisfied by the above recommendation that the province appoint a majority of board members.

- The province should establish two sets of criteria for board members. One set of criteria should require generic qualities, including the ability to consider issues critically, to work towards a consensus and to foster a positive working environment. The second set of criteria should be more directly applicable to a public health setting, including: a demonstrated interest in public health issues, a scientific or medical background, an understanding of risk communication, or some other qualifications such as business expertise or community development experience.

- Terms of board members should be staggered so that, at any one time, two-thirds of the board is comprised of experienced members.

- A medical officer of health's performance should be measured against agreed objectives.

- A board's performance should be measured against the objectives set by the board and the province.

- The performance of individual board members should be assessed each year in terms of their participation and contribution to the work of the board.

Recommendation

The Commission therefore recommends that:

- **The Ministry of Health and Long-Term Care introduce a package of governance standards for local boards of health with reference to those sources**

referred to above, such as the Scott and Quigley governance framework.

Conclusion

Public health at the local level needs attention. The existing problems faced in some health units cannot be permitted to continue. The government, for the reasons given above, needs to make a clear decision by the end of the year 2007 whether to upload the financing and control of public health 100 per cent to the province and away from the municipalities.

Although there is no consensus on the ultimate solution for the problems of split provincial-municipal governance, there is a consensus that improvements of the kind described above are required even within the existing system

Whatever the ultimate solution, the *Health Protection and Promotion Act* must be strengthened and enforced in the manner described above to ensure a uniform standard of protection across the province. Boards of health must likewise be strengthened to ensure that those who comprise the boards of health are committed to and interested in public health, that they clearly understand their primary focus is to be protection of the public's health, and that they broadly represent the communities they serve.

The current state of affairs cannot continue. The cost of failing to fix will be to risk more disease and death.

Recommendations

The Commission therefore recommends that:

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

- **The Ministry of Health and Long-Term Care enforce the *Health Protection and Promotion Act* to ensure the protection of the medical officer of health from bureaucratic and political encroachment in the administration of**

public health resources and to ensure the administrative integrity of public health machinery under the executive direction of the medical officers of health. In particular, the Ministry of Health and Long-Term Care should:

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

- **Take enforcement actions in respect of violations of s. 67;**

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

- **Amend the *Health Protection and Promotion Act* to provide local medical officers of health a degree of independence parallel to that of the Chief Medical Officer of Health, as set out in Chapter 1 of this Report.**

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

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

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

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

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

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

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

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