Ontario Medical Association
Input To
Walkerton Inquiry Part II:

Protecting the Public's Health

April 2001

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Public health, a key component of Ontario's health system has the responsibility for promoting and protecting health, preventing disease and injury through the delivery of the mandated Mandatory Health Programs and Services Guidelines.

It is important to acknowledge that an effective, stable and sufficiently funded public health system will contribute to safe drinking water.

The Ontario Medical Association's (OMA) key messages for the Walkerton Inquiry are:

- Public health is a key component of Ontario's health system
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- Public health spending is an investment not an expenditure

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- Coordination of stakeholders involved in safe water issues
- Consistent regulations for drinking water supply agencies/systems

The OMA's recommendations/suggestions are:

Organization of Public Health in Ontario

1. Consideration must be given to the continued practicality or cost effectiveness of boards of health servicing small populations (less than 100,000) given the range of expertise required to meet the board of health's mandated responsibilities.
2. All communities must maintain a certain consistent level of public health infrastructure to ensure that all Ontario residents are protected.
3. There must be coordination between provincial and federal public health systems. This must include the delivery of public health programs and services for Ontarians (e.g., military bases, Great Lake tour boats, Aboriginals on reserve, etc.) living on land under federal jurisdiction.

Public Health Programs and Services

4. All laboratories carrying out water testing should be subject to quality assurance controls similar to laboratories carrying out clinical testing.
5. The position of "Provincial Public Health Commissioner" be established to report to the Legislature on public health related matters including the health status of Ontarians.

Role of the Medical Officer of Health

6. Each board of health, as per the Health Protection and Promotion Act, (HPPA) must employ a full-time medical officer of health who reports to it.
7. The functions of the medical officer of health must be clear and include the administrative and organizational responsibility for all public health programs and services delivered including overall responsibility for staff who deliver public health programs and services.
8. There must be a specified term restricting the time that a person may serve as an acting medical officer of health and the skills required to fill this position should be specified.
9. Thought must be given to the population size that each board of health is responsible for before requiring the services of an additional medical officer of health.

Financial Issues

10. The province of Ontario should pay the greater portion of the cost of public health programs and services.
11. Funding for public health should be part of a formal agreement between the provincial and municipal government rather than a ministerial "grant" as outlined in the HPPA.
12. There should be continued examination of the potential to amalgamate boards of health to create stable, secure organizations fully capable of addressing public health needs in their jurisdiction.

Delivery of Safe Potable Water

13. The responsibility for the safety of water belongs to more than one government ministry. Which ministries are involved must be clearly articulated.
14. The needed relationships and communications systems between ministries involved in the delivery of safe water must be clearly defined.
15. An interministerial committee should be established to provide senior government leadership. As a part of this strategy interagency committees at the local and regional level should be created.
16. An alternative strategy may be to establish a unique agency that will be charged with the overall responsibility for water safety.

When public health, a key component of Ontario's health system, is successful, few are even aware that it is at work. Yet when a public health crisis strikes, the community expects rapid, knowledgeable, expert and quality attention to matters. At this point it is easy to convince government, local or provincial, to spend monies. Sufficient and reliable public health funding is critical.

The essential role of the medical officer of health in the public health system must be acknowledged, supported, respected and granted the needed authority to carry out the job.

One goal of public health is to reduce water-borne illnesses. To ensure a safe water system for the people of Ontario certain changes are required. As well, those ministries, which share responsibility for safe water, must work together in order to prevent future crisis.

Ontario Medical Association Input to Walkerton Inquiry Part II:
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Introduction

KEY MESSAGE/S: 1. Public health is a key component of Ontario's health system
2. The supply of safe and potable water is a shared responsibility

The Ontario Medical Association (OMA) believes that public health is a key component of Ontario's health system. The principal roles of public health are to promote and protect health and prevent disease and injury through the delivery of the Mandatory Health Programs and Services Guidelines, mandated by the provincial government, which address matters related to chronic diseases and injuries, family health and infectious diseases.

The Infectious Disease Standards in the Mandatory Health Programs and Services Guidelines include the Safe Water Program Standards, the goal of which is to reduce the incidence of water-borne illness in the population. (Ontario. Ministry of Health and Long-Term Care. Public Health Branch, 2000).

However, ensuring a safe and potable water supply is ultimately a shared responsibility. This involves the Ministry of the Environment (MOE), the Ministry of Health and Long Term Care (MOHLTC), the Ministry of Agriculture, Food and Rural Affairs (OMAFRA), local municipalities, owners and operators of private and public systems, public and private laboratories and private property owners, etc.

An understanding of the context of the Ontario public health system is important in order to be fully apprised of what is required in the provision of a safe water supply system in Ontario.

It is important to ensure that all agencies and groups, including public health work well together rather than focusing on one part or a singular problem.

From its inception in 1881 the OMA has been committed to the promotion of public health. The Committee on Public Health (now the Committee on Population Health) was an initial standing committee of the OMA as founding members were concerned about the unsanitary conditions that were endangering the health of Ontarians.

The OMA has continuously supported the Ontario government's efforts to improve public health including the appointment of a minister of health, the establishment of local health units and the appointment of full-time medical officers of health. In 1926 an amendment to the then Public Health Act, supported by the OMA, enabled municipalities to combine their efforts in obtaining a medical officer of health.

When a public health crisis strikes, the community expects rapid, knowledgeable, expert and quality attention to matters; all available resources must be marshaled on its behalf sometimes with little regard for cost, as is the case following the Walkerton tragedy.

The OMA submission will reflect the dual nature of its mission that is "to serve the medical profession and the people of Ontario in the pursuit of good health and excellence in health care".

The purpose of this document is to outline the public health system currently in place in Ontario highlighting the OMA's concerns regarding recent changes to public health and weaknesses of the system that impact on the public health of Ontarians. The OMA will indicate how an effective and efficient, stable and sufficiently funded public health system can contribute to providing safe water in Ontario.

Comments address how public health is organized and the programs and services public health is mandated to provide or ensure are provided. Particular attention is paid to the position and integral role of the medical officer of health in the delivery of public health programs and services. Comments also reflect the OMA concern with regard to public health resources and thus the impact on the delivery of the mandated health programs and services.

While the Walkerton Inquiry is focused on drinking water safety, an effective and efficient, stable and sufficiently funded public health system will contribute to safe drinking water.

Organization of Public Health in Ontario

KEY MESSAGE/S: 1. Boards of health face several challenges
2. Public health spending is an investment not an expenditure

The mandate of the boards of health is to deliver public health programs and services in order to prevent the spread of disease and to promote and protect the health of the people of Ontario. A board of health is the corporate entity that delivers public health programs and services. A health unit is the geographic jurisdiction under the board of health.

Ontario's public health system has evolved from a fragmented system of 800 boards of health to a more organized provincial system with provincial leadership and coordination comprising 37 boards of health legislated under the Health Protection and Promotion Act, (HPPA). Health units cover the geography of Ontario, vary in size from a population base of 40,000 residents to over 2.6 million people and are responsible for the delivery of programs and services to promote and protect the public health of all Ontario residents.

The OMA believes that the boards of health face many challenges. Of primary importance is the requirement to have sufficient stable resources to carry out their mandate. It is important to recognize that public health spending is **an investment and not an expenditure.**

The OMA strongly believes that *boards of health do not have sufficient financial resources to carry out their mandate* outlined in the Mandatory Health Programs and

Services Guidelines. This is further exacerbated when a new government mandated program is added to the workload without additional funds. For example, when the province determined that all school children required 2-step measles vaccination, in order to carry out the "catch-up" immunization, all other public health activities of boards of health had to be suspended or significantly reduced due to insufficient resources. The government's current universal influenza immunization program too has strained the limited resources of boards of health. A 1999 compliance survey carried out by the MOHLTC, Public Health Branch found that compliance with the Mandatory Health Programs Service Guidelines was only at 75%. (Ontario. Ministry of Health and Long-Term Care. Public Health Branch, 1999)

Given new technologies, a rapidly expanding body of knowledge, and an increasingly informed public it is challenging for boards of health to not only keep abreast of the fast pace of change in public health but to also deliver the needed programs and services to meet their community's needs.

Therefore, consideration must be given to the continued practicality or cost effectiveness of boards of health servicing small populations (less than 100,000) given the range of expertise required by a board of health to meet its mandated responsibilities. Public health decisions must be based on scientific analysis to fully determine the physical as well as the social impact on human health.

The provincial government has long recognized the municipalities' responsibilities for funding public health services. However, municipalities have been reluctant to pay for these services that they see as a provincial responsibility along with medical treatment and hospitals. This tension between municipalities and the province, on many occasions, required the provincial government to provide funding, in part or in whole, to ensure the adequate and appropriate provision of public health services.

While it is easy to convince government, local or provincial, to spend monies during a crisis, it is often difficult to convince them to spend smaller sums over many years in the interest of future well being. The significance of the ongoing delivery of public health programs and services is not fully appreciated by either the province or municipalities until a crisis occurs. This is especially true given that the benefits of public health programs and services often fall unevenly on the population and are often only apparent over the long term. However, when a public health crisis does occur, it results in expenditures that far exceed the cost of preventing it in the first place. This has been well illustrated in Walkerton and also in the increasing impact of preventable cases of tuberculosis (TB), especially multi-drug resistant TB cases that receive long term treatment and monitoring by health units as well as long term inpatient stays in hospital.

In reviewing the history of public health in Ontario, the tension between the provincial government, local municipalities, the medical officer of health and public health staff, the community and the board of health is an important factor. For example, in the control of communicable diseases, effective ongoing surveillance, applied research and evaluation, and appropriate disease control measures across the province are critical, as infectious

agents know no borders. The strength of Ontario's public health system is only as good as its weakest link. Balance is necessary so that boards of health meet the local needs of the community but not at the expense of neighbouring communities. Therefore, all communities must maintain a certain consistent level of public health infrastructure to ensure that all Ontario residents are protected. This infrastructure is in the end both a local and provincial resource.

The MOHLTC itself has realized this advantage by shifting from an illness approach to wellness, disease prevention and health promotion ideals embodied in the HPPA and the Mandatory Health Programs and Services Guidelines. To truly implement this shift, *public health must be seen as an integral part of the health system* through better, more dependable provincial funding. Stable funding will allow boards of health to invest in expertise and tools to efficiently deliver their mandated programs and services. Without stability the health units will continue to rely on stopgap solutions that eventually lead to crisis and deterioration in health.

The Walkerton outbreak highlighted the vital role that coordination plays across jurisdictions for the maintenance of public health. Acknowledging the importance of coordination, it is critical to realize that we should be concerned in other areas where there is a gap. At this point in time there are no formal relationships established between public health systems of the provincial and federal governments. Airports, railways, military bases, Aboriginal peoples living on reserve, Great Lake tour boat and freighters in Ontario fall under federal jurisdiction. Given individual mobility on and off federal land, disease prevention in Ontario is compromised by a lack of comprehensive coordination between provincial and federal public health systems.

Public Health Programs and Services

KEY MESSAGE/S: 1. Consistency across the province
2. Laboratory proficiency testing and quality assurance controls
3. Reporting accountability on the public's health

The HPPA provides the framework for the provision of public health in Ontario specifying the role, authority and responsibility of boards of health, medical officers of health, their staff, government, physicians and others.

Boards of health must provide or ensure the delivery of public health programs and services as detailed in the Mandatory Health Programs and Services Guidelines. Medical officers of health are required to respond to identified or potential health hazards in a timely and reasonable manner.

Public health decisions must be made based on sound scientific analysis to fully determine not only the physical but also the social impact on human health. These decisions rest on specific expertise found in the full time medical officer of health and a full range of staff expertise in the many components of public health. Boards of health are required to employ appropriately trained staff in areas including, epidemiology,

health promotion, speech pathology, toxicology, health inspection, public health nursing and other backgrounds that are appropriate for interdisciplinary program planning and effective program delivery. The staff must also have skill sets in risk assessment, case management, infection control, health hazard investigation and assessment and enforcement to name a few (Ontario. Ministry of Health and Long-Term Care. Public Health Branch, 2000).

A province-wide consistent approach to public health is vital in detecting and investigating trends and outbreaks of many different types of illness including vaccine preventable diseases and other communicable diseases. The success in tracing the 1996 outbreak of hepatitis B to EEG clinics in Scarborough, North York, Durham and York Region reflected a coordinated infrastructure functioning to its maximum capacity to identify, understand and respond to this critical health issue. Important to this example is a maintained, modern provincial-wide information technology system that enhances the collection, analysis and interpretation of important data for public health use. Without this coordinated public health information, the source of infection would not have been identified and most likely would have resulted in further primary infections and secondary spread to family and other contacts, resulting in increased mortality and morbidity as well as an increased cost to the health system.

Provincial public health laboratories are another important part of the infrastructure supporting the practice of public health. For the purpose of disease prevention and/or heath promotion, laboratory testing may provide information to assist in the maintenance or improvement of health status. The public health laboratories carry out laboratory testing specific to the public health system. These laboratories provide specialized lab tests, subtyping of organisms and interpretation of lab results that support decision making by the medical officer of health when determining the presence of an outbreak of disease, the specific pathogen implicated and possible public health responses. Since the early 90's resources available to boards of health through the provincial public health laboratories have been severely restricted including cutbacks in numbers of skilled technicians as well as changes in the testing carried out. This has had an impact on health unit's staff ability to receive timely information regarding changes in disease incidence in their community.

Testing of water by laboratories has been highlighted by the Walkerton tragedy as one component of a safe water system. *The OMA believes that when water is tested the proficiency of the testing laboratories is paramount.* Laboratory investigation is an integral part of patient care, disease prevention, and health promotion. For this reason, *all laboratories carrying out clinical testing must submit to regular proficiency testing. This level of protection should and must be extended to water testing. The OMA strongly recommends that all laboratories testing water quality should be subject to similar quality assurance controls as are laboratories carrying out clinical testing*

1. Accountability

The Office of the Provincial Auditor was established in 1869. The main function was and continues to be to promote accountability and value-for-money in government operations by reporting to the Legislature on the government's management of public funds. The Provincial Auditor is an officer of the Assembly, appointed by the Lieutenant Governor in Council and reports to the Speaker on an annual basis on issues specified in legislation (McNaught, 2000).

The Environmental Commissioner position was established in 1994. The Commissioner reports on an annual basis to the Legislature. This includes whether the ministries have co-operated with the Commissioner when he/she requests information, a list of proposals for policies, legislation or regulation, a summary of the information gathered when performing the duties listed and any other information prescribed or which the Commissioner considers appropriate. The Commissioner is also authorized to make special reports to the Speaker on urgent matters arising under the legislation and can be asked by the Assembly to perform special assignments (McNaught, 2000).

The OMA strongly recommends that the position of "Provincial Public Health Commissioner" be established to report to the Legislature on public health related matters including the health status of Ontarians. A position of this type will help promote accountability and value-for-money in the delivery of the MOHLTC's mandated public health programs and services. Perhaps if such an individual had reported the problems with regard to reporting relationships and who is responsible for what with regard to water to the Legislature, the Walkerton tragedy may have been prevented or at least diminished.

Role of the Medical Officer of Health

KEY MESSAGE/S: 1. The medical officer of health is a medical specialist
2. The position of medical officer of health must be full time
3. The medical officer of health is the community's doctor
4. The medical officer of health talks to community physicians
5. Public health complements and supports primary care

The medical officer of health is a *medical specialist with unique skills and ability*.

There are two educational options available to a physician in order to become eligible for appointment as a medical officer of health. There are post-graduate training programs in epidemiology, social sciences etc., and as part of a formal Royal College of Physicians and Surgeons of Canada residency programs in Community Medicine (Royal College of Physicians and Surgeons of Canada, 1995). Recruitment notices indicate that fellowship recognition is the preferred route for most positions of medical officer of health in Ontario.

The medical officer of health requires the skills and abilities needed to work as part of a

multi professional team including the skills needed for team building. This is especially critical given the number of links and associations that must be established with a variety of community organizations as well as local physicians and government to carry out the day-to-day responsibilities of the job.

The medical officer of health reports to the board of health. Each board of health, as per the HPPA, must employ a full-time medical officer of health who reports to it. In several jurisdictions, the regional council is the board of health; in the remaining areas the board of health is independent, except for the Toronto board which is a hybrid of the independent board and the regional council model.

The profile of the medical officer of health in a community can change abruptly. When the board of health is performing its mandated duties successfully, few are aware that it is at work and most are oblivious to the role played by the medical officer of health. This has led to questions about the need for this type of highly trained expertise. However, should there be a case of an unusual or particularly feared illness, or an outbreak of a preventable disease, the public's attention can quickly focus on the health unit's response.

It is important to highlight that even in 1926, the Public Health Act ensured that a local board of health could not dismiss the medical officer of health without the approval of the Province. Protection is also found in the present HPPA. Decisions made by the medical officer of health sometimes result in upfront costs to the municipality and unwanted publicity, while savings are seen in provincially funded programs. This has created periods of tension between the medical officer of health and local municipal officials. The legislated protection of their position has allowed the medical officers of health to advocate for the community's health and this security must continue to ensure the ongoing protection of the public's health.

Medical officers of health have faced challenges in obtaining sufficient resources to meet the public health needs of their communities. Many boards of health cover more than one municipality often combining one or more counties and separated cities. The HPPA designates "obligated" municipalities, which delineates funding responsibility for public health. In rural Ontario, county and district governments apportion the board of health budget requirements among its lower tier municipalities. This forces the medical officer of health to advocate for funding from multiple municipalities reducing the medical officer of health's ability to focus on the community's health.

Another challenge facing the medical officer of health is the ability to properly administer the Mandatory Health Programs and Services Guidelines as set out by the provincial government. The medical officer of health must be able to appropriately allocate financial resources as well as human resources where and when needed to meet these guidelines. This can be a challenge for smaller boards of health where budget restrictions may limit the expertise that the board of health can offer. In these situations the medical officer of health often is stretched very thin supporting a number of duties that for medical officers of health in larger health units are the responsibility of others.

The HPPA was recently amended to remove the medical officer of health as the "executive officer" of the board of health and removed the responsibility for the "administration of the health programs and services and business affairs of the board". This has created a variety of governance and administrative models across the province. The functions of the medical officer of health must be clear and include the administrative and organizational responsibility for all public health programs and services delivered including the overall responsibility for staff who deliver public health programs and services.

The medical officer of health must know, understand, interpret and be able to apply the HPPA and the many pieces of legislation that pertain to the responsibilities of the medical officer of health. Other legislation includes the Day Nurseries Act, Immunization of School Pupils Act, Cemeteries Act, Child and Family Act, Education Act, Environmental Protection Act, Meat Inspection Act, Municipal Act, Tourism Act, etc.

1. Role Improvement

There are several outstanding issues that must be addressed regarding the medical officer of health.

First, a medical officer of health is on call 7 days/week, 24 hours/day in many health units and must be available as back-up in all health units, an onerous responsibility. As well, when a medical officer of health takes vacation, coverage must continue. This can be difficult to arrange especially if neighbouring boards of health are unable to attract a qualified practitioner to assume the role of medical officer of health.

Secondly, the current legislation permits the appointment of an acting medical officer of health when there is no medical officer of health and no associate medical officer of health (HPPA, RSO 1990, cH7, s.69). There is no specified term restricting the time that a person may serve as an acting medical officer of health nor is there any requirement for special skills to fill this position. This must be rectified.

Thirdly, thought must be also given to the population size that each board of health is responsible for before requiring the services of an additional medical officer of health. As indicated earlier there is a substantial range of populations in the 37 boards of health. Some serve populations of less than 100,000 while others have close to one million people and Toronto has over 2.5 million. The smaller boards of health have difficulty recruiting medical officers of health. The larger boards of health often require the service of more than one medical officer of health but there are no set rules or guidelines to inform a board of health when it should consider hiring an additional medical officer of health. This often leads to unrealistic workloads for the medical officer of health with burnout and lower job satisfaction.

2. The Medical Officer of Health is the Community's Physician

The medical officer of health must carry out a wide variety of complex duties and

activities in order to care for his/her "patient", the community. This includes strategic planning and subsequent evaluation of a board of health's actions in the promotion and protection of health and the prevention of disease and injury in the community. This encompasses identifying and responding to community health issues and providing or ensuring provision of programs and services detailed in the Mandatory Health Programs and Services Guidelines.

In carrying out these responsibilities the medical officer of health functions as any other physician, collating, analyzing and interpreting complex information to determine the cause (or likely cause) of a public health problem. The medical officer of health must then look for and select the most appropriate solution(s). *The medical officer of health also provides medical interpretation of information.*

Having well-developed and coordinated policies, plans and strategies enables a board of health to respond to health issues in its community, whether they are routine or emergencies, in an effective and efficient manner. This includes the critical role of the medical officer of health as the spokesperson for the board of health communicating with people in a credible manner. The fact that the medical officer of health is a medical specialist allows him/her to speak to or allay concerns regarding risk factors and health impacts of a situation.

Based on health status reports, epidemiological input and other sources, the medical officer of health gathers the medical history of the community, determines the diagnosis and brings balance and specialized medical expertise to solve these public health concerns within the community.

Using this history and basic medical knowledge, the medical officer of health is able to advocate for the community. With input from staff and medical knowledge, the medical officer of health will make decisions that impact the health of the public. Importantly, the medical officer of health makes independent decisions that often require further action by municipalities and other parties.

The medical officer of health's expertise, both academic and experiential, is used to create a plan of action to "treat" the community, handle emergency situations such as an outbreak, and to coordinate the overall public health activities needed to protect and promote the community's health. The presence of a full time medical officer of health ensures that the community is well prepared for public health emergencies and also that the health of the entire community is strengthened.

3. The Medical Officer of Health as Clinical Liaison

The medical officer of health in carrying out his/her medical responsibilities must interact with a variety of individuals, organizations and government. The medical officer of health must remain connected to the board of health, the MOHLTC, Public Health Branch, the Chief Medical Officer of Health, several other provincial ministries such as the MCSS and the MOE, the federal government, community groups, Ministry of

Education, local physicians and many other groups.

The Mandatory Health Programs and Services Guidelines outline a board of health's and medical officer of health's responsibility to provide interventions that will influence health practice and patient care in the community (Simcoe County District Health Unit, 2001). One of the key target groups is the community's physicians.
Public health programs and services provide a complementary and supporting infrastructure to primary care, a fundamental underpinning of the health system. The medical officer of health communicates with physicians (specialists and general and family practices physicians) in the community. *Physicians, especially general and family practice physicians, depend upon their medical officers of health and the health units as a vital resource.* This includes information on contact tracing, interpretation of unusual clinical symptomatology, vaccination, communicable disease control, outbreak control, environmental health, cluster investigation, epidemiology, travel medicine etc.

A community physician, focused on the care of his/her patients, often sees just one piece of a community's health concerns. Symptoms detected in one patient may or may not be connected to others also suffering from similar illness. *The ability to call upon a medical colleague, the medical officer of health, who can put all of the disparate pieces of medical information into some order is critical to the care of the individual patient as well as for the care of the community.* This relationship results in early awareness by the medical officer of health of potential outbreaks and increases the alertness of community physicians to a potential health issue in their community. Without this communication between the local paediatrician and the medical officer of health in Walkerton, it is likely that this outbreak would have gone undetected longer and increased the number of people affected.

Public health in rural areas is often a critical link to physicians who do not have the time or resources to carry out effective communicable disease contact tracing, investigation and counseling. Health units keep practicing physicians within their geographic areas apprised of communicable disease, immunizations issues, environmental health and health promotion issues.

The medical officer of health strives to work with physicians in the community to ensure that the programs and services delivered meet their patients' needs and to enhance the individual physician's ability to provide optimum care for his/her patient.

Financial Issues

KEY MESSAGE/S: 1. Funding for public health should not be a ministerial "grant"
2. Funding for public health is unstable and insufficient
3. Critical public health programs must be provincially funded

Boards of health are mandated to provide public health programs and services to their geographical areas that together cover the entire province. Municipalities do not cover the complete geography of Ontario. The remainder of the province is made up of

"unorganized territories" and land under federal jurisdiction. The unorganized territories grant, previously the Northern Ontario Public Health Services funding scheme, provides dollars to the designated northern health units to deliver public health programs and services to Ontarians living in areas that are not within a municipality. This does not include Ontarians (Aboriginals on reserve) living on land under federal jurisdiction.

Municipalities provide 50% of the funding for public health programs and services.

Prior to 1997, the cost of public health was shared between the municipalities (or regional governments) and the Province with the Province responsible for 75% and the municipalities responsible for 25%. Cities within Metro Toronto were different with a 40% - 60% municipality funding split.

Starting in the 1970's certain public health programs received 100% provincial funding as it was realized that it would be difficult for municipalities to make the allocations to those areas, e.g., tobacco control programs, AIDS, sexual health programs. *Critically important public health issues need to be fully funded by the province of Ontario, as the cost-shared funding formula has proven to be unreliable.* One hundred percent funding is a policy instrument that government must utilize in appropriate areas.

In 1996 the "Who Does What Panel" saw public health as a key component of the provincial health system. It recommended full provincial funding for public health and amalgamation of local boards of health too small to adequately support their local health unit. The recommendations also recognized regional interest in public health (Ontario. Ministry of Municipal Affairs and Housing. 1998). Notwithstanding, government, in 1997, downloaded the full cost of public health to the municipalities. In 1999, this was altered to a 50-50 cost sharing arrangement. However, it should be noted that there is a considerable uncertainty on the part of municipalities as the HPPA reads only that: "the Minister may make grants for the purposes of this Act on such conditions as he or she considers appropriate." (HPPA, RSO 1990, cH7, s.76). The municipalities have no guarantee regarding the proportion of the board of health budget for which they will be responsible from one year to the next.

The OMA is concerned that decisions made on the basis of cost are carried out without the consideration of gains in effectiveness. The decision to transfer funding responsibilities to municipalities was not made with the full understanding of current and future funding implications that might arise. Nor did the decision take into account any impact on the delivery of public health programs and services.

Ontario benefits from an effective and efficient public health system. The OMA believes that the entire province is the ultimate beneficiary of a public health system that functions well and should therefore pay the greater portion of the cost of public health programs and services. *Many boards of health cannot afford 50% of the cost, as they do not have an adequate tax base.*

It is important to underscore the significance of grant structure for the provincial portion

of public health budgets. As the funding is not paid as part of a formal agreement between the two levels of government, considerable ongoing uncertainty exists as to the source of funding and the continued funding for public health. Additionally, the budget cycle for boards of health is different from that of the province. The consequence of this has been that boards of health have not heard confirmation of their provincial "grant" until well into the board's fiscal year (recently this has been 11 months into the fiscal year!) Programs, and thus health status, have suffered, as some boards have not been in a financial circumstance to proceed with staff hires until such confirmation is received.

A further consequence of this funding uncertainty is the difficulty that boards of health have not only in recruiting a medical officer of health but all required public health staff.

As noted there are currently 37 health units with a wide range in population size. Considerable thought must be given to the appropriate population served by a board of health. Factors that must be considered are the population size, geographic area of the board of health and the distribution of the population as well as the expertise required to deliver public health programs and services. Many boards of health are experiencing recruitment challenges for positions like the medical officer of health and dental consultants. There should be continued examination of the potential to amalgamate boards of health to create stable, secure organizations fully capable of addressing public health needs in their jurisdiction. Boards of health must have the ability to maintain currency of issues, address new and emerging health problems, and provide the required expertise to deliver public health programs and services to their communities.

Delivery of Safe Potable Water

KEY MESSAGE/S: 1. Public health is one component of a safe and potable water supply
2. Coordination of stakeholders involved in safe water issues
3. Consistent regulations for drinking water supply agencies/systems

The reduction of the incidence of water-borne illness in the people of Ontario is but one of the many responsibilities legislated to public health and further delineated in the Safe Water Program Standards of the Mandatory Health Programs and Services Guidelines. The Walkerton tragedy has highlighted the many challenges faced in providing Ontarians with safe drinking water.

The OMA strongly believes that public health must be adequately resourced to truly protect the health of Ontarians. Adequate resourceing of public health must mean that there is the ability to tackle critical public health programs and services that require provincial coordination. Today we are looking to develop the mechanisms, checks and balances and strategies needed to ensure safe water yet concurrently we are watching the breakdown of another facet of public health. TB a communicable disease, thought by many to be mostly eradicated in Canada, is rearing its ugly head. At this time there appears to be a lack of sufficient resources to provide a coordinated strategy to prevent the transmission of TB. Funding for TB clinics was eliminated in 1984 in the belief that TB no longer posed a problem. No thought was given to continued funding for the

purposes provincial coordination for effective and ongoing disease prevention, a principal role of the public health system

The responsibility for the safety of water belongs to more than one government ministry. This results not only in the fragmentation of responsibility, but also in significant gaps. Further it has not been clearly outlined in certain instances whether a ministry has a responsibility for the safety or water or not. For example, given the issues related to farming practices and animal waste, OMAFRA may have a role to play. Thought should also be given to the role that the Ministries of Consumer and Commercial Relations, Economic Development and Trade, Natural Resources and Northern Development and Mines may have in the delivery of potable water within a safe water system.

Needed relationships and communications systems between ministries have not been clearly defined and there are no ongoing interactions between the ministries that do have an identified role. As stated previously, Aboriginals living on reserve, etc., are under federal jurisdiction and it is not clear how water safety issues should be addressed in order to assure safe potable water in those areas.

The OMA recommends that a mechanism be developed so that those involved in water safety and the prevention of illness from contaminated water are able to work together towards common goals. An *interministerial committee* should be established to provide senior government leadership. As a part of this strategy *interagency committees* at the local and regional level should be created. This would enable the development of a collaborative culture that can then work to deal with a crisis when it arises, but more importantly **this may well prevent the crisis through identification of issues of mutual concern and interest or at least ensure a rapid and effective response.** An alternate mechanism may be to establish a *unique agency* that will be charged with the overall responsibility for water safety.

There are a variety of drinking water supply agencies and systems: large (often municipal) water systems; small systems which provide water to the public; and, private home owners who have a well. There is *no consistency regarding what is needed* so that the different size systems can ensure that safe drinking water is delivered.

The OMA will **not** be focussing in detail on many of the water-related issues as they will be addressed in submissions to the Walkerton Inquiry Part II by the Association of Local Public Health Authorities (ALPHA). The OMA has a longstanding working relationship with ALPHA on public health matters of mutual concern and interest.

Small water systems are not covered by the new Drinking Water Protection Regulation for large water systems, but nonetheless supply water to the public. **All** water supply systems must be taken onto account to ensure a safe water system throughout the province.

There is no consistent mechanism for supply agencies and boards of health to address contamination of the water supply. It is critical to the delivery of safe drinking water that

there be clear delineation of roles and responsibilities including the appropriate checks and balances so that no one error results in tragedy.

Conclusions

Public health, a key component of Ontario's health system has the responsibility for promoting and protecting health, preventing disease and injury through the delivery of the mandated Mandatory Health Programs and Services. When the board of health is performing its mandated duties successfully, few are even aware that it is at work. Yet when a public health crisis strikes, the community expects rapid, knowledgeable, expert and quality attention to matters. At that point it is easy to convince government, local or provincial, to spend monies.

Unstable and insufficient resources hamper the Ontario public health system. Steps must be taken by the provincial government to enhance the ability of boards of health to deliver public health programs and services that promote and protect health and prevent disease and injury. **Sufficient and reliable public health funding is critical.**

The well being of Ontarians must be addressed now as well as in the future. Investment must be made in the delivery of the public health programs and services.

The essential role of the medical officer of health in the public health system must be acknowledged, supported, respected and granted the needed authority to carry out the job. The credibility of the medical officer of health provides the community and health care professionals in the community, particularly physicians, with balance and specialized medical expertise on public health matters.

One goal of public health is to reduce water-borne illnesses. To ensure a safe water system for the people of Ontario certain changes are required. As well, those ministries, which share the responsibility for safe water must work together in order to prevent future crises.

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