2010

ORIENTATION

Manual

for
Board of Health Members

alPHa
Association of Local
PUBLIC HEALTH
Agencies

Table of Contents

2010 Orientation Manual for Board of Health Members
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Preamble to the 2010 Edition

Public health in Ontario has been tested by several events since the beginning of the new millennium, including the 2000 outbreak of E. coli O157:H7 in Walkerton, the emergence of West Nile virus and some well-publicized food safety issues. Each was used as evidence to support calls for improvements to an under-funded public health system that was consistently operating below its mandated standards, but it was the 2003 outbreak of Severe Acute Respiratory Syndrome (SARS) that illustrated the real dangers of ignoring public health's importance.

The SARS outbreak was the wake-up call that prompted several reviews of the response, each of which identified serious systemic deficiencies resulting from years of political neglect in the structures that provide the programs and services that protect and promote health, prevent disease and monitor community health.

These deficiencies have been itemized in great detail in the reports of the Ontario Expert Panel on SARS and Infectious Diseases (Walker), the National Advisory Committee on SARS and Public Health (Naylor), and the SARS Commission (Campbell) reports. Each of these makes recommendations that are viewed as critical to restoring Ontario's essential health promotion and protection functions.

The provincial government responded to these reviews by launching Operation Health Protection: An Action Plan to Prevent Threats to our Health and to Promote a Healthy Ontario in 2004. It introduced a number of policy and funding changes, as well as a series of closer examinations of the public health system, which would inform other appropriate policy and funding responses to improve it. A comprehensive chronology of developments to date and links to documents related to Operation Health Protection is available on alPHa's Web site: http://www.alphaweb.org/news.asp?nid=30

Of particular interest to Ontario's board of health trustees should be The Final Report of the Capacity Review Committee, Revitalizing Ontario's Public Health Capacity, released in May of 2006. It includes 50 recommendations on the public health work force, accountability, governance and funding, strengthening local service delivery, research and knowledge exchange, strategic partnerships and next steps for Ontario's 36 local health units (summarized by alPHa at http://www.alphaweb.org/docs/lib_008614835.pdf). While the government has yet to issue its policy response to these recommendations, board of health members should be familiar with the proposed changes. In the absence of a formal government response, a number of the recommendations have been addressed by the Ontario government through the work of the Public Health Division of the Ministry of Health and Long-Term Care. Notably, the outdated *Mandatory Health Programs and Services Guidelines* have been replaced *with the Ontario Public Health Standards*, a comprehensive set of evidence-based guidelines for the provision of public health services. An accountability framework is being developed for boards of health and should be in place in 2011. The Ontario Agency for Health Protection and Promotion (OAHPP) has been established to provide on-going professional development to public health professionals and evidence to support public health programs and services. A web site for public health information exchange, PublicHealthOntario.ca, has been set up to provide a home for up-to-date resources for boards of health and public health professionals.

Introduction

Purpose

The alPHa Board of Health Orientation Manual has been prepared to provide new Board members with the necessary background information on public health in Ontario. The following document will provide the contextual information on the operations of a Board of Health (BOH). The day–to-day operations are not covered as each organization will have its own set of procedures.

What is Public Health?

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

Public health:

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

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

History of Health Units in Ontario

The pattern of local public health services administration for Ontario was established in 1833 when the Legislature of Upper Canada passed an Act allowing local municipalities "*to establish Boards of Health to guard against the introduction of malignant, contagious and infectious disease in this province*." This delegation of public health responsibility to the local level established 150 years ago has persisted to the present day. There are currently 36 health units in Ontario: 22 independent of local municipal government; 7 regional health departments; and 7 health units tied in to single-tier or other municipal administration.

Important Milestones

1873 The first *Public Health Act* was passed.

1882 The first board of health was established.

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

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

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

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

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

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

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

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

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

2004 The government of Ontario announces *Operation Health Protection: an Action Plan to Prevent Threats to our Health and to Promote a Healthy Ontario.*

2005 The government of Ontario announces the creation of the new Ministry of Health Promotion, which will focus on programs dedicated to healthy lifestyles

2006 The *Smoke-Free Ontario Act* is introduced, which bans smoking in all enclosed public places

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

2007 The Ministry of Health and Long-Term Care to increase its grant to boards of health to 75% of the budgeted amount.

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

2008 The *Ontario Public Health Standards* are completed in collaboration with boards of health and Ontario public health professionals. They came into effect on January 1, 2009.

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

Legislation Governing Health Units and Boards of Health

The following is a summary of existing provincial legislation that is most significant to the activities of medical officers of health, boards of health and their designates. It is presented to promote a working knowledge of the origin of the most important of their legislated responsibilities. It is neither a detailed nor comprehensive itemization of what those responsibilities are, as local by-laws, federal statutes nor other provincial acts containing public health-related clauses may delegate additional responsibilities to the groups named above. There is some additional detail on legislation that affects boards of health and their directors in the companion document, ***A Review of Board of Health Liability*** **(Appendix 8)**. Also helpful is the government's E-Laws Web site, where all of Ontario's Acts and their associated Regulations have been posted: http://www.e-laws.gov.on.ca/. Some key pieces of legislation are:

1. The Health Protection and Promotion Act
   http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90h07_e.htm

2. Emergency Management and Civil Protection Act
   http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90e09_e.htm

3. Fluoridation Act
   http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90f22_e.htm

4. Immunization of School Pupils Act
   http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90i01_e.htm

5. Municipal Freedom of Information and Protection of Privacy Act
   http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90m56_e.htm

6. Personal Health Information Protection Act
   http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_04p03_e.htm

7. Smoke Free Ontario Act
   http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_94t10_e.htm

Public health in Ontario is currently in a period of transition and renewal, which is expected to include extensive legislative reform, including significant proposed changes to public health's central governing legislation – the *Health Protection and Promotion Act*. The rationale and recommendations for these changes are laid out in the Second Interim Report of the Campbell Commission (summarized by alPHa at www.alphaweb.org/docs/ lib_006761353.pdf). Some of these are minor and can be made quickly, while others will have larger impacts that will be subject to the sometimes lengthy and complex processes of the government bureaucracy.

Until these changes are made, the following remain in effect. As a board of health trustee, you are encouraged to keep up to date on announced or proposed changes, as well as opportunities to provide input at consultations. alPHa does its best to keep all of its members informed of such changes and opportunities to influence them.

Legislation Specific to Public Health

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

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

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

Background

The most recent revision of the HPPA was passed by the legislature in December 1997. The original HPPA came into force on July 1, 1984, replacing the *Public Health Act*, the *Venereal Disease Prevention Act* and the *Sanatoria for Consumptives Act*.

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

Section 7 further serves the modern approach by empowering the Minister of Health to publish guidelines for the provision of these mandatory programs and services. The first *Mandatory Health Programs and Services Guidelines* (MHPSG) were published in 1984, providing minimum province-

wide standards for programs and services aimed at reducing chronic and infectious diseases and improving family health. These were revised into the *Ontario Public Health Standards* (OPHS) that came into effect on January 1, 2009. This revision was accomplished with extensive support from Ontario public health professionals and the OPHS are published as a living document at: http://www.health.gov.on.ca/english/providers/program/pubhealth/oph_standards/ophs/index.html. The full set of documents that comprise the OPHS include a set of 15 standards, protocols for each standard, and guidance documents that provide information on evidence and best practices.

The 10 Parts of the Health Protection and Promotion Act

Part I - Interpretations
Definitions essential to interpreting the application of the Act and its regulations.

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

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

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

Part V - Rights of Entry and Appeals from Orders
This is the part that authorizes designated people (e.g., public health inspectors) to enter any premises in order to inspect, take samples, and perform tests and other duties under the Act. It is also the section that sets out the process by which a person to whom an order has been issued can appeal it.

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

Part VII - Administration
Noteworthy provisions under this part include:

- empowering the Minister to ensure that boards of health are in compliance with the Act;
- the establishment of public health labs;

- the appointment, qualifications and duties of the Chief Medical Officer of Health (CMOH); and
- protecting individuals carrying out duties in good faith under the Act from personal liability.

Part VIII - Regulations

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

Part IX - Enforcement

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

Part X - Transition

Several Statutes are repealed with the appropriate provisions thereof being incorporated into HPPA.

Ontario Public Health Standards

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

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

The Ontario Public Health Standards outline the expectations for boards of health. Boards of health are responsible for the assessment, planning, delivery, management, and evaluation of a variety of public health programs and services that address multiple health needs, as well as the contexts in which these needs occur. The Program Standards are built on a set of Principles and a Foundational Standard.

Principles

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

Effective public health programs and services take into account communities' needs, which are influenced by the determinants of health. As well, an understanding of local public health capacity and

the resources required including collaboration with partners to achieve outcomes is essential for effective management of programs and services.

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

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

Foundational Standard

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

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

Program Standards

Program Standards are published for the following areas:

Chronic Diseases and Injuries

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

Family Health

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

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

Infectious Diseases

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

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

Environmental Health

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

Emergency Preparedness

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

Immunization of School Pupils Act

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

Among other provisions, the Act:

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

Smoke-Free Ontario Act

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

The SFA:

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

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

Day Nurseries Act

- specifies the minimum regulations and standards for day nurseries; and
- provides the legislative authority for medical officers of health or their designates (public health inspectors) to inspect day nurseries, to ensure that children are properly immunized, that the premises and equipment are safe, and that procedures are in place to appropriately manage ill children and outbreaks of communicable diseases.

Safe Drinking Water Act

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

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

Ontario Regulation 319/08

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

Ontario Regulation 903/90

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

Bill 28 - Mandatory Blood Testing Act

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

Acts Pertaining to Health Units as Public Bodies

Municipal Act

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

Municipal Conflict Of Interest Act

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

French Language Services Act

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

Accessibility for Ontarians with Disabilities Act, 2005

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

Municipal Freedom of Information and Protection of Privacy Act

- gives individuals the legal right of access to information held by municipal governments, local boards and commissions. There are exceptions to this right but they are limited to the specific provisions of the legislation.
- also gives individuals a right of access to their personal information. Individuals also have the right to request correction of the personal information if they believe it contains errors or omissions.
- requires established standards of municipal governments, etc. that ensure personal information is kept confidential and stored in a safe place.

Roles and Responsibilities

The Board of Health

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

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

The board should adopt a philosophy and management process that allows it to carry out its mandate in an efficient, effective, and economical manner. This should be complemented with a sound organizational structure that reflects the responsibilities of the component parts.

The primary functions of the board of health should be planning and policy development, fiscal arrangements and labour relations. The board should not become involved in day-to-day management decisions, such as approving vacations, staff training, travel expenses, etc. These day-to-day management decisions are the responsibility of the medical officer of health and other senior staff.

The Medical Officer of Health

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

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

Board of Health Responsibilities

- establishes general policies and procedures which govern the operation of the health unit;
- upholds provincial legislation governing the mandate of the board of health under the *Health Protection and Promotion Act* and others;
- accountable to the community for ensuring that its health needs are addressed by the appropriate programs and ensuring that the health unit is well managed;
- establishes overall objectives and priorities for the organization in its provision of health programs and services, to meet the needs of the community;
- hires the medical officer of health and associate medical officer(s) of health with approval of the Minister; and
- responsible for assessing the performance of the medical officer of health and associate medical officer(s) of health.

Medical Officer of Health Responsibilities

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

Management Philosophy

The board of health should be committed to the effectiveness of its organization, its human resources, and a good management process. Its programs should be based on sound evidence and epidemiological principles. An effective program evaluation system needs to be developed to ensure cost efficiency, effectiveness, and benefits.

In terms of human resources, this philosophy implies that the board is committed to using the talents, initiative, and creativity of each employee and is dedicated to the fair treatment, growth, and development of each individual.

The management process which reflects this philosophy should focus on: achieving results efficiently (primary target of every program, service and policy), requiring accountability on every level of management; and systematic delegation of responsibility and authority to the lowest appropriate level in the organization.

Organizational Structure

The philosophy and objectives of good management require that the health unit should have a sound organizational structure that reflects the responsibilities at each level of the organization. It should be noted that all boards and health unit structures are unique.

The board of health is the governing body, the policy maker of the health unit. It monitors all operations within the unit and is accountable to the community and to the MOHLTC.

The medical officer of health advises the board on policy, is responsible for the implementation of board policy and decisions, and manages all aspects of health unit operations.

The management team is the operational nucleus of the unit. It is created to provide a forum for formal planning processes, that relate budgeting to programs and provides a mechanism for monitoring of staff, programs and organizational performance. This includes monitoring, evaluation and revision of the annual operational plan.

Guidelines for Board of Health Members

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

A member of a board of health should:

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

Public Appointments to Boards of Health

The composition of boards of health is outlined in Section 49 of the HPPA. Section 49(3) provides for the appointment of one or more provincial members by the Lieutenant Governor in Council. In 1990, the Premier of Ontario announced that the government would be implementing new measures to ensure greater fairness in the Order-in-Council appointments to government agencies, boards and commissions. Boards of health have the opportunity to participate in the recruitment, nomination and recommendation of individuals for public appointment positions on their boards of health. The guiding principle is that in recognition of unique local demographics, the local board is positioned to best determine public representation and geographic characteristics of the area they serve.

Applications to be a provincial member on a board of health can be made through an open competition (i.e. advertising) conducted by the board or by direct application to the Public Appointments Secretariat (http://www.pas.gov.on.ca).

In seven health units in Ontario, Regional Council acts as the board of health. In these boards, there is no provision for public appointments.

A number of boards of health also provide for representation by citizen members, who are often appointed by local council to the board.

Types of Board of Health Structures

Autonomous

In autonomous boards of health, the health unit staff operates separately from the municipal administrative structure. Autonomous boards of health have multi-municipal representation (including citizen representatives appointed by municipalities), and may have public appointees. There are 22 autonomous boards of health in Ontario:

- Algoma
- Brant County
- Eastern Ontario
- Elgin-St. Thomas
- Grey Bruce
- Haliburton-Kawartha-Pine Ridge
- Hastings-Prince Edward
- Kingston, Frontenac, Lennox & Addington
- Leeds, Grenville, Lanark
- Middlesex-London
- North Bay Parry Sound
- Northwestern
- Perth
- Peterborough
- Porcupine
- Renfrew
- Simcoe Muskoka
- Sudbury
- Thunder Bay
- Timiskaming
- Wellington-Dufferin-Guelph
- Windsor-Essex

Regional/Single-Tier

In this type of board of health, staff operates under the administration of regional government or a single-tier municipality. According to the Association of Municipalities of Ontario, a regional government is a federation of the local municipalities within its boundaries, and a single-tier municipality is defined as an area where there is only one level of municipal government. Regional/single-tier boards of health have no citizen representatives and no public appointees. The 10 regional/single-tier boards of health in Ontario include:

- Durham (regional)
- Haldimand-Norfolk
- Halton (regional)
- Hamilton
- Niagara (regional)
- Ottawa
- Oxford (regional)
- Peel (regional)
- Waterloo (regional)
- York (regional)

Municipal

In municipal boards, the staff of the health unit operates under the municipal administrative structure. Most municipal boards of health have the potential for both citizen and public appointees. Presently, there are 4 municipal boards of health:

- Chatham-Kent
- Huron
- Lambton
- Toronto (no public appointees)

The Ministry of Health and Long-Term Care

Public Health Division

The Public Health Division (PHD) in the Ministry of Health and Long-Term Care (MOHLTC) has provincial responsibility for public health in Ontario. In partnership with boards of health, the Division provides overall direction and program leadership in public health. Additionally, the Division has a responsibility to assist boards of health to implement public health programs through the provision of professional, technical and administrative consultation. The Branch is responsible for setting, monitoring and enforcing the *Ontario Public Health Standards*, on behalf of the province's health minister.

As part of its mandate, the Division has broad responsibilities to support the Minister of Health and Long-Term Care. Furthermore, it is responsible for informing other branches within the government on public health issues, and liaising with other provinces, territories and the federal government regarding public health in Ontario.

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

There are a number of important branches within the Public Health Division, some of which include:

- *Infectious Diseases* (oversees the prevention and control of infectious diseases in Ontario by monitoring, investigating and developing policies for infectious diseases in Ontario)
- *Environmental Health* (oversees issues related to environmental health such as safe water)
- *Public Health System Transformation* (provides strategic leadership for the transformation of the local public health system, steers the development and implementation of strategies to renew the public health system)
- *Public Health* (leads and oversees division operations, controllership, resource management decisions, and the implementation of key government commitments)

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

Chief Medical Officer of Health

Appointed to a term of five years, the Chief Medical Officer of Health (CMOH) provides advice and direction to boards of health, medical officers of health and to the people of Ontario.

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

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

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

Public Health Funding

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

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

On January 1, 1998, as part of the Local Services Realignment initiative, the Province of Ontario transferred all funding responsibility for public health to municipalities. This arrangement lasted little more than a year. On March 24, 1999, the Minster of Health and Long-Term Care announced that a grant, up to 50 percent of the budgeted amount for public health services within the Health Unit, would be provided to help offset the costs on the obligated municipalities. This 50-50 ratio of cost-shared funding between the province and municipalities continued until 2005. As part of Operation Health Protection, the province increased its funding share to 55% in 2005, 65% in 2006, and 75% in 2007. Municipalities, in comparison, saw their funding share decrease to 45% in 2005, 35% in 2006, and 25% in 2007.

Currently, the province funds 100% the following programs:

- Preschool Speech and Language Services
- Healthy Babies, Healthy Children - through the Ministry of Children and Youth Services
- Public Health Research Education and Development (PHRED) (at the time of publishing, the functions of this program are being transferred to the Ontario Agency for Health Protection and Promotion)
- Speech and Audiology
- Genetics Counselling
- Sexual Health Hotline and Resource Centre
- Unincorporated areas
- Small Drinking Water Systems (SDWS) - until 31 Dec 2011
- Infection Control (following SARS)
- Infection Control Nurse Position
- Healthy Smiles Ontario
- Smoke Free Ontario (SFO) - through the Ministry of Health Promotion and Sport

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

It should be noted that while provincial funding for boards of health is administered primarily through the Public Health Division of the Ministry of Health and Long-Term Care, the Ministry of Health Promotion, created in 2005, is responsible for the provincial administration of several areas of the *Ontario Public Health Standards*. These include programs falling under Smoke-Free Ontario, chronic disease prevention, injury prevention, and public health dentistry.

Related Organizations

Association of Local Public Health Agencies

http://www.alphaweb.org

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

What We Do

alPHa advises and lends expertise to members on the governance, administration and management of health units. The Association also collaborates with governments and other health organizations, advocating for a strong, effective and efficient public health system in the province. Through policy

analysis, discussion, collaboration, and advocacy, alPHa members and staff act to promote public health policies that form a strong foundation for the improvement of health promotion and protection, disease prevention and surveillance services in all of Ontario's communities.

How We Do It

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

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

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

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

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

The Association is regularly invited to appoint official representatives to both ad-hoc and standing policy analysis and advocacy committees struck by government, other associations, agencies and coalitions. A listing of some of these can be found on our Web site on the following page: http://www.alphaweb.org/external_cmtes.asp.

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

Value-Added Membership Benefits

Services/Products:

- Electronic mailing lists
- alPHa Web site
- Educational services
- Membership surveys
- Directories

Affinity Programs:

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

Association of Municipalities of Ontario

http://www.amo.on.ca

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

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

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

Local Health Integration Networks

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

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

LHINs were created in 2006 to allow patients better access to health care in a system that is currently fragmented, complex and difficult to navigate. This change in the way health services are managed in

Ontario will break down barriers faced by patients and ensure decisions are made in the interest of patient care.

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

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

Public health, as yet, does not have a role within LHINs. The provincial government to date has not included health units and boards of health in its vision for LHINs. As LHIN roles evolve over the next few years, it remains to be seen whether this situation will change. Most health units, however, participate on LHIN committees and are engaged with the LHIN(s) in their geographic region in a number of health service planning areas.

Ontario Council on Community Health Accreditation

http://www.occha.org

The Ontario Council on Community Health Accreditation (OCCHA) is an accreditation body that provides an independent, voluntary, peer evaluation of the administrative and operational aspects of local public health units, including a review of program planning, implementation, monitoring and evaluation.

Its mission is to promote accountability and excellence in public health programs and services by:

- defining, reviewing and publicizing standards related to structure, process and outcome;
- enhancing knowledge through consultation and shared experience;
- measuring agency performance against peer set standards;
- developing and submitting comprehensive, constructive reports for the agency; and
- conferring graduated awards.

Ontario Health Protection and Promotion Agency

The Ontario Agency for Health Protection and Promotion (OAHPP) was established in 2007. An arms-length government agency supports the Chief Medical Officer of Health and provides expert scientific leadership and advice to government, public health units, and the health care sector. The Agency is a centre for specialized research and knowledge of public health, focusing in the areas of infectious disease, infection control and prevention, health promotion, chronic disease and injury prevention, and environmental health.

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

Ontario Health Providers' Alliance

Formed in 1993, the Ontario Health Providers' Alliance (OHPA) is a coalition of provincial health providers that, together, represents more than 300,000 employees or 90 percent of all health care jobs in Ontario. The Alliance aims to build consensus for a provider vision of health care reform that is sensitive to government and consumer perspectives for health services delivery.

It shares information on providers' mandates and programs and services; identifies and resolves mutual issues and concerns; promotes understanding and collaboration on government legislation and policy; reviews and comments on the provincial planning framework for health services in Ontario; and fosters collaboration between member organizations and government on the funding for health services.

Ontario Public Health Association

http://www.opha.on.ca

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

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

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

Appendix 1- Glossary

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

Appendix 2 - Web Sites

Government Reports and Initiatives

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

For the Public's Health: Final Report of the Ontario Expert Panel on SARS and Infectious Disease Control (Walker Report)
http://www.health.gov.on.ca/english/public/pub/ministry_reports/walker04/walker04_mn.html

Learning from SARS - Renewal of Public Health in Canada (Naylor Report)
http://www.phac-aspc.gc.ca/publicat/sars-sras/naylor/

Operation Health Protection
http://www.health.gov.on.ca./english/public/pub/ministry_reports/consumer_04/oper_healthprotection04.pdf

SARS Commission (Campbell) Reports
http://www.sarscommission.ca/

Legislation

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

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

Public Appointments

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

Organizations

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

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

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

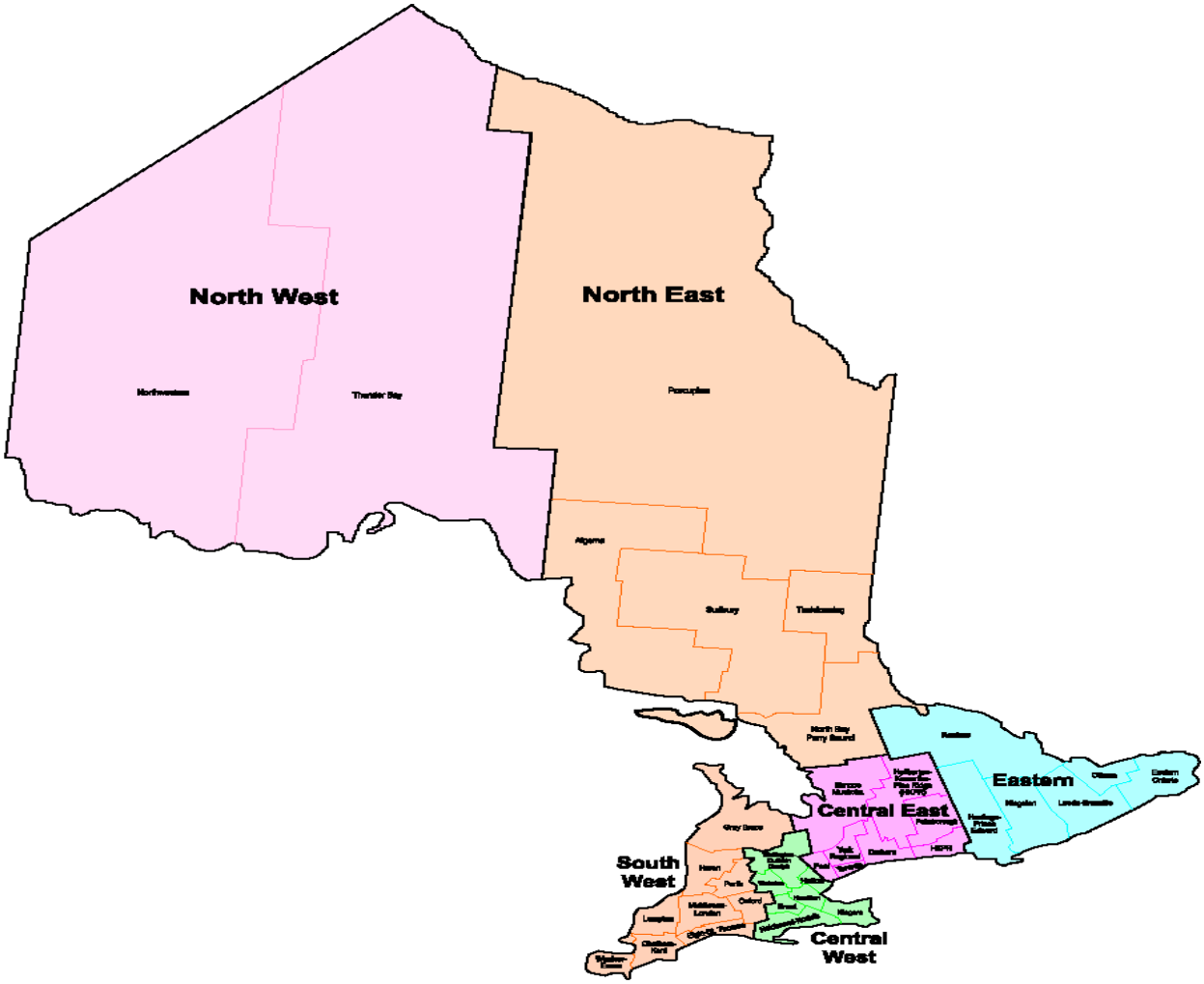
Ontario Council on Community Health Accreditation
http://www.occha.org

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

Ontario Ministry of Health Promotion
http://www.mhp.gov.on.ca/en/default.asp

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

Appendix 3 - Health Units Map



Appendix 4 - Ontario Health Unit Contacts

Note: Due to the recent municipal elections, boards of health Chairs may not be correct

Algoma Health Unit
6th Floor, Civic Centre, 99 Foster Drive
Sault St. Marie, Ontario P6A 5X6
Tel: (705) 759-5287
Fax: (705) 759-1534
Web: http://www.ahu.on.ca
Medical Officer of Health: Dr. Allan Northan
Board of Health Chair: Guido Caputo

Brant County Health Unit
194 Terrace Hill Street
Brantford, Ontario N3R 1G7
Tel: (519) 753-4937
Fax: (519) 753-2140
Web: http://www.bchu.org/
Medical Officer of Health: Dr. Malcolm Lock
Board of Health Chair: Dan McCreary

Chatham-Kent Public Health Services
435 Grand Avenue, P.O. Box 1136
Chatham, Ontario N7M 5L8
Tel: (519) 352-7270
Fax: (519) 352-2166
Web: http://www.chatham-kent.ca/
Acting Medical Officer of Health: Dr. David Colby
Board of Health Chair: Brian King

Durham Region Health Department
605 Rossland Road East,PO Box 730
Whitby, Ontario L1N 0B2
Tel: (905) 668-7711
Fax: (905) 666-6214
Web: http://www.region.durham.on.ca/
Medical Officer of Health: Dr. Robert Kyle
Board of Health Chair: April Cullen

Eastern Ontario Health Unit
1000 Pitt Street
Cornwall, Ontario K6J 5T1
Tel: (613) 933-1375
Fax: (613) 933-7930
Web: Engish - http://www.eohu-bseo.on.ca/home/index_e.php
Francais - http://www.eohu-bseo.on.ca/home/index_f.php
Acting Medical Officer of Health: Dr. Paul Roumeliotis
Board of Health Chair: Jim McDonnell

Elgin-St. Thomas Health Unit
99 Edward Street
St. Thomas, Ontario N5P 1Y8
Tel: (519) 631-9900
Fax: (519) 633-0468
Web: http://www.elginhealth.on.ca/
Acting Medical Officer of Health: Dr. Frank Warsh
Board of Health Chair: Bonnie Vowel

Grey Bruce Health Unit
920 First Avenue West
Owen Sound, Ontario N4K 4K5
Tel: (519) 376-9420
Fax: (519) 376-0605
Web: http://www.publichealthgreybruce.on.ca/
Medical Officer of Health: Dr. Hazel Lynn
Board of Health Co-Chairs: Larry Craemer

Haldimand-Norfolk Health Unit
12 Gilbertson Drive, P.O. Box 247
Simcoe, Ontario N3Y 4L1
Tel: (519) 426-6170
Fax: (519) 426-9974
Web: http://www.hnhu.org/
Acting Medical Officer of Health: Dr. Malcolm Lock
Board of Health Chair: Dennis Travale

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

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

Huron County Health Unit
Health & Library Complex, R.R #5
77722 London Road
Clinton, Ontario N0M 1L0
Tel: (519) 482-3416
Fax: (519) 482-7820
Web:
http://www.huroncounty.ca/healthunit/index.html
Medical Officer of Health: Dr. Nancy Cameron
Board of Health Chair: Bernie MacLellan

County of Lambton
Community Health Services Dept.
160 Exmouth Street
Point Edward, Ontario N7T 7Z6
Tel: (519) 383-8331
Fax: (519) 383-7092
Web: http://www.lambtonhealth.on.ca/
Acting Medical Officer of Health: Dr. Christopher Greensmith
Board of Health Chair: N/A

Middlesex-London Health Unit
50 King Street
London, Ontario N6A 5L7
Tel: (519) 663-5317
Fax: (519) 663-9581
Web: http://www.healthunit.com/
Medical Officer of Health: Dr. Graham Pollett
Board of Health Chair: Tom McLaughlin

Halton Region Health Department
1151 Bronte Road
Oakville, Ontario L6M 3L1
Tel: (905) 825-6000
Fax: (905) 825-8588
Web: http://www.region.halton.on.ca/health/
Medical Officer of Health: Dr. Robert Nosal
Board of Health Chair: Jeff Knoll

Hastings & Prince Edward Counties Health Unit
179 North Park Street
Belleville, Ontario K8P 4P1
Tel: (613) 966-5500
Fax: (613) 966-9418
Web: http://www.hpechu.on.ca/
Medical Officer of Health: Dr. Richard Schabas
Board of Health Chair: Ron Hamilton

Kingston, Frontenac, Lennox & Addington Public Health
221 Portsmouth Avenue
Kingston, Ontario K7M 1V5
Tel: (613) 549-1232
Fax: (613) 549-7896
Web: http://www.healthunit.on.ca/
Medical Officer of Health: Dr. Ian Gemmill
Board of Health Chair: N/A

Leeds, Grenville and Lanark District Health Unit
458 Laurier Boulevard
Brockville, Ontario K6V 7A3
Tel: (613) 345-5685
Fax: (613) 345-2879
Web: http://www.healthunit.org/
Medical Officer of Health: Dr. Paula Stewart
Board of Health Chair: Ken Graham

Regional Niagara Public Health Department
30 Hannover Drive
St. Catharines, Ontario L2W 1A3
Tel: (905) 688-3762 or 1-800-263-7248
Fax: (905) 682-3901
Web:
http://www.regional.niagara.on.ca/government/health/default.aspx
Medical Officer of Health: Dr. Robin Williams
Board of Health Chair: N/A

North Bay Parry Sound District Health Unit
681 Commercial Street
North Bay, Ontario P1B 4E7
Tel: (705) 474-1400
Fax: (705) 474-8252
Web: http://www.nbdhu.on.ca/
Medical Officer of Health: Dr. Jim Chirico
Board of Health Chair: N/A

Northwestern Health Unit
21 Wolsley Street
Kenora, Ontario P9N 3W7
Tel: (807) 468-3147
Fax: (807) 468-4970
Web: http://www.nwhu.on.ca/
Medical Officer of Health: Dr. James Arthur
Board of Health Chair: N/A

Ottawa Public Health
100 Constellation Cres.
Ottawa, Ontario K2G 6J8
Tel: (613) 580-6744
Fax: (613) 580-9641
Web: http://Ottawa.ca/health
Medical Officer of Health: Dr. Isra Levy
Board of Health Chair: N/A

Oxford County - Public Health & Emergency Services
410 Buller Street
Woodstock, Ontario N4S 4N2
Tel: (519) 539-9800
Fax: (519) 539-6206
Web: http://www.county.oxford.on.ca/publichealth
Acting Medical Officer of Health: Dr. Douglas Neal
Board of Health Chair: Paul Holborough
Director of Public Health and Emergency Service: Michael Bragg

Peel Public Health
44 Peel Centre Drive, 4th Floor
Brampton, Ontario L6T 4B5
Tel: (905) 791-7800
Fax: (905) 789-1604
Web: http://www.region.peel.on.ca/health/index.htm
Medical Officer of Health: Dr. David Mowat
Board of Health Chair: N/A
Acting Commissioner of Health: Janette Smith

Perth District Health Unit
653 West Gore Street
Stratford, Ontario N5A 1L4
Tel: (519) 271-7600
Fax: (519) 271-2195
Web: http://www.pdhu.on.ca/
Medical Officer of Health: Dr. Miriam Klassen
Board of Health Chair: N/A

Peterborough County-City Health Unit
10 Hospital Drive
Peterborough, Ontario K9J 8M1
Tel: (705) 743-1000
Fax: (705) 743-2897
Web: http://pcchu.peterborough.on.ca/
Medical Officer of Health: Dr. Rosana Pellizzari
Board of Health Chair: N/A

Porcupine Health Unit
169 Pine Street South
Timmins, Ontario P4N 8B7
Tel: (705) 267-1181
Fax: (705) 264-3980
Web: http://www.porcupinehu.on.ca/
Acting Medical Officer of Health: Dr. Susan Kaczmarek
Board of Health Chair: N/A

Renfrew County & District Health Unit
7 International Drive
Pembroke, Ontario K8A 6W5
Tel: (613) 732-3629
Fax: (613) 735-3067
Web: http://www.rcdhu.com/
Medical Officer of Health: Dr. Michael Corriveau
Board of Health Chair: N/A

Simcoe Muskoka District Health Unit
15 Sperling Drive
Barrie, Ontario L4M 6K9
Tel: (705) 721-7330
Fax: (705) 721-1495
Web: http://www.simcoemuskokahealth.org/
Medical Officer of Health: Dr. Charles Gardner
Board of Health Chair: N/A

Sudbury & District Health Unit
1300 Paris Street
Sudbury, Ontario P3E 3A3
Tel: (705) 522-9200
Fax: (705) 522-5182
Web: http://www.sdhu.com/
Medical Officer of Health: Dr. Penny Sutcliffe
Board of Health Chair: N/A

Timiskaming Health Unit
421 Shepherdson Road
New Liskeard, ON POJ 1PO
Tel: (705) 647-4305
Fax: (705) 647-5779
Web: http://www.timiskaminghu.com/
Acting Medical Officer of Health: Dr. Pat Logan
Board of Health Chair: N/A

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

Windsor-Essex County Health Unit
1005 Ouellette Avenue
Windsor, Ontario W9A 4J8
Tel: (519) 258-2146
Fax: (519) 258-6003
Web: http://www.wechealthunit.org/
Medical Officer of Health: Dr. Allen Heimann
Board of Health Chair: N/A

Thunder Bay District Health Unit
999 Balmoral Street
Thunder Bay, Ontario P7B 6E7
Tel: (807) 625-5900
Fax: (807) 623-2369
Web: http://www.tbdhu.com/
Medical Officer of Health: Dr. Henry Kurban
Board of Health Chair: N/A

Toronto Public Health
277 Victoria Street, 5th Floor
Toronto, Ontario M5B 1W2
Tel: (416) 392-7401
Fax: (416) 392-0713
Web: http://www.toronto.ca/health
Medical Officer of Health: Dr. David McKeown
Board of Health Chair: N/A

Wellington-Dufferin-Guelph Public Health
474 Wellington Road 18, Suite 100
RR #1
Fergus Ontario N1M 2W3
Tel: 519-846-2715
Fax: 519-846-0323
Web: http://www.wdghu.org/
Medical Officer of Health: Dr. Nicola Mercer
Board of Health Chair: N/A

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

Appendix 5 - alPHa Board of Health Section Policies and Procedures

Name

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

Objectives

2. The objectives of the Section shall be:

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

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

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

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

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

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

Membership

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

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

Meetings and Procedures

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

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

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

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

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

Executive Committee

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

- a Chair
- a Vice-Chair
- and 5 members-at-large

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

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

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

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

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

Elections

6. (a) Elections for members of the Section Executive Committee shall be held each year during the alPHa Annual Conference.

(b) Elected or appointed members of a member board of health or health committee of a regional municipal council may be elected to the Section Executive. Termination of election or appointment at the local level will terminate membership of the Section and its Executive Committee.

(c) The Executive shall have the power to fill any vacancy within 60 days, if they so choose.

(d) The Board of Health Section Executive shall consist of seven (7) members, elected at the inaugural meeting of the Association, four (4) for two (2) year terms, the remaining three (3) for one (1) year terms. Thereafter, all newly-elected members of the Executive shall serve two (2) year terms. This shall promote continuity of experienced Executive members.

(e) Nominations will be accepted until five (5) business days prior to the commencement the Annual Conference of the Association of Local Public Health Agencies, at which time all Section Executive candidates will be allowed up to 2 minutes each for a brief statement of position.

.

(f) Board of Health voting delegates will be asked to elect from the slate of nominees the number of candidates to fill the number of Section Executive vacancies.

(g) Nominations must be submitted in writing from the respective Board of Health, bearing the signatures of two (2) Board of Health members from the sponsoring Board and that of the nominee. A nomination form that shall be supplied by the Association of Local Public Health Agencies. A biography of the nominee outlining their suitability for candidacy, as well as a motion passed by the sponsoring Board of Health are also required to be submitted with the nomination form. The future meeting expenses for directors will be paid by the sponsoring health unit.

(h) Representation on the Section Executive will include one (1) representative from each of the following regions of Ontario: North West, North East, South West, Eastern, Central East, Central West, and Toronto, as defined by the Ministry of Health and Long-Term Care (see Appendix).

(i) The Executive Committee of the Section will endeavour to include at least one (1) representative from a Municipal Board of Health, meaning a Board that is separate from Council but where staff operations are integrated with the municipal administrative structures; at least one (1) representative from a Regional/Single-Tier Board of Health, meaning a Board where the Regional Council or a standing committee of Regional Council acts as the Board of Health; and at least one (1) member from an autonomous Board of Health, meaning a Board that is independent from local government.

(j) In general, candidates nominated by their Boards of Health must be present at the Annual General Meeting of the Association of Local Public Health Agencies to stand for election. However, absences may be permitted at the discretion of the existing Executive Committee in the case of emergency, catastrophic, or compulsory events that prevent a candidate from being present at an election.

(k) All Board of Health section members eligible to vote at the general meeting will participate in the election for each regional representative.

(l) Candidates shall be acclaimed to a position on the Section Executive where the candidate meets all of the nomination requirements and is the sole candidate in their region.

(m) The Executive Direector of the Association of Local Public Health Agencies or designate shall preside over the election and shall not vote. In the case of a tie vote, the tied candidates will be allowed up to 2 minutes each for a brief statement of position. Immediately following the statements, eligible voters will be asked to vote for one of the tied candidates.

Chair

7. (a) Immediately following the election of the Section Executive Committee members, the new committee shall elect a Chair.

Note: The Chair also serves on the Executive Committee of the alPHa Board of Directors.

(b) It shall be the duty of the Section Chair (or designate) to preside over all Section meetings, to preserve order and, to enforce the Section Policies and Procedures. The Section Chair shall decide all questions of order subject to the appeal by a member to the meeting.

(c) It shall also be the duty of the Section Chair to provide a report of the Section's activities to the alPHa Board of Directors regularly.

Vice-Chair

8. It shall be the duty of the Vice-Chair, in the absence of the Chair, to preside and perform all duties pertaining to the office of the Chair.

Amendments and Alterations

9. (a) The Section Policies and Procedures may be amended at an annual or special general meeting of the Section with a quorum by a consensus vote.

(b) Notice of proposed amendments shall be circulated to each member board of health and health committe 60 days in advance of the meeting at which the proposed amendment will be presented.

Approved by the General Membership
Board of Health Section, ALOHA
June 7, 1988

Amended by the General Membership
Board Trustee Section, ALOHA
June 23, 1991 and June 15, 1992

Amended by the General Membership
Board of Health Section, alPHa
June 10, 2002

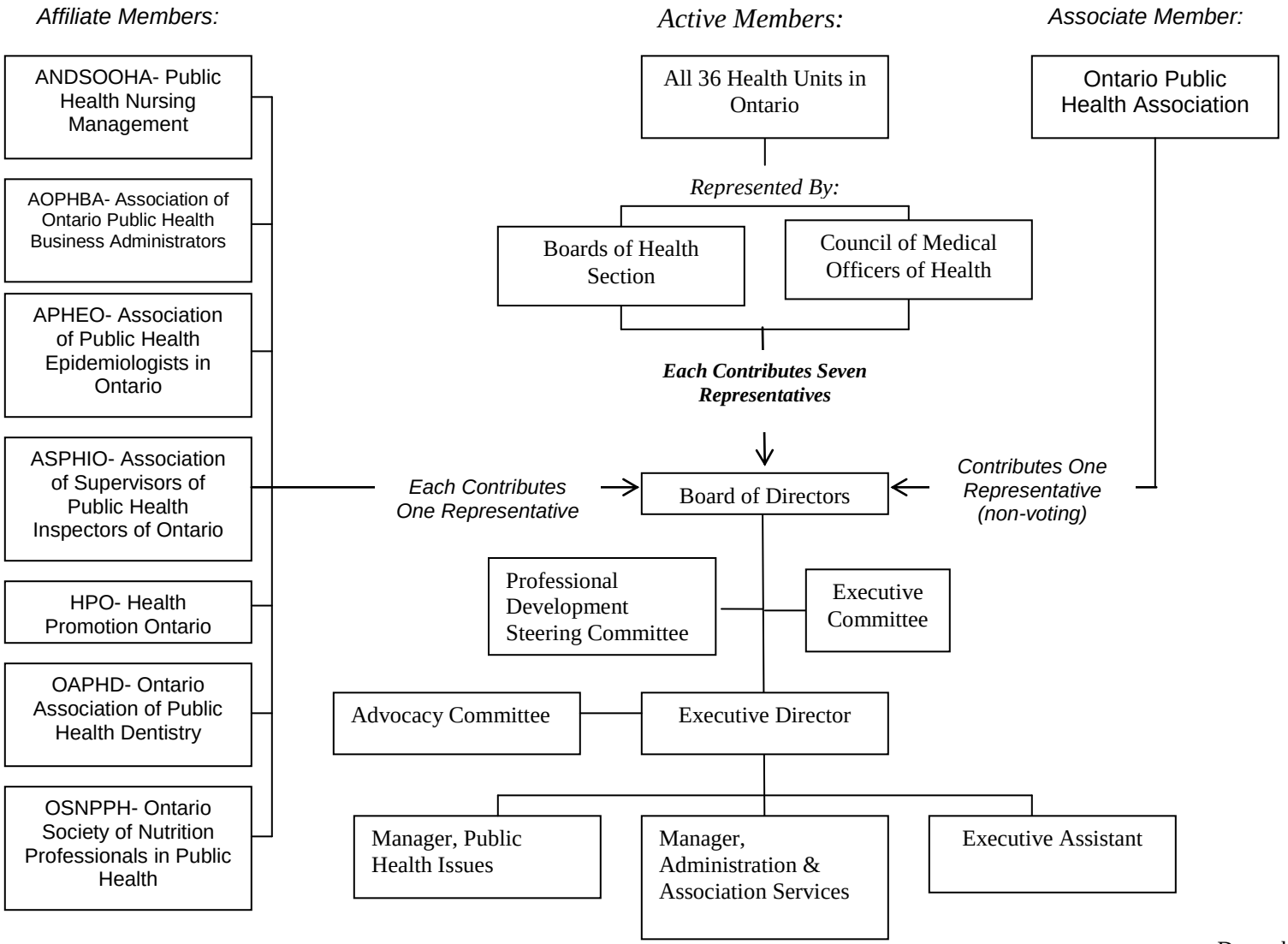
Amended by the General Membership
Board of Health Section, alPHa
January 29, 2004

Amended by the General Membership
Board of Health Section, alPHa
December 6, 2007

Appendix – Ontario Boards of Health by Region

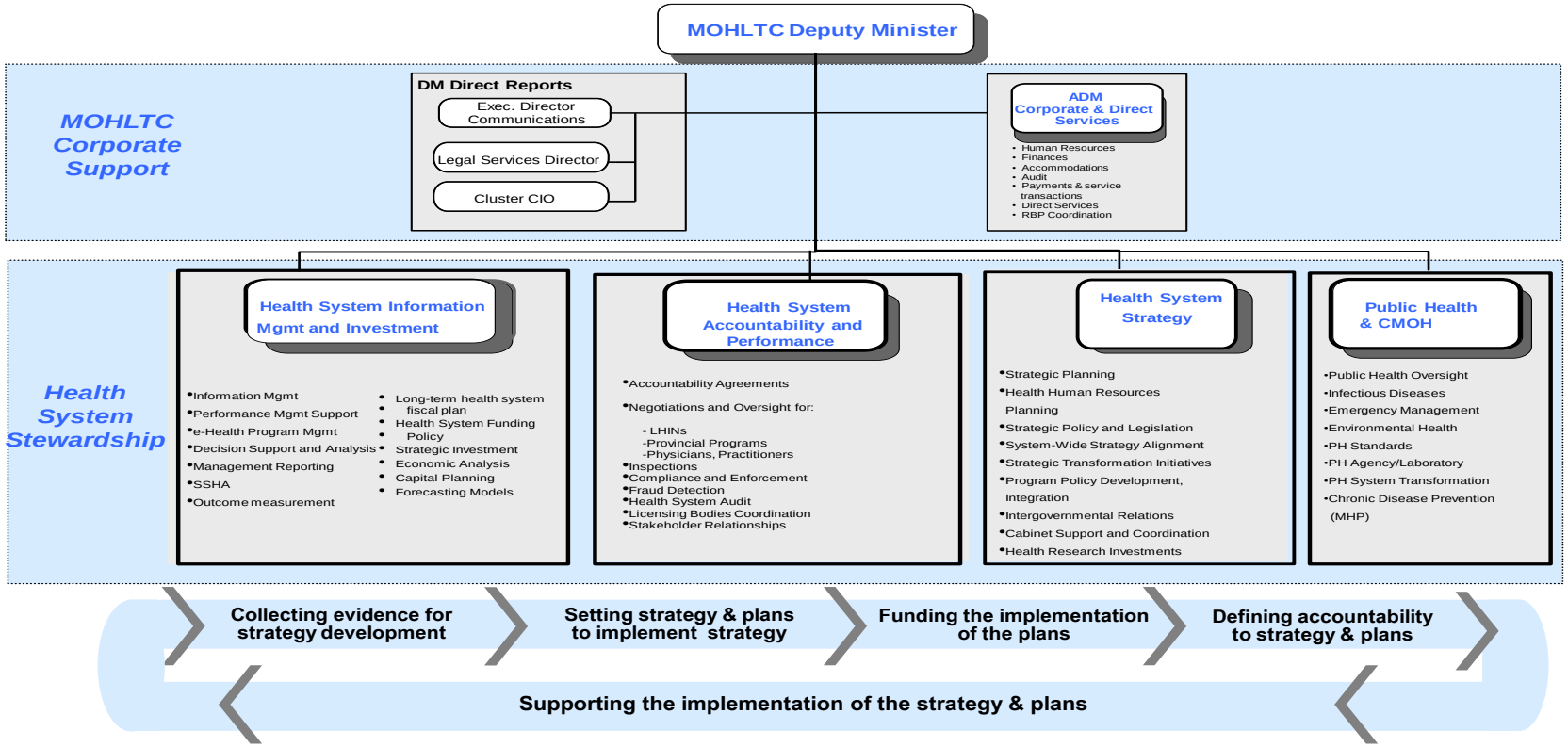
1	**North West Region**	NORTHWESTERN THUNDER BAY
2	**North East Region**	ALGOMA NORTH BAY PARRY SOUND PORCUPINE SUDBURY TIMISKAMING
3	**South West Region**	CHATHAM-KENT ELGIN ST THOMAS GREY BRUCE HURON LAMBTON MIDDLESEX LONDON OXFORD PERTH WINDSOR-ESSEX
4	**Central West Region**	BRANT HALDIMAND HALTON HAMILTON NIAGARA WATERLOO WELLINGTON DUFFERIN
5	**Central East Region**	DURHAM HKPR PEEL PETERBOROUGH SIMCOE MUSKOKA YORK REGION
6	**Toronto**	TORONTO
7	**Eastern Region**	EASTERN HASTINGS KINGSTON LEEDS OTTAWA RENFREW

Appendix 6 - alPHa Organizational Chart

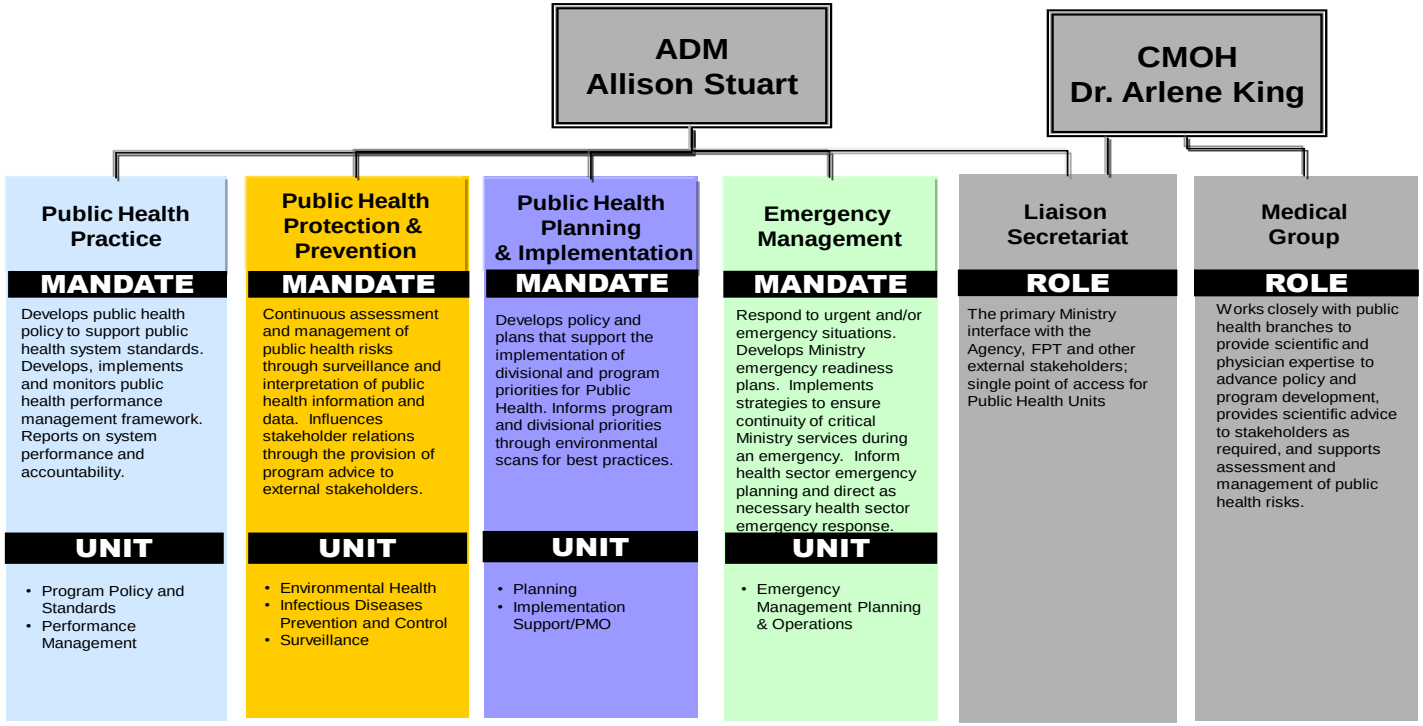


December 2010

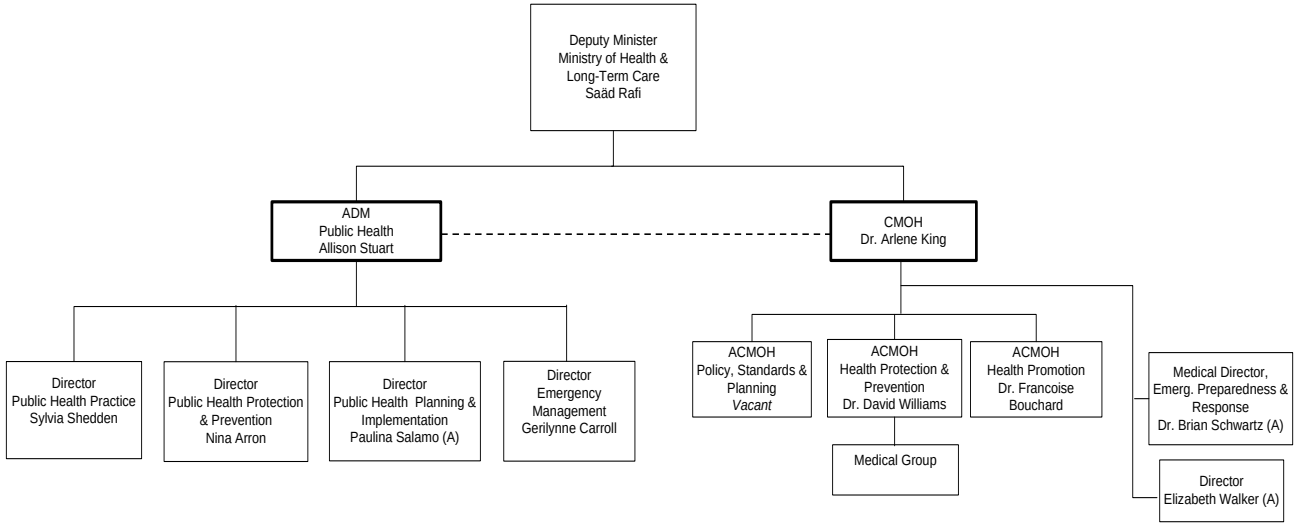
Appendix 7 - Ministry of Health and Long-Term Care Organizational Chart



Appendix 8 – Public Health Division Organizational Chart



Public Health Division



As of January 6th, 2011

Ministry of Health and Long-Term Care 1

Appendix 9 - Board of Health Liability Review

A REVIEW OF BOARD OF HEALTH LIABILITY

For:

The Association of Local Public Health Agencies

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Counsel to alPHa

Revised December 2006

Preface

This is a further update to a paper I originally presented in January 2004[1] and revised in November 2005. My January 2004 presentation originated from a paper I completed in

[1] I wish to thank my colleague John Middlebro who represents the Grey-Bruce-Owen Sound Health Unit for his comments in regard to the subject of this paper and my colleague Rod Flynn who contributed to the 2006 update.

November 2002 in which I was asked to review the liabilities of board members of Boards of Health in connection with carrying out their duties under the *Health Protection and Promotion Act.* In the January 2004 paper, I was asked to expand on the initial topic and include a review of the general liabilities to which a board member of a Board of Health is subject to as a director[2]. I also included a section on the public health responsibilities and liabilities under the *Safe Drinking Water Act, 2002*.

In my subsequent revision in November 2005, I provided an update on changes which had occurred to the legislation affecting Boards of Health between 2004 and the November 2005.

In this latest version, I have been asked to address still more developments in the applicable statutory regimes, recent outcomes from case law (including recent decisions involving a claim regarding West Nile virus[3] and another in which a municipality faced legal action arising from its public health aspect) and to address how public health may potentially be shaped by the prospective law of Bill 28 –the *Mandatory Blood Testing Act, 2006*[4].

Introduction

Public health is paradoxical. Public health attracts little attention when the system is functioning well. It is only in situations where the public's health is compromised that society turns its attention to the role of the public health system and the actions of public health providers. Sensational public health events such as the Walkerton Water Tragedy in May 2000, the SARS outbreak in 2003, West Nile virus and flu pandemic planning have prompted national and international attention to the role of public health and the actions of the public health providers.

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[2] For a helpful general overview of this topic, I recommend *Directors' Duties in Canada: Managing Risk, 2nd Edition* (2002), Margot Priest and Hartley R. Nathan, Q.C. CCH Canada Limited. I wish to thank Hartley Nathan for permission to use material from this book and to include the list of "Potential Questions for Board Self Evaluation" in Appendix A to this paper.

[3] *Eliopoulos Estate v. Ontario (Minister of Health and Long-Term Care* 2006 CanLII 37121 (Ont. C.A.).

[4] Bill 28 was referred to the Standing Committee on the Legislative Assembly which considered it on November 23 and 30, 2006. It received Third Reading in the Legislature on December 7, 2006 and got Royal Assent on December 20, 2006. As of this writing, it has yet to be proclaimed in force.

In the course of the Walkerton Water Inquiry, other parties alleged fault on the part of the public health providers for decisions and actions taken in responding to the water crisis. Ultimately, the actions of the Bruce-Grey-Owen Sound Health Unit were exonerated and the steps taken by the Health Unit were in fact praised by Commissioner Dennis O'Connor in Part 1 of his Report of the Walkerton Inquiry. With respect to individual health concerns, more recently, in 2006, the City of Toronto faced legal action arising from allegedly negligent administration of hepatitis B vaccine to a social worker with the Parkdale Community Health Centre who received 2 inoculations from "The Works", a Toronto outreach program."[5] This claim was dismissed by the Ontario Superior Court in reasons released on November 27, 2006[6]. Further, an action against the Province of Ontario with respect to West Nile Virus (representative of approximately 40 actions against the Government of Ontario in this regard) was also struck out by the Ontario Court of Appeal in November 2006.

Nonetheless, Walkerton, the SARS crisis and ongoing matters of public health (such as flu pandemic planning) have raised questions regarding the liability of boards of health and individuals for actions taken in the course of carrying out their duties on behalf of the public health system.

This paper addresses the topic of Board of Health liability in two main sections, each containing a number of interrelated topics:

I. GENERAL LIABILITIES OF DIRECTORS

1. **Prior to Accepting a Directorship**
2. **Statutory Liability**
3. **Determining Liability**
4. **Due Diligence**

[5] See *Morgan v. Toronto* (2006), (Unreported: November 27, 2006) (Ont. S.C.J.) at para. 2.
[6] *Ibid*.

II. SPECIFIC PUBLIC HEALTH LIABILITIES

1. **The Statutory Liability Exemption**
2. **Board Duties and Responsibilities**
3. **Board Governance**
4. **No Exemptions**
5. **Insurance**

Following a treatment of these main areas of interest, I will conclude by providing a brief update on the case law noted above and outline the significance of these decisions in the context of public health liability.

I. GENERAL LIABILITIES OF DIRECTORS

1. Prior to Accepting a Directorship

It is virtually impossible to be aware of every obligation and liability imposed upon a director. However, a board member can limit his or her own potential individual liability as a director by conducting his or her own process of "due diligence" prior to accepting and undertaking the obligations of being a director.

At a minimum, due diligence should involve:

- Requesting and receiving a written job description detailing the specific responsibilities expected of a director and what committees you may be expected to sit on;

- Request and take the opportunity to review board and committee minutes of the past 2 or 3 years to give you an understanding of the issues with which the board has been dealing;

- Attend the orientation program for new board members. If one does not exist, request an orientation;

- Request and receive a report on the current areas of concern and focus for the board of directors;

- Inquire whether the board has formal policies for compliance with its regulatory requirements, including the ones reviewed above; and

- Request and receive confirmation that the board has indemnification by-laws and insurance for its directors.

2. Statutory Liability

Corporations in Ontario and their directors are subject to statutory obligations and requirements under the *Ontario Corporations Act* and related statutes.

Section 52 of the *Health Protection and Promotion Act* ("*HPPA*") sets out that "…*every Board of Health is a corporation without share capital*". Because of their legislated status as corporations, Boards of Health ordinarily would be subject to the *Corporations Act*. However, section 52 of the *HPPA* specifically exempts Boards of Health from the provisions of these statutes applicable to ordinary non-share capital corporate legislation. This section provides that "the *Corporations Act* and *Corporation Information Act* **do not** apply to a Board of Health" [**emphasis added**]. As a result, board members of a Board of Health are not subject to directors' liabilities arising under the *Corporations Act*, including the personal liability to pay wages.

This does not end the matter. There are a number of other statutes (both federal and provincial) that hold directors personally liable for the failure of a corporation to comply with its obligations under the particular statute.

Income Tax, Employment Insurance, Workplace Safety

Directors can be found personally liable for failure of the Board of Health to deduct and remit amounts required under the:

- the *Income Tax Act;*
- the *Canada Pension Plan;*
- *Employment Insurance Act* (employment insurance premiums); *and*
- *Workplace Safety and Insurance Act, 1997* (Workplace Safety and Insurance Board premiums).

For your protection, you must ensure that these remittances are submitted in accordance with the requirements of the particular statute. In addition to liability for the outstanding remittances, directors may also be subject to additional penalties designated in the particular statute.

Employment Standards Act

The *Employment Standards Act*, 2000 ("*ESA"*) creates a director's personal liability for the payment of up to six months of employees' unpaid wages and vacation pay[7]. However, this provision does not apply to members of a Board of Health -as section 80 of the *ESA* sets out that the liability of directors under the *ESA* does not apply to directors of corporations "*…that are carried on* ***without*** *the purpose of gain*" [**emphasis added**]. Therefore, board members of a Board of Health are not liable under the *ESA* for employee unpaid wages and vacation pay.

Occupational Health and Safety

The Ontario *Occupational Health and Safety Act* ("*OHSA"*) establishes a comprehensive code of internal responsibility for health and safety within a workplace. This means that in addition to the employer as an entity, all individuals (from employees to directors) are responsible and liable for ensuring the health and safety of workers within a workplace, including a Public Health Unit.

Section 32 of the *OHSA* establishes the duties of directors and officers of a corporation. The section states that:

> Every director and every officer of a corporation shall take all reasonable care to ensure that the corporation complies with, (a) this Act and the Regulations; (b) orders and requirements of inspectors and directors; and (c) orders of the Minister.

In relevant circumstances, the Ministry of Labour pursues charges and prosecutes individuals connected with workplace accidents. The penalties for an individual (including a Director) who is convicted of an offence under the *OHSA* are:

- a fine of not more than $25,000: or
- imprisonment for a term of not more than 12 months; or

- both a fine and imprisonment.

Amendments to the *Criminal Code of Canada* (Bill C-45) came into force on March 31, 2004 under which corporations and individuals can be charged with criminal negligence arising from a workplace accident. Such criminal charges would be in addition to a prosecution under the *OHSA*[8].

To comply with the duty to take reasonable care, directors must be found to have been involved with and to be overseeing the health and safety program in the Public Health Unit. At a minimum, this requires the Board of a Health Unit:

- to approve a health and safety policy;
- to ensure compliance with health and safety programs and training; and
- to receive information on a regular basis regarding the health and safety activities of the Health Unit.

Human Rights Code

Section 5 of the *Ontario Human Rights Code* (*"HRC")* establishes that:

> Every person has a right to equal treatment with respect to employment without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, record of offences, marital status, same sex partnership status, family status or disability.

The *HRC* contains a specific provision that a person who is an employee has a right to freedom from harassment in the workplace by the employer or agent of the employer or by another employee.

Individuals (including directors of an employer) can be named as a Respondent to a complaint of discrimination or harassment in employment. To avoid being named as a Respondent to such a complaint, board members must ensure that their Health Unit:

---

[7] See *ESA*, s.81.

[8] The first prosecution under the Bill C-45 amendments was initiated after a workplace fatality in April 2004 and resolved by way of a guilty plea to OHSA offences (with a withdrawal of the criminal charges) in March 2005.

- has a policy stating that the employer upholds the principles of the *HRC*;
- has established a process for dealing with human rights complaints; and
- complies with the established complaint process.

3. Determining Liability

At law, a director may be found individually liable when that person's conduct falls short of the established standard of care. In many situations the standard is that of, "…*a reasonably prudent person*". However, for some persons the standard of care can be higher than that of the "*reasonably prudent person*". For those directors with expertise, the standard of care can be that "…*which may reasonably expected from a person of such knowledge and experience*", as the identified director. For example, a health care professional, accountant or lawyer is considered to have expertise. Under this higher standard, it is important that a director exercise due diligence in accordance with his or her expertise to ensure that the Board and the organization is complying with its obligations.

4. Due Diligence

Most regulatory liability provisions allow a defence of "due diligence" for the corporation and for directors if potential liability extends to them. What constitutes "due diligence" depends on the regulatory statute, the corporation and the situation. However, some generalizations can be made. As a very general matter, "due diligence" involves:

- Putting in place a system for preventing non-compliance;
- Training employees in applying the system;
- Documentation;
- Monitoring and adjusting the system;
- Ensuring that adequate authority is given to the appropriate employees; and
- Planning remedial action in case the system fails at any point.

There is an increasing emphasis on the responsibility of directors to implement systems that provide them with the information they need to know to make decisions. Directors must ask questions and learn about the affairs and status of the corporation. They must monitor the workings of the corporation and make the decisions necessary to ensure that the corporation and its employees comply with the law.

To assist you in being able to comply with the due diligence required of a Board, I have included as Appendix "A" to this paper a questionnaire entitled, "*Potential Questions for Board Self-Evaluation*" This questionnaire will assist you in determining whether your Board is complying with its duties and obligations.

II. SPECIFIC PUBLIC HEALTH LIABILITIES

1. The Statutory Liability Exemption

The governmental responsibility for Public Health falls under the Ministry of Health and Long term Care. The *HPPA* sets out the statutory regime for the provision of public health duties, services, administration, and enforcement for the citizens of Ontario. The *HPPA* is divided into ten parts:

1. Interpretation
2. Health Programs and Services
3. Community Health Protection
4. Communicable Diseases
5. Rights of Entry and Appeals from Orders
6. Health Units and Boards of Health
7. Administration
8. Regulations
9. Enforcement
10. Transition

Section 95 of the *HPPA* deals with the issue of liability. The section provides for an exemption in regard to personal liability with respect to the carrying out of responsibilities under the *HPPA*. The section states:

> Protection from Personal Liability
>
> 95(1) No action or other proceeding for damages or otherwise shall be instituted against a **member of a Board of Health**, a Medical Officer of Health, and Associate Medical Officer of Health of a Board of Health, an Acting Medical Officer of Health of a Board of Health or a Public Health Inspector for any act done in good faith in the execution or the intended execution of any duty or power under this Act, or, for any alleged neglect or default in the execution in good faith of any such duty or power. **[emphasis added]**

This section provides a broad exemption/protection to individual members of a Board of Health and the specified other individuals with respect to carrying out their responsibilities, **where their actions are done in good faith.**

It is noted that subsection 95(2) of the *HPPA* does state that the above-noted protection from personal liability does not apply to:

- prevent an application for judicial review of an action or an order;
- prevent a proceeding such as an appeal to the Health Services Appeal and Review Board; or
- prevent an inquiry that is specifically provided for in the *HPPA*.

Subsection 95(4) provides for protection from liability for reports. It states:

> 95(4) No action or other proceeding shall be instituted against a person for making a report in good faith in respect of a communicable disease or a reportable disease in accordance with Part IV (Communicable Diseases).

However, these broad protections against individual liability under the *HPPA* do not end the matter. Subsection 95(3) reads:

> Board of Health not Relieved of Liability
>
> 95(3), subsection (1) does not relieve a Board of Health from liability for damage caused by **negligence** of **or action without authority** by a person referred to in subsection (1), and a Board of Health is liable for such damage in the same manner as if subsection (1) had not been enacted **[emphasis added].**

"*Negligence*" may be defined as follows:

> …the failure to do something or to use such care as a reasonably prudent and careful person would use under similar circumstances, or alternatively, it is the doing of some act which a person of ordinary prudence would not have done under similar circumstances, or the failure to do what a person of ordinary prudence would have done under similar circumstances.

While subsection 95(1) provides protection to board members from personal liability in regard to alleged negligence or fault in the carrying out of any duty or power in good faith, subsection (3) makes the Board of Health corporately liable for damage caused by negligence, or action without authority, by one of the persons referred to in subsection (1). It is noted that subsection 95(1) is limited to the public health professionals that are named and does **not** include other public health professionals such as public health nurses.

As well as the public health persons identified in section 95(1), other professionals of the Public Health Unit are protected by the 2-year time limitation for action stipulated in the *Limitations Act, 2002* (which came into force on January 1, 2004) ("*LA*"). Section 4 of the *LA* states:

> Unless this Act provides otherwise, a proceeding shall not be commenced in respect of a claim after the second anniversary of the day on which the claim was discovered.

While the statement of the 2-year limitation under section 4 of the *LA* seems relatively straightforward, the *LA* sets out fairly complicated rules for determining when a claim is "*discovered*" as a matter of practice (see section 5 thereof

The proclamation of the *LA* repealed the existing protection given to health units as "public authorities" under the limitation stated in section 7 of the *Public Authorities Protection Act* ("*PAPA*"). However, the *PAPA* limitation may still have application in very limited circumstances stated in the transition rules under s.24 of the *LA*[9].

[9] Section 24(5) of the LA allows a "former limitation" to apply where a plaintiff has a cause of action and no action has been commenced before the LA effective date of January 1, 2004 where a limitation did not expire before January 1, 2004 and the claim was discovered before January 1, 2004.

2. Knowledge of Duties and Responsibilities

Given the limited protection from liability provided to members of a Board of Health under section 95, it is recommended that the first step to be taken to avoid claims of negligence and a finding of liability is that members of a Board of Health take the time to become familiar with their duties and responsibilities under the *HPPA*.

Part VI of the *HPPA* deals with the formation and functioning of health units and boards of health.

Sections 48 to 59 deal with the composition, administrative issues and functions of the board.

Sections 62 to 71 deal with the board's responsibilities with respect to the Medical Officer of Health and other staff hired by the local Public Health Unit.

Sections 72 to 77 deal with the issues of funding of the Board of Health by the municipality and the provincial Government. The legislation requires the Board of Health to submit written notice of the estimated expenses expected to be incurred in carrying out the functions and duties of the *HPPA* and any other Act. It is the duty of the Board of Health to set a budget that allows the Board of Health to do what it is legally obligated to do. It is the obligation of the municipality to pay the expenses of the Board of Health.

Section 61 sets out the duty of a Board of Health in regard to the provision of public health services by the local Public Health Unit. This section states:

Duty of Board of Health

> 61. Every Board of Health **shall superintend and ensure the carrying out** of Parts II, III and IV and the Regulations relating to those parts in the health unit served by the Board of Health **[emphasis added]**.

Part II of the *HPPA* deals with Health Programs and Services.

The duties of the Board of Health with regards to health programs and services are set out in section 4. This section states:

Duty of Board of Health

4. Every Board of Health:

(a) shall superintend, provide or ensure the provision of the health programs and services required by this Act and the regulations to the persons who reside in the health unit served by the board; and

(b) shall perform such other functions as are required by or under this **or any other act** [**emphasis added**]

The use of the word "*shall*" in subsection 4(a) makes the duty of the Board of Health to provide programs and services mandatory. Subsection 4(b) extends the obligation to perform public health functions required under any other act. A general computer search found a reference to the words "*Board of Health*" in 66 provincial Acts or regulations.

Section 5 of the *HPPA* sets out that health programs and services must be provided in the areas of: (1) community sanitation; (2) control of infectious diseases; (3) health promotion and health protection; (4) family health; and (5) homecare services ensured under the *Health Insurance Act.*

Section 6 deals with providing public health services to school pupils.

Section 7 states that the Minister may publish guidelines for the provision of mandatory health programs and services and every Board of Health **shall comply** with the published guidelines.

Section 8 qualifies the obligation to provide programs and services in that it states that a Board of Health is not required to provide or ensure the provision of a mandatory health program or service set out in Part II **except to the extent** and under the conditions prescribed by the regulations and the guidelines.

Section 9 states that a Board of Health **may** provide any other health program or service in any area in the health units served by the Board of Health if, (a) the Board of Health is of the opinion that the health program or service is necessary or desirable, having regard to the needs of persons in the area; and (b) the councils of the municipalities in the area approve the provision of the health program or service.

Part III of the *HPPA* deals with Community Health Protection. Part III establishes duties for the Medical Officer of Health and the professional staff of the local Public Health Unit with respect to conducting inspections for the purpose of preventing, eliminating and decreasing the effects of health hazards in the health unit; and dealing with complaints regarding a health hazard relating to occupational or environmental health.

Section 12 requires every Medical Officer of Health to keep him or herself informed in respect of matters related to occupational and environmental health.

Specific obligations are created in section 12(2) where it states that the Ministry of the Environment, the Ministry of Health, the Ministry of Labour or a municipality shall provide to a Medical Officer of Health such information in respect of any matter related to occupational or environmental health as is requested by the Medical Officer of Health, is in the possession of the Ministry or the municipality, and the Ministry or municipality is not prohibited by law from disclosing.

Part III also deals with the issuing of orders by the Medical Officer of Health or Public Health Inspector regarding a health hazard, specific obligations regarding food premises and food items, and the power of Medical Officer of Health or a Public Health Inspector when of the opinion upon reasonable and probable grounds that a health hazard exists to seize, examine, return and/or destroy a substance, thing, plant or animal.

Section 13 of the *HPPA* gives broad powers to a Medical Officer of Health or a Public Health Inspector in regard to issuing orders in respect of a health hazard. This section states:

Order by MOH or Public Health Inspector re Health Hazard

13(1) A medical officer of health or a public health inspector, in the circumstances mentioned in subsection (2), by a written order may require a person to take or to refrain from taking any action that is specified in the order in respect of a health hazard.

Condition Precedent to Order

(2) A medical officer of health or a public health inspector may make an order under this section where he or she is of the opinion, upon reasonable and probable grounds,

(a) that a health hazard exists in the health unit served by him or her; and

(b) that the requirements specified in the order are necessary in order to decrease the effect of, or to eliminate the health hazard.

Given the broad powers that are designated under this section, it is recommended that members of a board of familiarize themselves with the entire section 13 of the *HPPA*.

As discussed above, under section 61, the Board of Health has the mandatory responsibility to superintend and ensure the carrying out of the obligations in Part III of the Act.

Part IV of the *HPPA* deals with communicable diseases. This part of the Act deals with the powers that are designated to the Medical Officer of Health and her or his staff in dealing with communicable diseases, many of which are defined in the Act. Part IV deals with the designated powers to a Medical Officer of Health to issue and seek the enforcement of orders and directions to prevent, respond to and control communicable diseases.

The *HPPA* also provides in section 22.1 for a Medical Officer of Health to order blood samples in certain defined situations. Essentially, this provision allows a person who has come into contact with the bodily substances of another person in certain specified circumstances (which are set out in the *HPPA* –e.g., "…*as a result of being the victim of a crime*"), to apply to the local Medical Officer of health to have the blood of the other person analyzed to determine whether the other person has viruses which cause certain communicable diseases. Under the applicable regulation[10], upon receiving such an application, the local Medical Officer of Health can take up to 7 days attempting to get a blood sample or other evidence of seropositivity voluntarily from

[10] Ontario Regulation 166/03 –"Orders under Section 22.1 of the Act"Subsection 6(12)

the person. Failing the provision of a voluntary sample, an order may be made (with or without a hearing) requiring the person from whom the sample is sought to allow a medical practitioner (or other person mentioned in the order) to take a sample of blood. An appeal of the local Medical Officer of Health's decision in this respect may be made to the Chief Medical Officer of Health or the Health Services Appeal and Review Board.

Pursuant to legislation which has just been passed by the Legislature and has received Royal Assent, Section 22.1 of the *HPPA* is to be repealed and replaced by a freestanding statute to be called the *Mandatory Blood Testing Act, 2006***.** Bill 28, the *Mandatory Blood Testing Act, 2006*[11] (which received Royal Assent on December 20, 2006 but to date has yet to be proclaimed in force) will make three significant changes from the procedure currently in place under section 22.1[12]. These are as follows:

- the period during which a voluntary sample from the person (from whom blood is sought) may be pursued is to be shortened to 5 days (from the current 7 day period prescribed in subsection 6(12) of Ontario Regulation 166/03 –"Orders under Section 22.1 of the Act");

- the application under s.22.1(2) of the *HPPA* will no longer be directed to the local Medical Officer of Health but instead will be directed to the Ontario Consent and Capacity Board[13];

- the right of both an applicant for such an order or the respondent "other person" to appeal any decision made under the section (as currently provided in s.22.1(9)) is to be removed by Bill 28.[14]

In essence, the *Mandatory Blood Testing Act, 2006* will continue the involvement of the local Medical Officer of Health in the process of seeking voluntary provision of blood samples. However, in situations where a request for a voluntary sample is refused or ignored, under the

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[11] Bill 28 received third reading in the Legislature on December 7, 2006 and was given Royal Assent on December 22, 2006. As of this writing, it has not yet been proclaimed in force.
[12] In this respect, the author is indebted to Dr. Rita Shahin of alPHa who kindly shared with me her speaking notes with respect with respect to a speech she gave on November 23, 2006 concerning Bill 28.
[13] For information on the Consent and Capacity Board, see www.ccboard.on.ca
[14] *Ibid.*

Mandatory Blood Testing Act, 2006, a local Medical Officer of Health will not be called upon to make an order for a blood sample: the Consent and Capacity Board (Ontario) is given jurisdiction over making such findings under the new regime.

It is recommended that members of Board of Health familiarize themselves with Bill 28 including the amendments implemented when Bill 28 is brought into force.

Part IV also provides for appeals to the Health Services Appeal and Review Board and for applications to the courts in respect to orders and directions issued by the Medical Officer of Health.

Again, under section 61, the members of the Board of Health are responsible for superintending the actions of the Medical Officer of Health and staff of the local Public Health Unit under Part IV.

Safe Drinking Water Act

The *Safe Drinking Water Act*[15] ("*SDWA*") was introduced by the Ontario Government in response to the recommendations from the Walkerton Inquiry[16]. The *SDWA* establishes systems and obligations for the operators of water systems in the Province. The *SDWA* imposes a duty on persons:

- to report adverse water test results to the Ministry of the Environment and to the Medical Officer of Health;
- to consult with the local Medical Officer of Health in certain designated situations.

The *SDWA* also provides for the Medical Officer of Health to receive copies of orders from the Ministry of the Environment in regard to the operation and maintenance of water systems. The recipient Health Unit is obligated to respond to the communications in accordance with its mandate under the *HPPA*.

[15] S.O. 2002, c.32 (as amended).
[16] For background on the SDWA, see http://www.ene.gov.on.ca/envision/water/sdwa/index.htm

The *SDWA* has undergone several amendments since the January 2004 version of this paper. The most significant of these changes is the recent transfer of direct oversight of five categories of systems to Public Health Units.

Under Ontario Regulation 252/05[17] (which came into effect on June 3, 2005), Public Health Units will be responsible for ensuring facilities such as churches, community halls, bed and breakfasts and tourist outfitters have safe drinking water. These provisions will regulate systems serving non-residential and seasonal residential uses. This will include a risk-based, site-specific approach for all drinking water systems serving non-residential and seasonal uses. Health Units will evaluate risks at individual systems and develop a system-specific water protection plan to ensure compliance with provincial drinking water quality standards.

The protection from liability under section 95 of the *HPPA* applies to the carrying out of duties under the *SDWA.* That is, liability only accrues in the event that the Health Unit or individuals were found to have been negligent in regard to the prescribed obligations. As set out in section 95, a Health Unit and the persons identified cannot be held liable if the duties were carried out in good faith.

Clean Water Act, 2006

The *Clean Water Act, 2006* ("*CWA*") was passed by the Ontario Legislature and received Royal Assent on October 19, 2006, and came into force on July 3, 2007.

As described by the Government of Ontario Backgrounder on the Bill, under the *CWA*:

> For the first time, communities will be required to create and carry out a plan to protect the sources of their municipal drinking water supplies. The Clean Water Act will:
>
> - Require local communities to look at the existing and potential threats to their water and set out and implement the actions necessary to reduce or eliminate significant threats.
> - Empower communities to take action to prevent threats from becoming significant.

[17] The rather unwieldy title of this Regulation is "Non-residential and non-municipal seasonal residential systems that do not serve designated facilities."

- Require public participation on every local source protection plan. This means everyone in the community gets a chance to contribute to the planning process.
- Require that all plans and actions are based on sound science.[18]

Local boards of health (as "local boards" as defined in the *Municipal Affairs Act*[19]) may be called upon under the *CWA* to "*comply with any obligation that is imposed on it*…" pursuant to certain protection policies developed under the statute (see section 38). Boards of health may also be required to provide documents which relate "…*to the quality or quantity of any water that is or may be used as a source of drinking water*" including:

> (a) any technical or scientific studies undertaken by or on behalf of the person or body; and
>
> (b) any document or other record relating to a drinking water threat;

upon the request of a municipality, a provincial ministry or water protection authorities or committees which are to be created/authorized under the statute.[20]

Section 98(1)(c) of the *CWA* contains a provision protecting against liability for local boards such as Boards of Health. It reads:

> No cause of action arises as a direct or indirect result of:
>
> (c) anything done or not done by…a local board in accordance with Parts I, II or III.

Subsections (2) and (3) go further and preclude any remedy to any claimant with respect to anything done under section 98(1). Subsection (3) clarifies that any such proceeding is barred.

While a Board of Health's obligations under section 87 of the *CWA* fall in Part V (rather than Parts I through III which are protected under s.98), the ordinary protections of s.95 of the *HPPA* would apply to any duty under section 87 of the *CWA*. Nonetheless, section 99 of the *CWA* provides similar protections to "*employees or agents*….of local boards". Section 99(2) states that:

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[18] See http://www.ene.gov.on.ca/envision/news/2006/101801mb.htm
[19] Section 2 of the *CWA* imports the definition of "local board" from the *Municipal Affairs Act* which definition includes a "board of health" in section 1.
[20] See section 87.

> "No action or other proceeding shall be instituted against a person referred to in subsection (1) for any act done in good faith in the execution or intended execution of any power or duty to which this section applies or for any alleged neglect or default in the execution in good faith of that power or duty."

The omission of statutory protection to local boards (and their members) seems to be a significant oversight in the *CWA*, particularly given that presumably the local board would authorize the disclosure of any document under s.87 by an employee or agent, yet the shield from liability in the statute (as currently drafted) applies only to the actor and presumably not to the board which would authorize such steps.

3. Board Governance

Given the obligations and responsibilities of the Board of Health, it is clear that in order to carry out its responsibilities and to avoid liability, members of the Board of Health must take an active role in assuring themselves that the Medical Officer of Health and staff are carrying out their duties in compliance with the *HPPA* and its regulations. This may call for a review of a Board of Health's governance policies, procedures and practices.

The Board of Health must be assured that the Medical Officer of Health and staff are providing the health programs and services prescribed in Part II of the *HPPA*. In regard to Parts III and IV, the Board of Health must be satisfied that the duties under these parts are being carried out in compliance with the *HPPA* and its regulations. This means being satisfied that proper policies and procedures for carrying out the responsibilities under the *HPPA* and creating records have been put into place by the Medical Officer of Health and have been communicated to the staff. A protocol should be in place that establishes the expectation that the Medical Officer of Health will advise the Board of Health or the Chair of the Board of Health of crisis situations and of situations where there has not been compliance with the Act and regulations.

At the Walkerton Inquiry, one of the issues that arose was in regard to the Health Unit's receipt and follow-up with respect to communications with the Ministry of the Environment. The Board of Health must be assured that procedures are in place to ensure that its staff receives pertinent

information from outside sources and that follow-up information is provided, or received in order to complete the communications loop.

Under section 67 of the HPPA, a Medical Officer of Health is responsible for the employees and reporting to the Board of Health in relation to the delivery of public health programs or services and issues relating to public health concerns programs and services.

It is recommended that if a Board of Health has not already done so, that a standing item on the board's agenda should be the receipt of a report from the Medical Officer of Health on the status of compliance with required obligations under the HPPA.

At Appendix "B" is a sample "*Board of Director Duty of Care Report*". The report provided is from alPHa's executive director to the alpha Board. The report states that the statutory obligations of the organization have been met.

In Boards of Health where public health and administration duties are under the direction of separate individuals, a report from both of these persons regarding compliance in their areas of responsibility would be in order.

4. No Exceptions

It is posited that persons serving in public health, whether as staff or as a board member, have one of the most important and challenging roles in our society. Anyone who is aware of the history of the Province of Ontario knows that it is the contribution of public health that is responsible for the quality of health and standard of living that the citizens in our province enjoy.

I suggest that it is a particularly challenging responsibility to be a member of a Board of Health for municipal politicians. This is because municipal politicians are faced with many competing demands.

The political challenges faced by a Board of Health were described in an article commenting on the Krever Inquiry into the Blood Tragedy. In a section on politics and public health funding, the author writes:

> The final report states that public health has been chronically under funded, which contributed to the blood tragedy. I believe that public health has two characteristics that make its funding problematic.
>
> First, public health is least visible when it is working best. In the competition for public dollars and political priority, what is not visible may receive little attention. Preventative or protective functions are noticed most when they fail - as with Canada's blood supply.
>
> Public health is often in the position of justifying resource needs on the basis of problems successfully avoided, or of hypothetical future problems. Politicians rarely respond well to this kind of argument, particularly when faced with the public and professional pressure to put more money into the curative side of health. In many provinces, public health is less visible than ever as regionalization has pushed its operating side away from where major policy and resource decisions are made.
>
> Second, public health often has its highest political visibility when raising issues that politicians would just as soon avoid. Food and water safety, occupational and environmental health, alcohol and drugs, for example, provide many issues with significant political consequences that public health professionals champion. Often in the face of pressure from those with a vested interest in the status quo. Politicians rarely warm to those they believe are causing political problems, even when they are public health professionals simply doing their jobs.
>
> A concerted effort must be made to explain public health to the public, especially the preventative and protective functions that are seen only when they fail. At the same time, public health advocates must be careful not to generate a negative reaction in politicians and senior decision makers by how they approach their responsibilities. Politicians do listen to those with an understanding of the irresolvable dilemmas of modern politics, and to those who have a track record of not 'crying wolf', unless there really is one! [21]

These comments are also applicable to the Walkerton tragedy, SARS and to the challenges faced by Boards of Health in the last number of years, including planning for a flu pandemic.

The author quoted above was writing about the political challenges for public health *vis-à-vis* politicians who are not members of a local Board of Health. I suggest that the political challenges relating to public health are heightened for councillors who are also members of the local Board of Health. The Walkerton tragedy in 2000 and the SARS epidemic in 2003 have

[21] Jan Skirrow,: "Lessons from Krever - A Personal Perspective", Canadian HIV/AIDS Policy and Law Newsletter, Vol. 4, No. 2/3, Spring 1999.

served as stark reminders of the consequences if the public health system is weakened. These challenges are currently before members of Boards of Health in planning for a flu pandemic. Therefore, aside from the desire to avoid liability, the first duty of a member of a Board of Health is to ensure the integrity of the public health system. This is achieved by ensuring that the obligations under the *HPPA* are complied with, in order to protect the health of the citizens in the local health Unit.

Section 42 of the *HPPA* prohibits anyone from the obstruction of a public health professional from carrying out his or her duties. The section states:

> Obstruction
>
> 42.(1) No person shall hinder or obstruct an inspector appointed by the Minister, a Medical Officer of Health, a Public Health Inspector or a person acting under a direction of a Medical Officer of Health lawfully carrying out a power, duty or direction under this Act.

Notwithstanding the protection from liability under section 95 of the HPPA, an individual (including a board member) who is in violation of section 42 could be subject to being charged under the HPPA. While it is perhaps unlikely that a board member might face a charge under s.42 (as most, if not all, of a board member's actions in this regard would be official acts of the board itself as part of the directorship of the body corporate i.e. supporting or opposing the board acting by way of motion or by-law), it is conceivable that an individual's actions in his or her personal capacity to hinder or obstruct the actions of the board or its employees might attract such a charge in appropriate circumstances.

Section 101(1) provides that every person who is guilty of an offence under this Act is liable on conviction to a fine of not more than $5,000 for every day or part of a day on which the offence occurs or continues.

A member of a Board of Health cannot let competing interests override the duty to protect the public's health.

5. Insurance

This paper has reviewed the responsibilities of a Board of Health and the ways in which a Board of Health can avoid being found liable for breaches of the duties and responsibilities under the HPPA. Nevertheless, despite this review, your Board of Health could still find itself one day subject to a claim for negligence.

As a final practical matter, your Board of Health should review its liability insurance coverage on a regular basis to ensure that its coverage is adequate.

RECENT CASELAW

In the recent decision in the case of *Morgan v. Toronto*[22] ("Morgan"), the defendant was the City of Toronto. The City faced a claim for damages from a social worker with Parkdale Community Health Centre ("Parkdale"), who received 2 inoculations in 1994 from "The Works", a social and medical assistance program operated by Toronto arising from allegedly negligent administrations of a hepatitis B vaccine. After she started with Parkdale, the Plaintiff's supervisor suggested that because of her work with intravenous drug users, she should receive hepatitis B vaccinations. When Morgan objected to the $150 cost of the vaccinations, her supervisor arranged to have them administrated for free by "The Works". Morgan received 2 hepatitis B inoculations, which she claimed were done without her signing a consent form with respect to either administration. Morgan was later diagnosed with Chronic Fatigue Syndrome ("CFS") (which she attributed to the Hepatitis B vaccinations in view of her symptoms after both inoculations), which rendered her unable to work. She claimed damages against Toronto for, *inter alia*, loss of future earnings and loss of enjoyment of life arising from her CFS which she alleged were caused by these injections.

In the result, the Court dismissed the Plaintiff's claim. At the same time, the Court was not unsympathetic to the Plaintiff's claim and essentially made a finding that the hepatitis B vaccinations she had received were the cause of her CFS[23]. However, the reasoning of the

[22] *Supra*, note 4.
[23] *Ibid*. at para.392.

decision turned upon the Court's finding with respect to the limited medical knowledge about the risks from the inoculations at the time the hepatitis B vaccinations were given in 1994. The Court found that given that in 1994, the administrations of the particular hepatitis B vaccine were presumed to be safe and were not suspected to be associated with long-term neurological damage, the City (through the Works) could not be found to have breached its standard of care to the Plaintiff in failing to warn her about possible serious side-effects in taking the vaccinations.[24] Given the increased medical knowledge concerning these inoculations in the years after 1994, the Court added:

> Given the developments since 1994…and the recurring expressions of concern in the medical literature, had [the Plaintiff's] inoculation taken place in 2006, and obviously dependent upon the specific evidence adduced, it might well be open to a Court to conclude [despite the lack of proof to scientific certainty] that inoculees should be advised of continuing expressions of concern in the medical literature about a possible link between the vaccine and serious sequelae, including serious neurological sequelae/CFS/demylination. It might be well open for a Court to find that these are known, "material" risks about which a reasonable patient would want to know before making a decision to undergo a vaccination….It might well be open for a Court to hold that failing to disclose that information would breach the requisite standard of care.[25]

In addition to the insight the decision provides with respect to how courts may handle allegations of negligence against public authorities (including Boards of Health), the *Morgan* decision is of interest to public health units because in the course of the trial, broader allegations were raised against, among others, public health authorities with respect to alleged suppression or concealment of hepatitis B vaccinations. The Court documented this at para. 4 of the decision as follows:

> "At trial, [the Plaintiff's] counsel alleged that the pharmaceutical companies, Health Canada, and other public health agencies have withheld and/or suppressed information concerning known dangers of the hepatitis B vaccine in order to promote widespread and therefore effective inoculation."[26]

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[24] *Ibid* at para. 343.
[25] *Ibid*. at para. 353.
[26] *Ibid*., para. 4.

Despite these allegations, the Court confined its ruling to the issues between the parties, leaving these broader aspects largely unresolved, saying:

> While I agree that these broader issues are deserving of further consideration, and I have made some general observations at the end of these reasons, I have not made and would not make findings about the conduct of unrepresented persons. I have focused, as I must, on the issues between the parties.[27]

Toward the end of its reasons, the Court added comments which underscored the importance of public health activities (from a societal perspective) while acknowledging that the protection of the public from ongoing or emergent threats to public health often occurs in a context of scientific and factual uncertainty and debate, calling upon the Legislature to be proactive to create funds for compensation of those who may be injured in these circumstances.[28]

The *Morgan* decision demonstrates, in an individual context, the difficult challenge facing public health boards and officials: while allegations of negligence (and widespread attention) may follow compromises in public health (either on an individual or broader basis), public health endeavours to operate within the parameters of the specific medical and scientific context of its time and resources. This recent recognition by a court is somewhat comforting, but at the same time, highlights again the ongoing paradox of public health.

The difficult job faced by those who work in public health was also underscored by the Ontario Court of Appeal's decision (released on November 3, 2006) in the case of *Eliopolous Estate v. Ontario (Ministry of Health and Long Term Care)*[29]. The matter involved a claim brought by the estate of a man who was bitten by an infected mosquito and contracted West Nile Virus ("WNV") in 2002[30]. He was treated in hospital and released. In 2003, however, he suffered a

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[27] *Ibid*. para. 10.
[28] *Ibid*. para. 417-446.
[29] *Supra*, note 3. While not specified to be a "class action" in the decision, the Court of Appeal mentions in paragraph 1 of its reasons that "*This action is one of approximately forty similar actions brought by Ontario residents who contracted WNV in 2002.*" An application for leave to appeal to the Supreme Court of Canada was filed by the plaintiff on December 29, 2006.
[30] As noted in the reasons, Mr. Eliopoulos was one of forty claimants re: WNV. All of the actions were at the same stage in litigation.

fall and died from the complications which ensued. His estate sued the Province of Ontario, claiming that it "*could have*" and "*should have*" prevented the outbreak of WNV.

Faced with the claim, Ontario sought to strike the plaintiff's lawsuit on the grounds it disclosed no cause of action. Unsuccessful in both the motions Court and at the Ontario Divisional Court with this position, Ontario made a further appeal to the Ontario Court of Appeal. In the second paragraph of its decision in the case, the Court of Appeal summarized the central issue before it:

> "The central issue is whether, on the facts that have been pleaded, Ontario owed [the plaintiff] a private law duty of care [so as to provide the plaintiff] with the necessary legal basis for a negligence action for damages." [31]

The plaintiff's contention was that Ontario owed a duty of care "…*to take reasonable steps to prevent the spread of WNV and that Ontario failed at the operational level to implement a plan it developed for the expected outbreak of WNV.*" Ontario countered by denying that it owed any private law duty of care to the plaintiff. However, it was the Province's secondary position on this appeal which had primary significance for Ontario boards of health:

> "Ontario further submits that any liability for failure to implement measures to prevent WNV rests with local boards of health."

The Court of Appeal concluded (reciting the legal test used on a motion to strike a claim) that it was "*plain and obvious*" that the plaintiff's claim would not succeed. It allowed the appeal and struck the plaintiff's statement of claim. In so doing, however, it made somewhat startling and somewhat disconcerting statements concerning the responsibility of public boards of health for health crises such as WNV.

As noted above, the Court determined that the primary question before it was the proximity of the relationship between the plaintiff and defendant and whether under the circumstances, "…*it is just and fair having regard to that relationship to impose a duty of care on the defendant*."[32] In embarking upon its analysis of this question, the Court of Appeal held that this was a legal question which could be resolved, primarily by reference to the HPPA.[33] After reviewing the role of the Minister and Ministry of Health under the HPPA, the Court of Appeal found that the

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[31] *Supra*, para. 2.
[32] *Supra*, para. 11.
[33] Supra, para. 14-15.

Ministry/Minister of Health accrues "*discretionary powers*" under the HPPA which were insufficient to create a "*private duty*" of care to the plaintiff.[34]

Next, the Court of Appeal dealt with the plaintiff's argument that its issuance of "West Nile Virus: Surveillance and Prevention in Ontario 2001" ("the Plan") amounted to a policy decision "…*of the kind that would engage Ontario at the operational level*".[35] The Court rejected this argument for reasons including:

> "…to the extent that the Plan amounted to a policy decision to act and created a duty of care, it is clear from the terms of the Plan itself and from the relevant legislation to which I will refer that any operational duties under the Plan resided with the local boards of health."[36]

On the issue of whether promulgation of the Plan by Ontario amounted to "*the adoption of a policy at the operational level*", the Court ruled that the Plan's impact was primarily informational and not practical, with the latter aspect falling to public health units:

> "…the Plan represented an attempt by the Ministry to encourage and coordinate appropriate measures to reduce the risk of WNV by providing information to local authorities and the public. The Ministry undertook to do very little, if anything at all, beyond providing information and encouraging coordination. The implementation of specific measures was essentially left to the discretion of members of the public, local authorities and local boards of health."[37]

Finding that the operational aspects of the Plan (including the collection and reporting of dead birds; necessary liaison with hospitals and testing of mosquito pools) were "*left to local authorities*"[38], the Court of Appeal determined that the Plan fell "…*well short of the sort of policy decisions to do something about a particular risk that triggers a private law duty of care*."[39]

The Court of Appeal returned to this aspect again, identifying that like the HPPA, the Plan outlines general duties of the Province, but by contrast delineates a specific, practical role for local health agencies:

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[34] *Supra*, para. 17.
[35] *Supra*, para 21.
[36] *Supra*, para. 22
[37] *Supra*, para. 23
[38] *Supra*, para. 24
[39] *Supra*, para. 25.

> "To the extent that the Plan may be read as identifying specific operations to be performed, those tasks are left to local health authorities and local boards of health. In this regard, the Plan mirrors the scheme of the HPPA, ss.4 and 5: responsibility for implementation of health policy, including superintending and carrying out health promotion, health protection, disease prevention, community health protection and control of infectious diseases and reportable diseases, rests with local boards of Health, not the Ministry."[40]

The Court did acknowledge however, that local boards could be directed by the Ministry:

> "Local boards of health are subject to direction from the Minister (s.83(1)), and in the event the local board of health fails to follow such direction, the Minister can act in its stead (s.84(1)). However, this serves only to emphasize that under the HPPA, local boards of health, constituted as independent non-share capital corporations, bear primary operational responsibility for the implementation of health promotion and disease prevention policies."[41]

In concluding that it would "…*create an unreasonable and undesirable burden on Ontario that would interfere with sound decision-making in the realm of public health*" to impose a private law duty of care on Ontario with respect to the plaintiff, the Court of Appeal finished its reasons with some perhaps more comforting words for those working in the public health sector:

> "Public health priorities should be based upon the general public interest. Public health authotities should be left to decide where to focus their attention and resources without the fear or threat of lawsuits."[42]

The plaintiff filed a notice of appeal with the Supreme Court of Canada on December 29, 2006. While seeking leave to appeal does not necessarily mean that the top Court will hear the case (particularly given the absence of a dissenting opinion on the Court of Appeal), I will keep you apprised of the developments in this case in further updates to this paper.

The thrust of the Court of Appeal's decision in *Eliopoulos* was that Ontario did not owe the plaintiff a duty of care with respect to WNV, the breach of which could give rise to an action for damages. The main rationale for this finding was that with respect to WNV specifically (and as a general matter under the HPPA), the Province has primarily an advisory rather than operational role with respect to matters of public health.

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[40] *Supra*, para. 27.
[41] *Supra*, para. 27.
[42] *Supra*, para. 33.

Unfortunately, the reasons of the Court of Appeal in *Eliopoulos*, in emphasizing the lack of proximity between Ontario and individual citizens with respect to operational matters of public health, perhaps overplays the legal responsibility of local public boards during any crisis in public health (such as WNV). It must be remembered that there is a difference between the existence of statutory duties to the public in this context and the breach of such duties: the case should not be misread as suggesting that losses attributable to crises in public health are necessarily recoverable from one or more local public boards of health (or their members). While certainly underplaying the importance of the Province's coordination of public health initiatives and operations in the face of public health crises, *Eliopoulos* does highlight that much of the hard work in responding to such health crises falls to the local units. It also acknowledges that under the structure of the HPPA, local units do have legal duties to citizens within their respective jurisdictions. At the same time, it must be remembered the fact that the Court of Appeal in *Eliopoulos* has identified that local units do have duties to members of the public with respect to public health crises (such as WNV) pursuant to the HPPA regime, it does not necessarily follow that any harm to a member of the public from such a crisis amounts to negligence on the part of a local public health unit (or any of its members) or to reasonably foreseeable damage.

In my view, the mere existence of duties of local health units to the citizens within their jurisdictions does not necessarily predicate that any loss from a public health crisis will be give rise to a finding of liability against the unit (or indeed any of its members). To show negligence, in addition to showing the existence of a duty, a plaintiff has to show:

- a breach of the duty by the defendant (i.e. less than the required standard of care);
- the breach of duty caused damages to the plaintiff which were reasonably foreseeable.

In these respects, individual members of local boards of health will still have the protection of s.95 of the HPPA for acts done in good faith in the "*execution or intended execution of any duty or power*" under the HPPA. Further, under the law of negligence, defendants are only responsible for reasonably foreseeable damages. The fact that loss occurs by virtue of a public health crisis does not mean that such damage was caused by a breach of duty by a local public health authority or any of its members. In this context, it is submitted that the Court of Appeal's

decision in *Eliopoulos* recognizes that, like so much in the public health realm, compromises of public health are reviewed retrospectively with the benefit of hindsight illuminating how the system could have worked better. I believe that courts which review the *Eliopoulos* decision in the future will not necessarily use it as a basis to readily find that local public health agencies (or their members) are liable for losses suffered by members of the public. I contend future interpretations of this case are likely to recognize the inherent difficulty in making decisions in the context of emergencies –as the Court of Appeal stated, decisions about "….*where to focus their attention and resources*"[43] –and provide at least some deference to judgments made by local boards of health and their members in these trying contexts.

CONCLUSION

Although there is statutory protection from liability for individuals and the Board of Health when carrying out responsibilities under the statute in good faith, the Board of Health remains liable for harm caused by the negligence of an individual. Members of a Board of Health in order to avoid liability must be aware of the duties and activities of the employees of the Local Public Health Unit and be satisfied that the activities of health unit employees are being carried out in accordance with statutory requirements and in a professionally recognized manner. Board of Health members cannot allow for any exemptions from their public health obligations. Sufficient liability insurance should be purchased to ensure adequate coverage in the event a lawsuit is brought against the Board of Health.

JAL/cig

[43] *Supra*, note 44.

APPENDIX A

Potential Questions for Board Self-Evaluation

1. Does the Board get enough information of the right kinds, at the right time, from the right members of management?

2. Does the Board have an effective orientation and training program, both for new directors and for current directors?

3. Does the Board have active committees, composed of an effective number of directors to deal with such matters as audit, governance, nominations, environmental issues, human resource, program and other matters?

4. Are the committee members and chairs rotated at appropriate intervals?

5. Are the Board meetings conducted effectively, with appropriate frequency and according to well-thought-out agendas and circulated in advance?

6. Do Board members receive the necessary briefing material for Board meetings in sufficient time to prepare?

7. Are Board meetings characterized by open communication and diligent questions on the points discussed in a collegial manner?

8. Does the Board meet regularly in private, apart from the CEO or other senior managers?

9. Are the Board's actions motivated by the furtherance of the objectives of the corporation and enhancing the ultimate value to shareholders?

10. Does the Board communicate regularly with its shareholders and other stakeholders?

11. Does the Board establish goals for management and review their effectiveness and performance on at least an annual basis?

12. Does the Board establish guidelines for managers that clearly specify their authority?

13. Does the Board micromanage operations or, at the other extreme, does it ignore them and let management handle everything with little Board oversight?

14. Has the Board reviewed legal exposures and assessed legal compliance processes and records?

15. Does the Board receive regular reports on compliance with applicable legislation, including compliance with the Income Tax Act and the Employment Standards Act and environmental statutes?

16. Does the Board have an effective audit and financial oversight process?

17. Does the Board have effective standards and procedures to minimize and disclose potential conflicts of interest by members or officers?

APPENDIX "B"

alPHa Board of Director Duty of Care Report

The following actions are being completed on behalf of the Board of Directors of the Association of Local Public Health Agencies:

1. The payroll functions are being completed by the Haliburton, Kawartha, and Pine Ridge District Health Unit (HKPR). Included in this is the payment of Canada Pension Plan contributions, Employment Insurance contributions, Ontario Municipal Employees Retirement Plan contributions to the appropriate sources and timely remuneration of Association staff. The current contract with HKPR expires March 31, 2003.

2. The Non-Profit Information Return (R1044) is filed within six months of March 31, (year end) of each year. Activities such as trades or business are not completed ensuring the Association maintains its non-profit status. The Association is exempt from Income Tax.

3. The General Sales Tax (GST) is reconciled and filed every three months. The Association is Provincial Sales Tax (PST) exempt.

4. Adequate Board of Directors' Liability Insurance is being maintained through the timely payment of its premiums.

5. All staff is operating under the alPHa Personnel Policies at all times when performing work for the Association.

6. No other information material to the financial operation of the Association has been withheld.