2022
ORIENTATION MANUAL
FOR
BOARDS OF HEALTH

Orientation Manual for Boards of Health
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Introduction

The 2022 alPHa Orientation Manual for Boards of Health has been updated to provide new Board members with summary information on public health in Ontario and on the roles and responsibilities of a board of health.

A companion document, *Governance Toolkit for Ontario Boards of Health*, currently under construction for release later in November 2022, provides boards of health with practical tools, best practices and templates to help them govern more effectively.

Orientation Manual Content:

- What is Public Health
- Legislation and Standards governing Boards of Health (BOH)
  - Health Protection and Promotion Act (HPPA)
  - Ontario Public Health Standards (OPHS)
- Roles and Responsibilities
  - Board of Health
  - Medical Officer of Health
  - Governance
  - Guidelines for BOH members
- Board of Health Members and Structures
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- Ontario Ministry of Health
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  - Public Health Funding
- Association of Local Public Health Agencies (alPHa) and Key Stakeholders
- Appendixes
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  - History of Health Units in Ontario and Key Milestones
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Context for the November 2022 Edition

The Association of Local Public Health Agencies (alPHa) is pleased to provide the 2022 edition of the Orientation Manual for Boards of Health. The manual brings together in one place key information for board of health members. It includes information about public health and public health units; the structures, roles, and responsibilities of boards of health; and relevant legislation and the Ontario Public Standards which each Board of Health must follow.

The public health system in Ontario is characterized by a balance of local and provincial oversight that is all but unique in Canada. The importance of the local voice in the programming and delivery of public health services throughout Ontario's communities is incorporated into the structure and governance of the system itself. As a member of a board of health, you have a key role to play in keeping your community healthy, which in turn contributes to the health of the entire population.

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/priority populations, rather than individuals (i.e. population health).

It is useful to understand the public health ethical orientation as its focus is on population health rather than the acute health care system's focus on the individual. This helps understand some of the differences in practices and approaches between the public health system and the health care system in Ontario.

Public health is the organized efforts of society to keep people healthy and prevent injury, illness, and premature death. It is a combination of programs, services and policies that protect and promote the health of all Canadians. - Last, J. (2001). Dictionary of Epidemiology (4th ed.). New York: Oxford University Press.

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, community agencies and local governments to ensure long-term health for all.

Social Determinants of Health include:

- *Income and social status*
- *Housing*
- *Social support networks*
- *Access to health services*
- *Education, literacy + skills*
- *Gender*
- *Employment + working conditions*
- *Culture and race*
- *Social environments*
- *Indigenous status*
- *Physical environments*
- *Unemployment and job security*
- *Personal health practices and coping skills*
- *Social inclusion/exclusion*
- *Early childhood development*

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.

Since the implementation of the *Ontario Public Health Standards*, public health programs and services have included a stronger focus on the social determinants of health and health equity. It has been more formally recognized that the health of individuals and communities is significantly influenced by complex interactions between social and economic factors, the physical environment, and individual behaviours and conditions.

The *Ontario Public Health Standards* incorporate and address the determinants of health throughout and include a broad range of population-based activities designed to promote the health of the population and reduce health inequities by working with community partners.

Public health programs and services are delivered in communities within local health units, each of which is governed by a board of health. Boards of health are established by the authority of the *Health Protection and Promotion Act* (HPPA), and include regional municipalities, single-tier municipalities and boards prescribed by regulation. Each must respond to the unique demographic, social, economic, and geographic conditions within their health units to ensure that the health needs within their communities are met.

For the last twenty-plus years, Ontario's public health system has been on the front line of high-profile public health emergencies and events. This includes the 2000 outbreak of E. coli O157:H7 in Walkerton and the Severe Acute Respiratory Syndrome (SARS) outbreak three years later. Public health and its capacity and effectiveness were thoroughly examined through the lens of these events, which identified serious systemic deficiencies resulting from years of political neglect and underfunding in the structures that provide the programs and services that protect and promote health, prevent disease, and monitor community health. Many reports from this time provided evidence-based recommendations to improve public health's capacity and efficacy.

Three major initiatives were undertaken by the provincial government to start to strengthen the public health system. They were:

- The May 2006 release of the *Revitalizing Ontario's Public Health Capacity*, the Final Report of the Capacity Review Committee, which included 50 recommendations for the public health work force, accountability, governance and funding, strengthening local service delivery, research and knowledge exchange, strategic partnerships and next steps for the local public health sector. This report remains an excellent reference for understanding public health in Ontario and the importance of reinforcing its capacity. Many of its recommendations have been implemented, however, its recommendations on local public health restructuring were not undertaken.

- The replacement of the outdated prescriptive 1998 *Mandatory Health Programs and Services Guidelines* with the 2008 *Ontario Public Health Standards (OPHS),* a comprehensive set of evidence-based guidelines for the provision of public health services. These were revised in 2018 and updated in June 2021 *Ontario Public Health Standards* and they remain the blueprint for the activities of all boards of health throughout the province. They are also the foundation for the Public Health Accountability Framework that sets out the conditions for the receipt of the provincial government's portion of cost-shared funding. Each of these is further described below.

- The creation of a public health agency for Ontario with the mandate to focus on the provision of scientific and technical support to the provincial government, public health units and front-line health

care workers, similar to the Centers for Disease Control in the United States. In 2007, Public Health Ontario (then known as the Ontario Agency for Health Protection and Promotion, which remains its legal name) was established to "provide the scientific evidence and expert guidance that shapes policies and practices for a healthier Ontario."

These initiatives did start to strengthen the local public health system. There were some high-profile public health events such as the 2009 H1N1 pandemic and the emerging vector-borne diseases in Ontario due to climate change (e.g. West Nile, Lyme Disease).

In 2017, the province released its Expert Panel on Public Health that recommended "ways to strengthen and increase the integration of the public health sector within the rest of the health care system across the province." It was not well received by the public health and municipal sectors as it essentially recommended that the local public health system be "integrated" within the acute health care system under the 14 Local Health Integration Networks. It was not implemented as then the June 2018 provincial election happened with a change in government.

In the 2019 Ontario Provincial Budget, the province set out its plans for Public Health Modernization including the goal of establishing 10 regional public health entities and 10 new regional boards of health with one common governance model by 2020–21. After much expression of concern about this approach, the provincial government announced in the fall of 2019 that there would be a consultation on both Public Health and Emergency Health Services (Paramedics) lead by a Provincial Advisor, Jim Pine, who is the Chief Administrative Officer for Hastings County. Rather than using the terms "modernization" or "transformation" of public health, the provincial government refers to it as "Strengthening Public Health."

In 2020, the COVID-19 pandemic emerged as an ongoing global viral pandemic of coronavirus disease 2019 (COVID-19), a novel infectious disease caused by severe acute respiratory syndrome coronavirus 2. The COVID-19 Pandemic was officially announced by the World Health Organization (WHO) in March 2020 and the Ontario Premier declared a state of emergency for the province on March 17, 2020.

The provincial government amended the public health funding formula for 2020. It was announced that the funding is split 70% provincial and 30% municipal. However, the key difference between this and the former funding split of 75/25, was that the new cost-sharing formula now covers everything. Previously there was 100% provincial funding for some provincially-driven programs such as oral health, with cost-sharing only for the mandatory Ontario Public Health Standards' programs.

As of early 2021, effective COVID-19 vaccines were available to the public, although in limited amounts at the start of the roll-out. Local public health was, and is, at the forefront of working to protect Ontarians, particularly those who were especially vulnerable (i.e., seniors in long-term care homes, immunocompromised), from the serious impacts of this deadly pandemic.

As of November 2022, the COVID-19 pandemic continues with multiple waves with mutated variants of the virus. Local public health is exhausted and has reduced staff given the challenging three years with the necessary focus on the pandemic response.

These extraordinary efforts by local public health have come at the expense of nearly all the routine programs and services mandated by the *Ontario Public Health Standards* as resources were redeployed

almost exclusively to the pandemic response. This has resulted in a backlog of public health work that will have immediate and longer-term impacts on population health. alPHa documented these impacts in the February 2022 paper *Public Health Resilience in Ontario.*

Legislation Governing Boards of Health

The *Health Protection and Promotion Act* and the *Ontario Public Health Standards* that are published under its authority govern nearly all of the activities of boards of health. Summaries of these key documents are presented in this section to familiarize board of health members with these, but you are encouraged to read these in full.

Several other pieces of provincial legislation are also significant to the activities of boards of health, medical officers of health and their designates. A detailed and comprehensive itemization and description is beyond the scope of this manual, but a list of links to and brief outlines of some of the key public health-related provincial statutes are provided in Appendix 2. The provincial government's E-Laws Website provides convenient access to all of Ontario's Acts and their associated Regulations.

As a BOH member, you are encouraged to keep up to date on current legislation, including announced or proposed changes, as well as opportunities to provide input on consultations.

One of alPHa's principal roles is to keep its members informed of such changes and give opportunities to have influence. Please review alPHa's updates and policy materials to remain current.

The Health Protection and Promotion Act

The *Health Protection and Promotion Act* (HPPA) is the most important piece of provincial legislation for boards of health, as it enables their existence, structures, governance and functions, outlines the authority of the medical officers of health and boards of health, prescribes the broad responsibilities for local public health and serves as the parent legislation 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 19 different Regulations made under the HPPA, including those that govern board of health composition, qualifications of staff, food safety, swimming pool health and safety, school health, and communicable disease control.

The original Act came into force on July 1, 1984, replacing the *Public Health Act*, the *Venereal Disease Prevention Act,* and the *Sanatoria for Consumptives Act*. It has undergone over 40 revisions since that time to keep it aligned with current evidence, best practices, and changes to other pieces of legislation.

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. Part II 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.

HPPA Part II Section 5 - Mandatory health programs and services

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

1. Community sanitation, to ensure the maintenance of sanitary conditions and the prevention or elimination of health hazards.

    1.1 The provision of safe drinking water by small drinking water systems.

2. Control of infectious diseases and reportable diseases, including provision of immunization services to children and adults.
3. Health promotion, health protection and disease and injury prevention, including the prevention and control of cardiovascular disease, cancer, AIDS, and other diseases.
4. Family health, including:
    i. counselling services;
    ii. family planning services;
    iii. health services to infants, pregnant women in high-risk health categories and the elderly;
    iv. preschool and school health services, including dental services;
    v. screening programs to reduce the morbidity and mortality of diseases;
    vi. tobacco use prevention programs; and
    vii. nutrition services.

4.1 Collection and analysis of epidemiological data.

4.2 Such additional health programs and services as are prescribed by the regulations.

Part II Section 7 further serves the current approach by empowering the Minister of Health to publish standards for the provision of these mandatory programs and services. The first *Mandatory Health Programs and Services Guidelines* were published in 1984, with revisions for 1998, 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 and were again revised for 2018 and 2021. In both cases, this was accomplished with extensive support and input from Ontario's public health professionals. The OPHS are supported by protocols, guidance documents and toolkits that public health staff use to implement effective health promotion and protection programs locally.

The Nine Parts of the *Health Protection and Promotion Act*

Part I - Interpretation
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 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 under Section 9.

Part III - Community Health Protection
Provisions relating 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 for its duties under the Act (s. 72), but also enables the province to make offsetting grants (s.76). It also includes rules for the appointment of the MOH.

P*art VI.1- Provincial Public Health Powers*
This is the latest legislative addition from 2011. It provides that the Chief Medical Officer of Health, when they are of the opinion that a situation exists anywhere in Ontario that constitutes or may constitute a risk to the health of any persons, to act with the powers of a Board of Health or Medical Officer of Health, and where there is an immediate risk to the health of persons provide directives to any health care provider or health care entities respecting precautions and procedures to be followed to protect the health of persons. It also outlines where the CMOH shall consider the precautionary principle, order the provision of information, and where the Minister may make an order for the emergency procurement of medications and supplies.

Part VII - Administration
Noteworthy provisions under this part include empowering the Minister to ensure that boards of health comply with the Act; the establishment of public health labs; the appointment, qualifications, and duties of the Chief Medical Officer of Health; 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.

For your reference:
Health Protection and Promotion Act and HPPA Associated Regulations
Please click on the middle tab for the regulations.

Ontario Public Health Standards: Requirements for Programs, Services and Accountability

The *Ontario Public Health Standards* (OPHS) are province-wide standards that steer the local planning and delivery of public health programs and services by boards of health. They set minimum requirements for fundamental public health programs and services targeting the prevention of disease, health promotion and protection, and community health surveillance. These are published by the Minister of Health 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 provided. The OPHS are mandatory and they ensure the maintenance of minimum standards for core public health programs and services for all Ontario.

The OPHS set the policy foundation for public health programs and services through 90 outcome-focused requirements spread across four foundational standards and nine programs standards. Rather than measuring performance through compliance, they are meant to enable and demonstrate public health's contribution to population health outcomes through population health assessment and evidence-informed and risk-based approaches to improving it. They are also the basis for the accountability framework that sets out the conditions under which boards of health receive the provincial share of local public health funding.

Public health's impact on population health is realized through a multitude of activities on a wide range of issues, often in partnership with other organizations. Clinical service delivery (where appropriate for a population-based approach), education, inspection and surveillance, advocacy, policy development and enforcement of legislation are among the required activities undertaken by the sector every day. Each is focused on the upstream prevention of poor health outcomes. Ontario's local public health system reflects the diversity of Ontario's population, and the OPHS therefore recognizes the disparate demographic, geographic, economic, and social conditions under which the 34 boards of health operate and provides the flexibility required for local planning and service delivery.

The following infographic is taken from the 2018 edition of the OPHS. It outlines the core functions of public health (assessment and surveillance, health promotion and policy development, health protection, disease prevention, and emergency management) across four domains (Social Determinants of Health, Healthy Behaviours, Healthy Communities and Population Health Assessment) that are guided by four principles (Need, Impact, Capacity, and Partnership, Collaboration and Engagement). In so doing, it illustrates the contribution of public health to improving population health outcomes.

Figure 2: Policy Framework for Public Health Programs and Services

Goal	To improve and protect the health and well-being of the population of Ontario and reduce health inequities			
Population Health Outcomes	• Improved health and quality of life • Reduced morbidity and premature mortality • Reduced health inequity among population groups			
Domains	**Social Determinants of Health**	**Healthy Behaviours**	**Healthy Communities**	**Population Health Assessment**
Objectives	To reduce the negative impact of social determinants that contribute to health inequities	To increase knowledge and opportunities that lead to healthy behaviours	To increase policies, partnerships and practices that create safe, supportive and healthy environments	To increase the use of population health information to guide the planning and delivery of programs and services in an integrated health system
Programs and Services	**Goals** • To increase the use of public health knowledge and expertise in the planning and delivery of programs and services within an integrated health system • To reduce health inequities with equity focused public health practice • To increase the use of current and emerging evidence to support effective public health practice • To improve behaviours, communities and policies that promote health and well-being • To improve growth and development for infants, children and adolescents • To reduce disease and death related to infectious, communicable and chronic diseases of public health importance • To reduce disease and death related to vaccine preventable diseases • To reduce disease and death related to food, water and other environmental hazards • To reduce the impact of emergencies on health			
Principles	**Need** • Assess the distribution of social determinants of health and health status • Tailor programs and services to address needs of the health unit population	**Impact** • Assess, plan, deliver, and manage programs and services by considering evidence, effectiveness, barriers, and performance measures	**Capacity** • Make the best use of available resources to achieve the capacity required to meet the needs of the health unit population	**Partnership, Collaboration and Engagement** • Engage with multiple sectors, partners, communities, priority populations, and citizens • Build and further develop the relationship with Indigenous communities. These relationships may take many forms and need to be undertaken in a way that is meaningful to the particular community and/or organization

Protecting and Promoting the Health of Ontarians: Ontario Public Health Standards: Requirements for Programs, Services, and Accountability (2018, revised June 2021). ISBN 978-1-4868-0928-8 (PDF) Queen's Printer of Ontario (p.8)

What Public Health Does: OPHS Foundational and Program Standards

Foundational Standards

The four Foundational Standards outline requirements that are common to each of the subsequent Program Standards:

1. *Population Health Assessment*: measurement, monitoring, analysis, and interpretation of population health data to ensure that public health responses to current and evolving conditions are effective, and to improve population health with programs and services that are informed by the population's health status, including social determinants of health and health inequities.

2. *Health Equity*: assessment of the social determinants of health to foster understanding of the impact of various social constructs within their communities, help identify priority populations and tailor programs to meet their needs so that all people can reach their full health potential regardless of race, ethnicity, religion, gender, age, social class, socioeconomic status or other socially determined circumstance. This is also the springboard for the priority of Indigenous engagement and delivering public health programs to Indigenous people.

3. *Effective Public Health Practice*: the application of skills in evidence-informed decision-making, research, knowledge exchange, program planning and evaluation, and communication, to ensure that public health practice is transparent, responsive to current and emerging evidence, and emphasizes continuous quality improvement.

4. *Emergency Management:* effective emergency planning ensures that boards of health are resilient and prepared to respond to and recover from threats to public health or disruptions to public health programs and services.

Program Standards

1. *Chronic Disease Prevention and Well-Being:* Reduction of the burden of chronic diseases (e.g. obesity, heart and respiratory diseases, diabetes, mental illness, and addictions) through a comprehensive health promotion approach that addresses risk and protective factors in areas such as built environment, healthy eating, healthy sexuality, mental health promotion, oral health, physical activity, and sleep.

2. *Food Safety:* reduction of the burden of food-borne illnesses through detection and response to food-borne illness and associated risk factors, promotion, and enforcement of safe food-handling practices, and respond to food-related issues that may arise from floods, fires, and power outages.

3. *Healthy Environments:* reduction of exposure to health hazards and promotion of the development of healthy environments that support health and mitigate existing and emerging risks, including the impacts of a changing climate. This includes addressing local needs related to healthy built and natural environments, exposure to hazardous environmental contaminants and biological agents, exposure to radiation including UV light and radon, extreme weather, indoor and outdoor air pollutants, and other emerging environmental exposures.

4. *Healthy Growth and Development*: achievement of optimal preconception, pregnancy, newborn, child, youth, parental, and family health. Topic areas for this standard include breastfeeding, healthy pregnancies, healthy sexuality, mental health promotion, oral health, preconception health, pregnancy counselling, preparation for positive parenting and visual health. This is also the area that mandates the provision of the Healthy Babies, Healthy Children program.

5. *Immunization*: reduction or elimination of the burden of vaccine-preventable diseases through immunization by ensuring that children have up-to-date immunizations in accordance with recommendations and legislated requirements (e.g. *Immunization of School Pupils Act*), promotion of immunization programs for all ages and the importance thereof, outbreak management of vaccine preventable diseases, and oversight of provincially-funded vaccine inventory management (storage and distribution requirements).

6. *Infectious and Communicable Diseases Prevention and Control*: reduction of the burden of communicable diseases and other infectious diseases of public health importance through detection, investigation and management of risks and exposures and public communications and awareness strategies. Public health has specific responsibilities for surveillance, outbreak and case management, control of specific diseases such as rabies and tuberculosis, promoting and enforcing infection control practices, and working with community partners to prevent diseases transmitted sexually or through injection drug use.

7. *Safe Water*: prevention or reduction of the burden of water-borne illnesses and injuries related to drinking water and recreational water use. This includes surveillance of drinking water systems, public beaches, swimming pools, spas, and splash pads. Training of operators, enforcement of related regulations and public notification of risks to health from adverse drinking or recreational water are key public health activities.

8. *School Health*: achievement of optimal health of school-aged children and youth through partnership and collaboration with school boards and schools though health assessments and the implementation of strategies to address health inequities and other factors that affect healthy growth and development. Public health has defined responsibilities in the areas of oral health, vision screening (new in 2018) and childhood immunizations as well as supporting activities related to concussion and injury prevention, healthy eating and physical activity, mental health promotion, UV exposure and many others.

9. *Substance Use and Injury Prevention*: reduction of the burden of substance use (including tobacco, opioids, e-cigarettes, alcohol, cannabis) through comprehensive tobacco control programs, supporting access to substance use harm reduction programs, mental health promotion and strategies to prevent youth initiation; reduction of the burden of preventable injuries through programs that address such things as concussions, falls prevention, road safety and violence.

Strengthened Accountability: Public Health Accountability Framework and Organizational Requirements

The 2018 OPHS is the first one that embeds a formal accountability framework that supports an effective accountability relationship between boards of health and the Ministry of Health (MOH) through the clear articulation of the latter's expectations and the requirement of the former to report on the work they do, how they do it, and the outcomes.

The stated objectives are to ensure that boards of health have the necessary foundations for the delivery of programs and services, financial management, governance, and public health practice; to support a strong public health sector; and to provide evidence of the value of public health and its contribution to population health outcomes leading to better health for Ontarians.

Detailed expectations, organizational requirements and reporting mechanisms are laid out in section 3 of the OPHS, but the principal obligations for all the Common Domains are as follow:

1. The board of health shall submit an Annual Service Plan and Budget Submission to include all programs and services delivered by boards of health and program costing for Ministry-funded programs.

2. The board of health shall submit action plans as requested to address any compliance or performance issues.

3. The board of health shall submit all reports as requested by the Ministry.

4. The board of health shall have a formal risk management framework in place that identifies, assesses, and addresses risks.

5. The board of health shall produce an annual financial and performance report to the general public.

6. The board of health shall comply with all legal and statutory requirements.

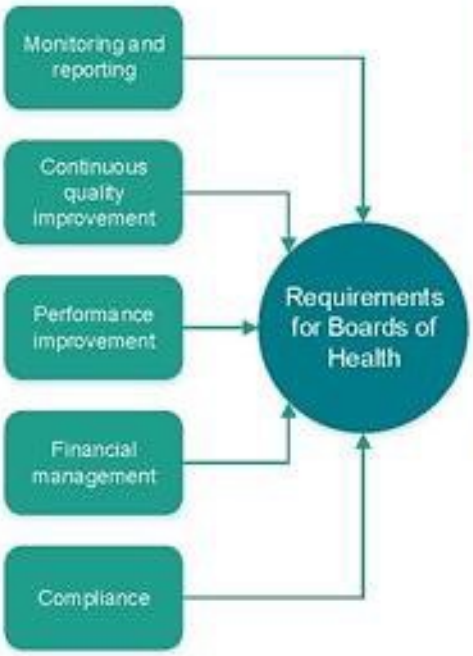
The following infographic illustrates the various expectations and reporting mechanisms that are features of the framework:

Figure 5: Public Health Accountability Framework

The Accountability Framework is composed of four Domains

Domain	Delivery of Programs and Services	Fiduciary Requirements	Good Governance and Management Practices	Public Health Practice
Objectives of Domain	Boards of health will be held accountable for the delivery of public health programs and services and achieving program outcomes in accordance with ministry published standards, protocols, and guidelines.	Boards of health will be held accountable for using ministry funding efficiently for its intended purpose.	Boards of health will be held accountable for executing good governance practices to ensure effective functioning of boards of health and management of public health units.	Boards of health will be held accountable for achieving a high standard and quality of practice in the delivery of public health programs and services.

Organizational Requirements incorporate one or more of the following functions:



The Accountability Framework is supported by:

Accountability Documents	• **Organizational Requirements:** Set out requirements against which boards of health will be held accountable across all four domains. • **Ministry-Board of Health Accountability Agreement:** Establishes key operational and funding requirements for boards of health.
Planning Documents	• **Board of Health Strategic Plan:** Sets out the 3 to 5 year local vision, priorities and strategic directions for the board of health. • **Board of Health Annual Service Plan and Budget Submission:** Outlines how the board of health will operationalize the strategic directions and priorities in its strategic plan in accordance with the Standards.
Reporting Documents	• **Performance Reports:** Boards of health provide to the ministry regular performance reports (programmatic and financial) on program achievements, finances, and local challenges/issues in meeting outcomes. • **Annual Report:** Boards of health provide to the ministry a report after year-end on the affairs and operations, including how they are performing on requirements (programmatic and financial), delivering quality public health programs and services, practicing good governance, and complying with various legislative requirements.

Protecting and Promoting the Health of Ontarians: Ontario Public Health Standards: Requirements for Programs, Services, and Accountability (June 2021). ISBN 978-1-4868-0928-8 (PDF) Queen's Printer of Ontario (p.61)

Transparency and Demonstrating Impact: Public Health Indicator Framework and Transparency Framework

In addition to the accountability planning and reporting tools, the 2018 OPHS has embedded a requirement to monitor progress and measure success of boards of health using public health indicators. These are intended to measure the impacts of mandated public health programs and services.

Some of these are set at the provincial level to measure outcomes in all public health units. Others will be established by local boards of health for the standards that are aimed at responding to local needs, priorities, and contexts (i.e., Chronic Disease Prevention and Well-Being, Healthy Growth and Development, School Health, and Substance Use and Injury Prevention). The broad categories of measurable population health outcomes include improved health and quality of life, reduced morbidity and premature mortality, and reduced health inequities.

The following infographic summarizes the components of this framework:

Figure 6: Public Health Indicator Framework for Program Outcomes and Contributions to Population Health Outcomes

Goal	To provide an evidence-informed basis for monitoring progress and measuring success of boards of health in achieving program outcomes, and understanding the contribution to population health outcomes
Objectives	• Monitoring progress in the delivery of public health programs and services • Measuring board of health success in achieving program outcomes • Assessing public health's contributions to population health outcomes

Program Outcomes	
Focus Area	**Indicators and Information**
Chronic Disease Prevention and Well-Being; Healthy Environments; Healthy Growth and Development; School Health; Substance Use and Injury Prevention	• Locally determined program outcome indicators Indicators will be developed in accordance with locally determined programs of public health interventions
Food Safety	• Proportion of food premises that shift between moderate and high risk based on annual risk categorization assessment • Percentage of Salmonella and E. Coli foodborne outbreaks investigated for which a probable source was identified • Incidence of reportable Salmonella, Campylobacter and E. Coli foodborne illness cases
Immunization	• Percentage of 7 and 17 year olds whose vaccinations are up-to-date for all *Immunization of School Pupils Act* (ISPA) designated diseases • Percentage of grade 7 students whose vaccinations are up-to-date for Hepatitis B, Meningococcal and HPV (12 and 13 year olds) • Percentage of public health units that meet the provincial reporting rate for adverse events following immunization (AEFI) for the three vaccines administered through school-based programs (HPV, Meningococcal, and Hepatitis B)
Infectious and Communicable Diseases Prevention and Control	• Incidence rate of Hepatitis C, Gonorrhea, and Syphilis • Percentage of active respiratory Tuberculosis (TB) cases that complete recommended treatment
Safe Water	• Percentage of re-inspections of spas per year • Percentage of recreational water premises with no critical infractions in the last year (pools, spas, wading pools, splash pads, and receiving basins for water slides)
Contributions to Population Health Outcomes	
Improved Health & Quality of Life	• Adoption of healthy lifestyle behaviours • Perceived health • Health expectancy • Life satisfaction
Reduced Morbidity and Mortality	• Overweight/Obesity • Incidence and prevalence of chronic diseases • Chronic disease and substance use related morbidity and mortality • Life expectancy • Avoidable deaths • Infant mortality • Small for gestational age • Rate per 100,000 of VPD outbreaks by disease • Incidence rates of reportable VPDs • % of the public with confidence in immunization programs

Reducing Health Inequities among Population Groups	• Relative index of inequality associated with:
	  ○ Chronic Diseases
	  ○ Injuries
	  ○ Substance Use
	  ○ Healthy Growth and Development
	• Vulnerability associated with:
	  ○ Early development
	  ○ School readiness
	• Deprivation Index
	• Food Security
	• Disability Rates

Protecting and Promoting the Health of Ontarians: Ontario Public Health Standards: Requirements for Programs, Services, and Accountability (2018, June 2021). ISBN 978-1-4868-0928-8 (PDF) Queen's Printer of Ontario (p.74).

The 2018 OPHS has also embedded a Transparency Framework, which is meant to increase transparency in the public sector and promote public confidence in the public health system.

This is achieved through requirements of boards of health to disclose information to the public that supports making informed decisions to protect their health (e.g. restaurant inspection reports, drinking water advisories, infection control lapses) and reports on the activities of boards of health and associated level of investment (e.g. annual reports, strategic plans). The following infographic summarizes the components of this framework:

Figure 7: Draft Transparency Framework[23]

Goal	Promote awareness, understanding, and public confidence in Ontario's public health system.	
Domains	**Protecting the Public's Health**	**Public Reporting**
Objectives	The public knows of the work of public health to protect and promote individual and community health	The public knows how Boards of Health are responding to local community needs

BOH Responsibilities	Post on the board of health website:
	• Results of routine and complaint based inspections of:
	  ○ Food Premises
	  ○ Public Pools and Spas
	  ○ Recreational Water Facilities
	  ○ Personal Services Settings
	  ○ Tanning Beds
	  ○ Recreational Camps
	  ○ Licensed Child Care Settings
	  ○ Small Drinking Water Systems
	• Convictions of tobacco and e-cigarette retailers
	• Infection prevention and control lapses
	• Drinking water advisories for small drinking water systems
	• Status of beach water quality
		Post on the board of health website:
		• Strategic Plan
		• Annual performance and financial report

[23]The Transparency Framework is draft and subject to change.

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Protecting and Promoting the Health of Ontarians: Ontario Public Health Standards: Requirements for Programs, Services, and Accountability (2018, June 2021). ISBN 978-1-4868-0928-8 (PDF) Queen's Printer of Ontario (p.75).

Roles and Responsibilities

The Board of Health

As summarized above, The *Health Protection and Promotion Act* provides the authority to local boards of health to control communicable disease and other health hazards in their communities and the *Ontario Public Health Standards* describe in detail how this authority is to be exercised.

In carrying out its mandate, the governing body must 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 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 MOH as described above.

The primary functions of the BOH are to provide good governance and strategic leadership to the organization. It is important to note that while the BOH works closely with the MOH/CEO, it is the MOH/CEO's responsibility to lead the public health unit in achieving board-approved directions. Therefore, the responsibility for the day-to-day management and operations of the health unit lies with the MOH/CEO.

The Board of Health:

- establishes general policies and procedures which govern the operation of the health unit and provide guidance to those empowered with the responsibility to manage health unit operations;
- upholds provincial legislation governing the mandate of the BOH under the *Health Protection and Promotion Act* and others;
- ensures accountability to the community by ensuring that its health needs are addressed by the appropriate programs and ensuring that the health unit is well-managed;
- ensures program quality and effectiveness and financial viability;
- establishes overall objectives and priorities for the organization in its provision of health programs and services, to meet the needs of the community;
- hires the MOH and associate medical officer(s) of health with approval of the Minister;
- assesses the performance of the MOH and associate medical officer(s) of health;
- assesses the Board's own performance and ensures Board effectiveness; and
- follows the requirements of the MOHLTC Public Health Accountability Framework.

The Medical Officer of Health

Every board of health is required by Section 62(1)(a) of the HPPA to appoint a full-time, fully qualified medical officer of health (MOH) without exception. The MOH reports to the BOH and is primarily responsible for public health programs and services to the board of health.

As such, the MOH:

- reports directly to the board of health on issues relating to public health concerns and to public health programs and services under the HPPA or any other Act;
- provides policy advice to the BOH;
- directs employees of and others whose services are engaged by a board of health whose duties relate to the delivery of mandated public health programs and services;
- accountable to the board for day-to-day operations of the health unit;
- supervises and evaluates performance of senior staff and advises or assists department heads in hiring staff;
- encourages and promotes the continuing education of all staff;
- evaluates the effectiveness of programs and services;
- recommends appropriate changes and reports these findings regularly to the board; and
- engages on issues relating to local health system planning, funding, and service delivery with the local Ontario Health Team(s) where the geographic area intersects with the public health unit in whole or in part.

In most boards of health (about two-thirds), the MOH serves the dual function of MOH and Chief Executive Officer (CEO) of the board of health. In the others, the MOH and CEO (or CAO in some cases) are separate positions, where the former takes on more responsibility for the administrative and operational aspects of the agency. The BOH determines the roles and responsibilities of these positions.

To ensure that the intent of section 67 of the HPPA is consistently applied across all boards of health (i.e. that the MOH reports directly to the BOH on matters related to public health in all cases) the Ministry requires the following (extracted from the 2018 MOHLTC *Policy Framework on Medical Officer of Health Appointments, Reporting, and Compensation, p.4*):

- that the MOH have a direct reporting relationship to the board of health (i.e., a solid line for matters of public health significance/importance on the organizational chart regardless of the board of health governance model);
- that the MOH be part of the senior management team;
- that staff responsible for the delivery of public health programs and services under the HPPA or any other Act must report directly to the MOH without any need to report to intermediaries (i.e., a solid line relationship between staff and the MOH).

Governance

Governance can be thought of as the stewardship or oversight of the affairs—particularly the strategic direction—of an organization. The BOH, acting in its governance role, sets the desired goals for the organization and establishes the systems and processes to support achievement of those goals.

Critical elements of an effective public health unit governance policy framework include:

- principles of governance and BOH accountabilities;
- statement of the BOH's obligations to act in the best interest of the public health unit;
- defined roles and responsibilities of the BOH;
- defined roles and responsibilities of individual BOH members, including a code of conduct;
- guidelines for the selection of BOH members;
- a range of specific skills and expertise;
- standing and ad hoc committees that support the BOH;
- clear differentiation between governance and management;
- maintaining focus on strategic leadership and direction; and
- self-evaluation and continuous quality improvement.

As outlined in the Public Health Legislation section above, each of these elements will be defined within the context of the prescriptive provincial policies that are laid out in the HPPA, OPHS and related documents that each BOH is obliged to follow. alPHa's Governance Toolkit expands upon the above by giving guidance, practical tools and templates to help BOHs govern more effectively.

Guidelines for Board of Health Members

A member of a BOH should:

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

Board of Health Members and Structures

BOH Members

There are three categories of BOH members:

1. **Elected Officials or Municipal Appointments**. These may be appointed to an autonomous BOH to represent their municipality. In the case of the seven regional boards of health, Regional Council acts as the BOH and all members are elected officials. In other boards, some municipalities may select to appoint a community representative, rather than a municipal elected member, to the BOH who then works with the municipality who appointed them.

2. **Public Appointees**. The composition of autonomous BOHs is outlined in Section 49 of the HPPA. Section 49(3) provides for the appointment of one or more provincial members by the Lieutenant Governor in Council (Provincial Cabinet). Applications to be a provincial member on a BOH can be made through to the Ontario Public Appointments Secretariat. Board vacancies are posted to this provincial website.

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

BOH Structures

Autonomous

In autonomous BOHs, the administrative structures of the public health unit and the municipality or municipalities are separate. Most autonomous boards of health have multiple obligated municipalities with representation on the BOH. Some may have citizen representatives appointed by municipalities and/or public appointees. When there are a number of municipalities represented on a board, the municipalities themselves may work out a rotating schedule of representation so that all obligated municipalities have an opportunity to be on the board regularly. There is also a category is known as "Autonomous/ Integrated," where only one municipality appoints representatives and operations are integrated with the municipality's administrative structure. There are 24 autonomous BOHs in Ontario:

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

**autonomous/integrated*

Regional

In a Regional BOH, staff operates under the administration of regional government (also known as an upper-tier municipality with lower tier municipalities within the regional boundaries). Regional boards of health have no citizen representatives and no public appointees.
The 6 regional boards of health in Ontario are:

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

Single-Tier / Semi-Autonomous

In Single-Tier municipalities (where the municipal has both lower and upper tier responsibilities), municipal councils serve as the board of health and the staff of the health unit operates under the municipal administrative structure. A subset of this category is “Semi-Autonomous,” in which the municipal council appoints members to a separate board of health but retains authority for budget and staffing approvals.

Presently, there are 4 municipal boards of health, two of which are Semi-Autonomous and 2 of which have municipal council acting as the BOH. They have no provincial appointees and the 2 cases where the BOH is independent of municipal council, citizen appointees are possible.

- Haldimand-Norfolk - Council acts as BOH
- Hamilton - Council acts as BOH
- Ottawa - Semi-Autonomous
- Toronto - Semi-Autonomous

Public Health Unit Map

The Ministry of Health

Minister

The Minister of Health is the cabinet member with the portfolio for public health and is the lead minister named in public health-related legislation. Under the HPPA, the Minister of Health is given the authority to publish guidelines for the provision of mandatory health programs and services (the OPHS), to make regulations related to controlling diseases of public health significance, to make appointments of public health staff (e.g. medical officers of health, inspectors) and exercise certain powers in the case of emergencies.

Section 76 of the HPPA gives the Minister the power to make discretionary grants for the purposes of the HPPA on such terms and conditions as the Minister considers appropriate. This is the authority under which provincial grants are used to fund boards of health, which are in turn governed by the conditions of the Accountability Framework described above.

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

The Minister must approve all MOH and Associate MOH appointments, as well as any dismissal of a MOH or an Associate MOH by the BOH as part of the set-out process for such a dismissal.

Office of the Chief Medical Officer of Health

The Ontario Chief Medical Officer of Health (CMOH) has the critical role in leading the public health system as a whole–focusing on their legislated role in *the Health Protection and Promotion Act*, linking with Public Health Ontario and providing public health advice both within and beyond government. This includes the provision of advice and direction to boards of health, medical officers of health and to the people of Ontario. The CMOH is both appointed by the Ontario Legislature for a five-year term while is also an Assistant Deputy Minister within the Ministry of Health.

Within the Ministry, the Office of Chief Medical Officer of Health is responsible for determining provincial public health needs, developing public health initiatives and strategies, and monitoring public health programs delivered by Ontario's local public health units (described below). Ontario's public health programs focus on disease prevention and control, screening for health conditions, and public education on health matters such as communicable diseases and healthy living.

The CMOH reports directly to the Deputy Minister of Health. The Office of the CMOH works to ensure that appropriate actions are taken to respond to urgent and emergency situations. It engages with local, national, and international partners to develop public health strategies. It advises other parts of government on the potential health impacts of government initiatives, and they provide training and other supports to advance Ontario's public health system. (Sourced from the Ontario Public Health System | Public Health Ontario).

The CMOH powers, when of the opinion that a situation exists anywhere in Ontario that constitutes or may a risk to the health of any persons, under the HPPA includes:

- Investigate and take any action they consider appropriate to prevent, eliminate or decrease the risk
- act anywhere in Ontario with the powers of a BOH or MOH;
- request information from a BOH;
- issue a directive to any health care provider or health care entity respecting precautions and procedures to be followed to protect the health of persons;
- provide written information to the MOH Minister so they can order emergency procurement of medications and supplies;
- that they, and ensure provision of, required public health programs not being provided by a BOH;
- investigate, advise, guide and, if remedial action is not taken, issue a written direction in cases where the Minister of Health is of the opinion that a BOH has failed to comply with the Act, its regulations or provincial program standards. If the BOH fails to comply with the direction, the CMOH may act on behalf of the BOH;
- investigate situations, which, in the opinion of the Minister of Health, 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.

The Office of the Chief Medical Officer/Public Health Division is headed by the CMOH. There are 5 branches within the Division that report to the Executive Lead, Public Health. The five branches are:

- *Accountability and Liaison Branch*
- *Health Promotion and Prevention Policy and Programs Branch*
- *Health Protection and Surveillance Policy and Programs Branch*
- *Immunization*
- *Strategy and Planning Branch*

The *Health System Emergency Management Branch,* which formerly was under the Office of the CMOH/Public Health Division, is now under the Pandemic Response and Recovery Division as it serves the entire health system—both the health care and public health systems.

Current Ministry of Health Organizational Chart

Provincial Government's Public Health Web Page

Public Health Funding

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

72. (1) The obligated municipalities in a health unit shall pay,

(a) the expenses incurred by or on behalf of the board of health of the health unit in the

performance of its functions and duties under this or any other Act; and

(b) the expenses incurred by or on behalf of the medical officer of health of the board of health in the performance of his or her functions and duties under this or any other Act. 1997, c. 30, Sched. D, s. 8.

(2) In discharging their obligations under subsection (1), the obligated municipalities in a health unit shall ensure that the amount paid is sufficient to enable the board of health,

(a) to provide or ensure the provision of health programs and services in accordance with sections 5, 6 and 7, the regulations and the guidelines; and

(b) to comply in all other respects with this Act and the regulations. 1997, c. 30, Sched. D, s.8.

This means that the obligated municipalities within a health unit are legally 100% responsible for funding the costs of delivering public health programs and services. That said, Section 76 of the HPPA states the following:

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

This enables the Province to provide funding for these programs and services, and it has traditionally done so as a matter of policy, but it is not under the same legal obligation as the municipal governments for funding local public health.

To illustrate, prior to 1997, funding responsibility for public health was shared by the Province (75%) and municipalities (25%). 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 through amending the HPPA, but this lasted little more than a year. Without amending the HPPA, in March 1999, the Province announced that a grant of up to 50% would be provided to help offset the costs on the obligated municipalities. The 50/50 cost-sharing arrangement continued until 2005. In 2004, the Province announced an incremental increase to its funding share, to 55% in 2005, 65% in 2006, and 75% in 2007.

For 2020, the provincial government amended this long-standing public health funding formula. It was announced that the funding is split 70% provincial and 30% municipal. However, the key difference between this and the former funding split of 75/25, was that the new cost-sharing formula now covers everything. Previously there was 100% provincial funding for some provincially-driven programs such as oral health, with cost-sharing only for the mandatory Ontario Public Health Standards' programs.

Given to the needed provincial COVID-19 mitigation funding to keep local public health whole during the ongoing pandemic, the full 2020 funding changes and their impacts have not been fully realized to date, although it is a huge overwhelming concern for all local public health agencies. It is alPHa's position that the 75-25% OPHS funding and the 100% funding for provincial programs should be restored.

It is worth noting that growth limitations imposed by the Province on increases to the Ministry share of the contribution in the intervening years have resulted in an erosion of the total funding envelope and

in many cases boards of health have contributed more than 25% to offset shortfalls.

Association of Local Public Health Agencies www.alphaweb.org

Who We Are

Established in 1986, the Association of Local Public Health Agencies (alPHa) is the non-profit organization that provides leadership to Ontario's public health units and their boards of health.

A Strong Association

alPHa's mission statement is to, through a strong and unified voice, advocate for public health policies, programs, and services on behalf of member health units in Ontario. The strength and unity of this voice is best served when all of Ontario's communities are represented. alPHa is currently enjoying unprecedented recognition and credibility in many public policy discussions, and its voice is strong as the representative of all 34 Ontario health units.

alPHa works closely with the senior leadership of its member health units, including board of health members, medical and associate medical officers of health, and senior public health managers in each of the following public health disciplines:

- nursing
- inspection
- dentistry
- nutrition
- epidemiology
- health promotion
- business administration

alPHa represents the interests of member public health units and lends expertise to members on the governance, administration and management of public health units and their boards of health. The Association also works with governments and other health organizations, advocating for healthy public policy and a strong, effective, and efficient public health system in Ontario.

What We Do

Through policy analysis, discussion, partnership and advocacy, alPHa's 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. alPHa also provides member benefits such as group plans, networking opportunities, and recognition, to name just a few. Here are key activities that we engage in as the voice of Ontario's public health units:

Advocacy – alPHa communicates on behalf of members on public health matters to government and decision-makers. It also develops and disseminates positions and reports on key public health issues and

relevant legislation.

Communications – alPHa keeps members informed on the latest news and events as well as emerging issues.

Education – alPHa holds timely and informative sessions on matters affecting the governance and delivery of public health programs and services.

Representation – alPHa representatives participate on key public health working groups and committees.

Members of alPHa

Membership is open to all Ontario public health units and their boards of health. Representatives from member public health units include:

- board of health members
- medical and associate medical officers of health
- senior public health managers in nursing, inspection, dentistry, nutrition, epidemiology, health promotion and business administration

alPHa's members also comprise of the following Affiliate Organizations:

- Association of Ontario Public Health Business Administrators (AOPHBA)
- Association of Public Health Epidemiologists in Ontario (APHEO)
- Association of Supervisors of Public Health Inspectors of Ontario (ASPHIO)
- Health Promotion Ontario (HPO)
- Ontario Dietitians in Public Health (ODPH)
- Ontario Association of Public Health Dentistry (OAPHD)
- Ontario Association of Public Health Nursing Leaders (OPHNL)

Benefits of Membership with alPHa

alPHa delivers good value to its members through the use of its resources. alPHa does not receive funding from the government of Ontario. We are funded through our members, sponsors, and events. The financial support we receive from our members accounts for 70 percent of our annual budget, so it is top priority to show good value for their membership fees. Our members are the boards of health and local public health units in Ontario and we maintain a strong focus on their collective needs.

Through participation in alPHa, members are better positioned to do their jobs locally and have the opportunity to participate at the provincial level to help shape the future of the local public health system in Ontario. As transformation of local public health continues to be considered by the Province, there has never been a better time to be a member of alPHa.

Recognizing that health unit resources vary across the province, alPHa's membership requirements are

graded to ensure that any board of health in Ontario can enjoy all of the membership benefits equitably and have access to member services such as advocacy, communications, education, and professional development.

WHAT WE DO FOR OUR MEMBERS

Promote

alPHa supports its members to be better understood and valued by municipal and provincial governments. We create communications tools that are designed to inform municipal politicians about local public health and encourage their interest in participating on boards of health. We meet with provincial policy advisors and senior government staff to ensure they understand the role, value, and expertise of local public health.

Represent

alPHa communicates health units' issues, concerns, and solutions on public health matters to government and decision-makers. It facilitates joint meetings between members and provincial decision-makers to share information and expertise to improve Ontario's public health system. alPHa focuses on representing its members in responding to member resolutions and public health sector issues where a collective voice best serves the membership as a whole; e.g., issues that impact the structure and funding of local public health. alPHa is regularly invited to identify members for provincial or partner committees addressing issues of primary importance for local public health.

alPHa maintains strong relationships with key partners, stakeholders and decision makers who impact our members.

Support

alPHa ensures that members are aware of proposed legislation and matters that are of interest to public health units. alPHa facilitates the sharing of member positions, resolutions, and discussion documents to encourage broader support for member issues among alPHa's membership.
alPHa has established the "Current Consultations" page on its web site where information is posted about government consultations. Members are informed and provided links through email and alPHa's "Information Break" e-newsletter. alPHa has also established a web page for posting existing and proposed health promoting local by-laws, categorized by social determinants of health.

Connect

alPHa works with members to coordinate networking opportunities for public health professionals working in local public health. alPHa has established web-based approaches for the sharing of information wherever possible, for example providing work space for working groups to post information. alPHa also helps members in their day-to-day jobs, by keeping members informed on latest news and events as well as emerging issues through current technologies, including our website, e-newsletters, and group mailing lists.

Enrich

alPHa provides professional development to support excellence in public health leadership and public

health unit management and governance professional development is delivered throughout the year through an annual conference, symposiums, and other educational opportunities. alPHa holds timely, relevant, and informative sessions and programs to enrich members' knowledge on issues, developments and challenges affecting the delivery of public health programs and services.

HOW WE DO IT

A 21-member Board of Directors oversee alpha's business, consisting of 7 medical officers of health or associate medical officers of health, 7 board of health trustees and representation from each of the 7 public health disciplines listed above. All regions of the province are represented to ensure that all communities' interests can be served. The Board meets at least 5 times each year to discuss emerging and ongoing issues in public health policy, governance, funding, and programs and services.
alPHa also conducts regular meetings of its **Boards of Health Section** and **Council of Medical Officers of Health** (COMOH) to discuss issues particular to their positions. In addition, ad hoc committees are frequently assembled to discuss action plans for Association Resolutions, as well as emerging issues raised by members, public, government or media. These committees often provide the opportunity for wider participation in alPHa business by interested health unit staff with expertise in the operational and programmatic aspects of these issues. In addition, alPHa's Affiliate members frequently meet and contribute to alPHa's public policy efforts.

alPHa 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.

Our staff regularly consults with other partners in the health and policy sector, including government ministries, Public Health Ontario, the Association of Municipalities of Ontario, the Ontario Medical Association and Ontario Health.

VALUE-ADDED BENEFITS OF MEMBERSHIP

❖ Member Services

- **Electronic mailing lists**: interactive e-mail lists where members can seek advice from colleagues and send and receive information instantly throughout the province. It also allows alPHa staff to request and receive broad input from each of its members when formulating its positions.
- **alPHaWeb**: our website, www.alphaweb.org, includes extensive resources on public health issues, information about alPHa, links to the web presence of each of its members, and job postings. Secure Members' Areas are also available for the posting of non-public material such as meeting information.
- **Educational opportunities**: seminars, workshops, and general meetings as described above.

❖ Products

- **Directories**: alPHa updates its online *Directory of Public Health Agencies*, which contains contact information for each of Ontario's health units, including sub-offices and direct lines for senior management staff.

- **Group Affinity Programs**
  alPHa periodically negotiates group rates for member health units and their employees including group rates on personal home and auto insurance

AT YOUR SERVICE

The alPHa Staff is a small professional team and is responsive and capable. Through the Executive Director, staff support the governance role of the alPHa Board as well as the policy, representation, communications, member services and professional development work alPHa members rely on.

Key Stakeholders

alPHa works closely with a number of stakeholders as part of its role representing leadership in the public health system.

Ontario Ministry of Health
Ontario Chief Medical Officer
Public Health Ontario
Association of Municipalities of Ontario
Ontario Medical Association
Ontario Public Health Association
Canadian Public Health Association

alPHa also works with faculty and students in post-secondary Public Health programs in Ontario, particularly with the Dalla Lana School of Public Health at the University of Toronto.

Appendix 1 – Links to Key alPHa Resources

Key alPHa Documents

- **alPHa Constitution**
- **Strategic Plan**
- **Annual Report**
- **alPHa resolutions**
- **alPHa correspondence**
- **alPHa Position Papers and Reports**

- **BOH Shared Resources Page**, including: **BOH Orientation Manual** and **BOH Governance Toolkit**

- **A Review of Board of Health Liability 2018**

- **Information Break** - sent by email. alPHa's monthly newsletter is delivered to all members by email and highlights public policy submissions, key events, and activities.
- Public Health Matters Primer – Infographic
- Public Health Matters – Video
- alPHa Brochure

Social Media

- **alPHa's Social Media Accounts:** Twitter **@PHAgencies** and **LinkedIn**

Many members follow alPHa on social media. If you are active on Twitter or LinkedIn, please follow and like alPHa's tweets and retweets that help to profile association activities with members and stakeholders.

Appendix 2: Legislation and Other Governing Documents

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

Provincial legislation of Public Health Interest:
Just click on the link for information on the legislation and its details.

- *Cannabis Control Act 2017*
- Child Care and Early Years Act
- Healthy Menu Choices Act
- Immunization of School Pupils Act
- Mandatory Blood Testing Act
- Safe Drinking Water Act
- Skin Cancer Prevention Act (Tanning Beds)
- Smoke-Free Ontario Act

Acts Pertaining to Health Units as Public Bodies

- Accessibility for Ontarians with Disabilities Act (AODA)
- French Language Services Act
- Municipal Act
- Municipal Conflict of Interest Act
- Municipal Freedom of Information and Protection of Privacy Act
- Occupational Health and Safety Act
- Personal Health Information Protection Act

Appendix 3: 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 34 boards of health in Ontario.

Important Milestones

1873 The first *Public Health Act* is passed.

1882 The first board of health is established.

1884 A more comprehensive *Public Health Act* is prepared by Dr. Peter B. Bryce. This Act establishes 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 are in operation.

1886 The *Compulsory Vaccination Act* is passed.

1934 The Eastern Ontario Health Unit becomes the first county-wide health unit in Ontario, 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.

1944 The *Public Health Act* is amended with the legislative foundation for the establishment of public health units. 27 health units are established by the end of 1949, with an additional 10 in place by 1965.

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

1967 The *Public Health Act* is amended to require organized municipalities 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 that suggested optimum population sizes (100,000) for health unit catchment areas. The province encourages health units to regroup on a multi-county basis to become more efficient.

1984 The *Health Protection and Promotion Act* (HPPA) is proclaimed, replacing the *Public Health Act* and several other public health-related statutes. It sets out minimum standards for public health programs and services throughout the province. It has been kept current with several amendments but remains substantially the same to the present day.

1997 The HPPA was revised as part of Bill 152, the *Services Improvement Act*. Through this legislation, municipal governments were made 100% responsible for the funding of public health whereas the provincial government can provide grants as a matter of policy, not legislation.

1998 The *Mandatory Health Programs and Services Guidelines* (the precursor to the present-day Ontario Public Health Standards) are in effect.

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

2006 The *Smoke-Free Ontario Act* is introduced, which bans smoking in all enclosed public places. This replaced the patchwork municipal by-laws at the time.

2006 The government of Ontario introduces the *Health System Improvements Act,* which includes enabling legislation for the Ontario Agency for Health Protection and Promotion, Ontario's "CDC of the North."

2006 The Final Report of the Capacity Review Committee is released.

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. These come into effect on January 1, 2009 and replace the 1998 *Mandatory Health Programs and Services Guidelines*.

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

2011 The first accountability agreements are put in place between boards of health and the Ministry of Health. In addition, the HPPA is amended to give the Chief Medical Officer of Health the power to issue directives to a board of health or local medical officer of health.

2017 The *Patients First Act* includes a clause that formalizes engagement between the local Medical Officer of Health and LHIN CEOs on issues related to local health system planning, funding, and service delivery.

2017 The report from the Minister's Expert Panel on Public Health Report—*Public Health Within an Integrated Health System*—is released.

2018 The Elgin-St.Thomas and Oxford County Public Health Units formally merge on May 1 as the Oxford - Elgin - St. Thomas Public Health Unit, which is branded as Southwestern Public Health.

2018 The modernized *Ontario Public Health Standards: Requirements for Programs, Services, and Accountability* begin to be implemented.

2019 The Spring 2019 Provincial Budget outlines the provincial direction on Public Health Modernization (i.e., restructuring of the local public health system). Later that year, the province announced that Jim Pine, County of Hastings CAO would serve as an advisor for renewed consultations on strengthening and modernizing public health and emergency health services.

2020 The Huron County and Perth District Health Units formally merge on January 1 as the Huron Perth Health Unit, branded as Huron Perth Public Health.

2020 In March 2020, the World Health Organization declared that COVID 19 was a global pandemic. Public health, provincial and local, focused primarily on public health measures with the objective of keeping people safe from this unknown (at the time) infectious disease. All consultations on public health modernization were paused.

2020 The province revised the public health funding to 70% provincial and 30% municipal and this formula now includes all the previously funded provincial programs. Due to the needed provincial mitigation funding to keep local public health whole during the COVID-19 pandemic, these funding changes and their impacts were not felt or fully understood at the time.

APPENDIX 4- Association of Local Public Health (alPHa) Organizational Chart (as of November 2022)