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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.

As you read through this manual, you should keep in mind that many policy and funding changes have recently been made to Ontario’s public health system based on the above reviews, with others in progress and still more expected, including significant reforms to the Health Protection and Promotion Act (HPPA) and the Mandatory Health Programs and Services Guidelines (MHPSG) – the primary legal documents that govern the business of Ontario’s public health units.
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: 25 county-district health units; 6 regional health departments; and 5 health units in single-tier municipalities.
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.

**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 and 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/](http://www.e-laws.gov.on.ca/)

As stated in the preamble, 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](http://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. 3).

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 are also currently undergoing revisions and are further described below.

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 Mandatory Health Programs and Services Guidelines 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, 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.

**Mandatory Health Programs and Services Guidelines**

The *Mandatory Health Programs and Services Guidelines* (MHPSG) 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 MHPSG set out the goals, objectives, requirements and standards for their provision. Because the MHPSG 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.

As a result of the current agenda of transformation of Ontario’s public health system, the government of Ontario is currently engaged in the review and renewal of the Guidelines. It is unknown what the nature and extent of the changes will be at this time, but they are expected in 2007 and it is anticipated that the adjustments will be more than minor. Until those changes are made however, boards of health will continue to deliver the programs and services described here.

The current MHPSG were published in 1997, and contain goals, objectives and program standards for a host of required board of health activities. In addition to general standards for equal access, health hazard investigations and program planning and evaluation, Program Standards are published for the following areas:

**Chronic Disease 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).

In addition to preventive measures that address the potential for infectious disease, there is a requirement built into this section that ensures the existence of emergency response protocols for the investigation and control of outbreaks should they occur.

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
• immediately restricts the retail promotion of tobacco products and imposes a complete ban on the display of tobacco products by 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 Mandatory Health Programs and Services Guidelines (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 has 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 252/05

Ontario Regulation 252/05 regulates drinking water systems serving non-residential and seasonal residential uses until their intended transfer to the public health units, as recommended by the Advisory Council on Drinking Water Quality and Testing Standards. After the proposed transfer of responsibility, public 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. This transfer is expected to be complete in 2007 and is one of the legislative reforms included in Bill 171, described below. O. Reg. 252/05 does not apply to municipal and private systems that provide water to year-round residential developments or designated facilities under Ontario Regulation 170/03.

Ontario Regulation 170/03

The ODWAC has also made a specific recommendation that public health inspectors oversee facilities that serve vulnerable populations. Termed Designated Facilities under this regulation, they 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. Despite the ODWAC recommendation, responsibility for these facilities remains with the MOE.

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 171 – The Health System Improvements Act

This Bill was introduced in December of 2006, and it includes a multitude of proposals for legislative change that are aimed at improving Ontario’s health system. Among these are several proposals to improve the public health system in particular.

Transfer of Drinking Water Systems

The Ontario government is proposing to transfer legislative responsibility for five categories of non-residential and seasonal residential drinking water systems from the Ministry of the Environment to the Ministry of Health and Long-Term Care in response to public consultations that indicated a preference for public health units to oversee small drinking-water systems as described above. Boards of health would receive funding to hire, equip and train health inspectors to assess these drinking water systems.

Expected to start in January 2008, public health inspectors would commence conducting individual site assessments followed by advice to owners/operators on what they must do to ensure that their systems provide safe drinking water.

Establishment of Ontario’s Agency for Health Protection and Promotion

The Ontario government intends to create Ontario’s first-ever arms-length public health agency. The proposed Ontario Agency for Health Protection and Promotion would be a centre for specialized research and knowledge of public health, specializing in the areas of infectious disease, infection control and prevention, health promotion, chronic disease and injury prevention and environmental health. The agency would have similar areas of specialization as the American Centers for Disease Control and Prevention (CDC).

Amendments to the Health Protection and Promotion Act

The Ontario government intends to amend the Health Protection and Promotion Act (HPPA) to incorporate recommendations from the Second Interim Campbell Report on SARS. The amendments would ensure public health officials have the necessary powers and authority to intervene and effectively manage public health emergencies. These include powers for procurement of medical supplies and provision of information for the purposes of investigations.

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.

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 Mandatory Health Programs and Services Guidelines (MHPSG), 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 of health with approval of the Minister; and
- responsible for assessing the performance of the medical officer of health and associate medical officer 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 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 epidemiological principles and 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, which 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. To carry out this directive, a committee of Public Health Division (formerly the Public Health Branch) and alPHa representatives developed guidelines for recruiting and recommending nominees for public appointments (formerly referred to as provincial appointments) on boards of health.

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 the unique demographic, the local board best determines public representation and geographic characteristics of the area served by the board.

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 six 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. There are 21 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
- 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. The 10 regional/single-tier boards of health in Ontario include:

- Durham (regional)
- Haldimand-Norfolk
- Halton (regional)
- Lambton
- Niagara (regional)
- Oxford
- Peel (regional)
- Simcoe Muskoka
- Waterloo (regional)
- York (regional)

**Municipal**
In municipal boards, the staff of the health unit operates under the municipal administrative structure. Presently, there are 5 municipal boards of health:

- Chatham-Kent
- Hamilton
- Huron
- Ottawa
- Toronto
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. It provides funding for selected programs (e.g. Healthy Babies, Healthy Children). The Branch is responsible for setting, monitoring and enforcing the Mandatory Health Programs and Services Guidelines, 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 in the new direction toward a stewardship model of guiding and planning for the health system and away from actual delivery of health care. A transitional structure for the Ministry is expected to be phased in by December 31, 2007. The Public Health Division, however, has moved directly into this transitional structure.

There are a number of important branches within the newly re-organized 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 Laboratories** (manages the provision of testing, surveillance and research in public health labs)
- **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 Minister of Health and Long-Term Care announced that a grant, up to 50 percent of the budgeted amount for public health services within the Health Unit, would be provided to help offset the costs on the obligated municipalities. This 50-50 ratio of cost-shared funding between the province and municipalities continued until 2005.
As part of Operation Health Protection, the province increased its funding share to 55% 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
- Public Health Research Education and Development (PHRED)
- Speech and Audiology
- Genetics Counselling
- Sexual Health Hotline and Resource Centre
- unincorporated areas

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

If a topic demands it or members request it, alPHa will periodically arrange seminars, workshops and general meetings for full discussion and planning. alPHa has conducted such day-long workshops as orientation of new board members, West Nile virus and drinking water safety, 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 currently holds the Co-Chair 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 will do the following:
- 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.

**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 proposed Ontario Health Protection and Promotion Agency ("Ontario's Own CDC of the North") will be a centre for specialized research and knowledge of public health, specializing in the areas of infectious disease, infection control and prevention, health promotion, chronic disease and injury prevention, and environmental health. An arms-length agency, it will support the Chief Medical Officer of Health and provide expert scientific leadership and advice to government, public health units, and front-line health care workers.

Its responsibilities will include the provision of specialized public health laboratory services to support timely health surveillance, support of infection control and provision of communicable disease information as well as assistance with emergency preparedness (e.g. provincial outbreak of pandemic influenza, local outbreaks).

The Agency will be established in the spring of 2007.

**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.

Through alPHA’s membership in the OHPA, public health is fully integrated into the provincial health care system.
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
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

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)

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

Operation Health Protection

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

Legislation

Mandatory Health Programs and Services Guidelines, 1997

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 Public Health Association
http://www.opha.on.ca
### Appendix 4 - Ontario Health Unit Contacts

Note: Due to the recent municipal elections, many boards of health have yet to elect their 2007 Chair

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<tr>
<th>Health Unit</th>
<th>Address</th>
<th>Telephone</th>
<th>Fax</th>
<th>Web Link</th>
<th>Medical Officer of Health</th>
<th>Board of Health Chair</th>
</tr>
</thead>
</table>
| **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: N/A |  |
| **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 McCready |  |
| **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: N/A |  |
| **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: English - 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: N/A |  |
| **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. Sharon Baker  
Board of Health Chair: N/A |  |
| **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: Don Lewis |  |
| **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/ | Medical Officer of Health: Dr. Jeff Tschirhart  
Board of Health Chair: Dennis Travale |  |
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<th>Health Unit</th>
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<th>Board of Health Chair</th>
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<tr>
<td><strong>Haliburton, Kawartha, Pine Ridge District Health Unit</strong></td>
<td>200 Rose Glen Road</td>
<td>Tel: (905) 885-9100</td>
<td>Dr. Lynn Noseworthy</td>
<td>N/A</td>
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<tr>
<td></td>
<td>Port Hope, Ontario L1A 3V6</td>
<td>Fax: (905) 885-9551</td>
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<td>Tel: (905) 885-9100</td>
<td>Web: <a href="http://www.hkpr.on.ca/">http://www.hkpr.on.ca/</a></td>
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<td>Medical Officer of Health: Dr. Lynn Noseworthy</td>
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<td>Board of Health Chair: N/A</td>
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<tr>
<td><strong>Halton Region Health Department</strong></td>
<td>1151 Bronte Road</td>
<td>Tel: (905) 825-6000</td>
<td>Dr. Robert Nosal</td>
<td>N/A</td>
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<tr>
<td></td>
<td>Oakville, Ontario L6M 3L1</td>
<td>Fax: (905) 825-8588</td>
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<td>Tel: (905) 825-6000</td>
<td>Web: <a href="http://www.region.halton.on.ca/health/">http://www.region.halton.on.ca/health/</a></td>
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<td>Fax: (905) 825-8588</td>
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<tr>
<td><strong>City of Hamilton - Public Health &amp; Social Services</strong></td>
<td>1 Hughson Street North, 4th Floor</td>
<td>Tel: (905) 546-2424</td>
<td>Dr. Elizabeth Richardson</td>
<td>N/A</td>
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<tr>
<td></td>
<td>Hamilton, Ontario L8R 3L5</td>
<td>Fax: (905) 546-4075</td>
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<td>Tel: (905) 546-2424</td>
<td>Web: <a href="http://www.hamilton.ca/phcs">http://www.hamilton.ca/phcs</a></td>
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<td>Fax: (905) 546-4075</td>
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<tr>
<td><strong>Huron County Health Unit</strong></td>
<td>Health &amp; Library Complex, R.R #5</td>
<td>Tel: (519) 482-3416</td>
<td>Dr. Beth Henning</td>
<td>N/A</td>
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<tr>
<td></td>
<td>77722 London Road</td>
<td>Fax: (519) 482-7820</td>
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<td></td>
<td>Clinton, Ontario N0M 1L0</td>
<td>Web: <a href="http://www.huroncounty.ca/healthunit/index.html">http://www.huroncounty.ca/healthunit/index.html</a></td>
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<td>Tel: (519) 482-3416</td>
<td>Medical Officer of Health: Dr. Beth Henning</td>
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<td>Fax: (519) 482-7820</td>
<td>Board of Health Chair: N/A</td>
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<tr>
<td><strong>County of Lambton</strong></td>
<td>Community Health Services Dept.</td>
<td>Tel: (519) 383-8331</td>
<td>Dr. Christopher Greensmith</td>
<td>N/A</td>
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<tr>
<td></td>
<td>160 Exmouth Street</td>
<td>Fax: (519) 383-7092</td>
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<td></td>
<td>Point Edward, Ontario N7T 7Z6</td>
<td>Web: <a href="http://www.lambetonhealth.on.ca/">http://www.lambetonhealth.on.ca/</a></td>
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<td></td>
<td>Tel: (519) 383-8331</td>
<td>Acting Medical Officer of Health: Dr. Christopher Greensmith</td>
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<td>Fax: (519) 383-7092</td>
<td>Board of Health Chair: N/A</td>
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<tr>
<td><strong>Middlesex-London Health Unit</strong></td>
<td>50 King Street</td>
<td>Tel: (519) 663-5317</td>
<td>Dr. Graham Pollett</td>
<td>N/A</td>
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<td>London, Ontario N6A 5L7</td>
<td>Fax: (519) 663-9581</td>
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<td>Tel: (519) 663-5317</td>
<td>Web: <a href="http://www.healthunit.com/">http://www.healthunit.com/</a></td>
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<td>Web: <a href="http://www.healthunit.com/">http://www.healthunit.com/</a></td>
<td>Board of Health Chair: Tom McLaughlin</td>
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<tr>
<td><strong>Hastings &amp; Prince Edward Counties Health Unit</strong></td>
<td>179 North Park Street</td>
<td>Tel: (613) 966-5500</td>
<td>Dr. Richard Schabas</td>
<td>N/A</td>
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<td>Belleville, Ontario K8P 4P1</td>
<td>Fax: (613) 966-9418</td>
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<td>Tel: (613) 966-5500</td>
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<td>Fax: (613) 966-9418</td>
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<td>Board of Health Chair: N/A</td>
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<tr>
<td><strong>Kingston, Frontenac, Lennox &amp; Addington Public Health</strong></td>
<td>221 Portsmouth Avenue</td>
<td>Tel: (613) 549-1232</td>
<td>Dr. Ian Gemmill</td>
<td>N/A</td>
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<td>Kingston, Ontario K7M 1V5</td>
<td>Fax: (613) 549-7896</td>
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<td>Tel: (613) 549-1232</td>
<td>Web: <a href="http://www.healthunit.on.ca/">http://www.healthunit.on.ca/</a></td>
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<td></td>
<td>Fax: (613) 549-7896</td>
<td>Medical Officer of Health: Dr. Ian Gemmill</td>
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<td>Board of Health Chair: N/A</td>
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<tr>
<td><strong>Leeds, Grenville and Lanark District Health Unit</strong></td>
<td>458 Laurier Boulevard</td>
<td>Tel: (613) 345-5685</td>
<td>Dr. Anne Carter</td>
<td>N/A</td>
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<td></td>
<td>Brockville, Ontario K6V 7A3</td>
<td>Fax: (613) 345-2879</td>
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<td>Tel: (613) 345-5685</td>
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<td>Fax: (613) 345-2879</td>
<td>Medical Officer of Health: Dr. Anne Carter</td>
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<td>Web: <a href="http://www.healthunit.org/">http://www.healthunit.org/</a></td>
<td>Board of Health Chair: Ken Graham</td>
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<tr>
<td><strong>Regional Niagara Public Health Department</strong></td>
<td>30 Hannover Drive</td>
<td>Tel: (905) 688-3762 or 1-800-263-7248</td>
<td>Dr. Robin Williams</td>
<td>N/A</td>
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<td>St. Catharines, Ontario L2W 1A3</td>
<td>Fax: (905) 682-3901</td>
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<td>Tel: (905) 688-3762 or 1-800-263-7248</td>
<td>Web: <a href="http://www.regional.niagara.on.ca/government/health/default.aspx">http://www.regional.niagara.on.ca/government/health/default.aspx</a></td>
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<td>Fax: (905) 682-3901</td>
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<td>Web: <a href="http://www.regional.niagara.on.ca/government/health/default.aspx">http://www.regional.niagara.on.ca/government/health/default.aspx</a></td>
<td>Board of Health Chair: N/A</td>
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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. Catherine Whiting
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. Pete Sarsfield
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. David Salisbury
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. Jeff Nichols
Board of Health Chair: N/A
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
Acting Medical Officer of Health: Dr. Megan Ward
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. Rosana Pellizzari
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. Garry Humphreys
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. Alberto de la Rocha
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

Thunder Bay District Health Unit
999 Balmoral Street
Thunder Bay, Ontario P7B 6E7
Tel: (807) 625-5900
Fax: (807) 623-2369
Web: http://www.tbnu.com/
Medical Officer of Health: Dr. Nancy Cameron
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

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

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

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/
Interim Medical Officer of Health: Dr. Douglas Kittle (as of January 15, 2007)
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

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 - aPHa 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 half the number 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) In the event of a tie vote on any motion or resolution the Section Chair shall have the necessary vote in order to decide the matter.

(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 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, 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, 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 the Candidates’ Speeches session at the Annual Conference, at which time all Board of Health 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 Board of Health vacancies.

(g) Nominations must be submitted in writing, using the Form of Nomination and Consent. The signatures of two (2) board of health members from the sponsoring health unit are required, as the future meeting expenses for directors are expected to be, at least, cost-shared by the sponsoring health unit.

(h) County/district boards of health shall be guaranteed four (4) members on the Executive Committee of the Section; health committees of Regional Council/Large Urban Centre shall be guaranteed two (2) members; and the board of health for Toronto shall be guaranteed one (1) member; only if the guaranteed number of candidates are present at the annual general meeting and supported by their board for election.

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 aPHa Board of Directors regularly.

Vice-Chair

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

Amendments and Alterations

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

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

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

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

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

Amended by the General Membership
Board of Health Section, aPHa
January 29, 2004
Appendix 6 - alPHa Organizational Chart

Affiliate Members:
- ANDSOOHA - Public Health Nursing Management
- AOPHBA - Association of Ontario Public Health Business Administrators
- APHEO - Association of Public Health Epidemiologists in Ontario
- ASPHIO - Association of Supervisors of Public Health Inspectors of Ontario
- HPO - Health Promotion Ontario
- OAPHD - Ontario Association of Public Health Dentistry
- OSNPPH - Ontario Society of Nutrition Professionals in Public Health

Active Members:
- All 36 Health Units in Ontario
- Represented By:
  - Boards of Health Section
  - Council of Medical Officers of Health
  - Each Contributes Seven Representatives

Associate Member:
- Ontario Public Health Association
  - Contributes One Representative (non-voting)

Each Contributes One Representative

Board of Directors

Executives:
- Advocacy Committee
- Executive Committee
- Executive Director
- Manager, Public Health Issues
- Manager, Administration & Association Services
- Executive Assistant
TRANSITIONAL STRUCTURE — BY DECEMBER 31, 2007

Ministry Mandate: Sets direction and province-wide priorities, central oversight, sets standards, develops policy, legislation and regulations, funding, monitors and reports against plans and strategy

To be implemented by December 31, 2007

To be reviewed for implementation in 2008/2009 or beyond
A REVIEW OF BOARD OF HEALTH LIABILITY

For:
The Association of Local Public Health Agencies

James A. LeNoury
LeNoury Law
82 Scollard Street
Toronto, Ontario

T: (416) 926-1107
F: (416) 926-1108

Counsel to alPHA
Revised December 2006

Preface

This is a further update to a paper I originally presented in January 2004 and revised in November 2005. My January 2004 presentation originated from a paper I completed in November 2002 in which I was asked to review the liabilities of board members of Boards of Health in connection with carrying out their duties under the Health Protection and Promotion Act. In the January 2004 paper, I was asked to expand on the initial topic and include a review of
the general liabilities to which a board member of a Board of Health is subject to as a director. 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 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.

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.

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

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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.
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.
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

II. SPECIFIC PUBLIC HEALTH LIABILITIES
   1. The Statutory Liability Exemption
   2. Board Duties and Responsibilities
   3. Board Governance
   4. No Exemptions

6 Ibid.
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

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.

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\(^7\) See ESA, s.81.
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*.

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:

- 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.

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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.
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.

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.

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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.
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\(^\text{10}\), 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 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.

\(^{10}\) Ontario Regulation 166/03 –“Orders under Section 22.1 of the Act”Subsection 6(12)
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, 200611 (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 22.112. 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 Board13;

- 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 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.

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 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.
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*.

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. As it was at the time of the November 2005 update to this paper,
this transfer remains incomplete.\(^ {17}\) However, on December 12, 2006, the Ontario Government
introduced for first reading in the Legislature, Bill 171, the short title of which is the *Health
Systems Improvement Act, 2006* ("Bill 171") which is to implement this transition.

\(^{15}\) 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
Under Ontario Regulation 252/05\(^\text{18}\) (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 regulatory framework that will detail the requirements for owners and operators under the new regime, as well as the roles and responsibilities of the Public Health Units has not been finalized. The proposed framework was scheduled to be released for public consultation in the fall of 2005, but was delayed.\(^\text{19}\) However, this transition is to be implemented under Bill 171, which as of this writing has just received first reading in the Legislature.

The protection from liability under section 95 of the *HPPA* would apply to the carrying out of duties under the *SDWA*. That is, liability would only accrue 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, but it has yet to be proclaimed in force as of this writing.

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

\(^{18}\) The rather unwieldy title of this Regulation is “Non-residential and non-municipal seasonal residential systems that do not serve designated facilities.”

\(^{19}\) The Ontario Gov't website on Regulation 252/05 ([http://www.ene.gov.on.ca/envision/water/sdwa/reg252.htm](http://www.ene.gov.on.ca/envision/water/sdwa/reg252.htm)) provides the following indistinct information: “After the proposed transfer of responsibility, public 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. Requirements may change when the new approach is implemented. Additional information will be made available on this site as soon as it is available.” Presumably this information will be updated in accordance with any final version of Bill 171 which is brought into force.
For the first time, communities will be required to create and carry out a plan to protect the sources of their municipal drinking water supplies. The Clean Water Act will:

- Require local communities to look at the existing and potential threats to their water and set out and implement the actions necessary to reduce or eliminate significant threats.
- Empower communities to take action to prevent threats from becoming significant.
- Require public participation on every local source protection plan. This means everyone in the community gets a chance to contribute to the planning process.
- Require that all plans and actions are based on sound science.20

Local boards of health (as “local boards” as defined in the Municipal Affairs Act21) 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.22

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.

21 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.
22 See section 87.
While a Board of Health’s obligations under section 87 of the *CWA* fall in Part V (rather than Parts I through III which are protected under s.98), the ordinary protections of s.95 of the *HPPA* would apply to any duty under section 87 of the *CWA*. Nonetheless, section 99 of the *CWA* provides similar protections to “employees or agents….of local boards”. Section 99(2) states that:

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

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

3. **Board Governance**

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

The Board of Health must be assured that the Medical Officer of Health and staff are providing the health programs and services prescribed in Part II of the *HPPA*. In regard to Parts III and IV, the 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.23

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.

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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 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. Toronto24 (“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.

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24 Supra, note 4.
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\textsuperscript{25}. However, the reasoning of the decision turned upon the Court’s finding with respect to the limited medical knowledge about the risks from the inoculations at the time the hepatitis B vaccinations were given in 1994. The Court found that given that in 1994, the administrations of the particular hepatitis B vaccine were presumed to be safe and were not suspected to be associated with long-term neurological damage, the City (through the Works) could not be found to have breached its standard of care to the Plaintiff in failing to warn her about possible serious side-effects in taking the vaccinations.\textsuperscript{26} 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.\textsuperscript{27}

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:

\textsuperscript{25} Ibid. at para.392.
\textsuperscript{26} Ibid at para. 343.
\textsuperscript{27} Ibid. at para. 353.
“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.”28

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.29

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.30

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)31. The matter involved a claim brought by the estate of a man who was bitten by an infected mosquito and contracted West Nile Virus

28 Ibid., para. 4.
29 Ibid. para. 10.
30 Ibid. para. 417-446.
31 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
(“WNV”) in 2002\textsuperscript{32}. He was treated in hospital and released. In 2003, however, he suffered a fall and died from the complications which ensued. His estate sued the Province of Ontario, claiming that it “could have” and “should have” prevented the outbreak of WNV.

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

“The central issue is whether, on the facts that have been pleaded, Ontario owed [the plaintiff] a private law duty of care [so as to provide the plaintiff] with the necessary legal basis for a negligence action for damages.”\textsuperscript{33}

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.”\textsuperscript{34}

\textsuperscript{32} 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.

\textsuperscript{33} Supra, para. 2.

\textsuperscript{34} Supra, para. 11.
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.\(^{35}\) After reviewing the role of the Minister and Ministry of Health under the HPPA, the Court of Appeal found that the Ministry/Minister of Health accrues “discretionary powers” under the HPPA which were insufficient to create a “private duty” of care to the plaintiff.\(^{36}\)

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”.\(^{37}\) 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.”\(^{38}\)

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.”\(^{39}\)

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”\(^{40}\), 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.”\(^{41}\)

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\(^{35}\) Supra, para. 14-15.
\(^{36}\) Supra, para. 17.
\(^{37}\) Supra, para 21.
\(^{38}\) Supra, para. 22
\(^{39}\) Supra, para. 23
\(^{40}\) Supra para. 24
The Court of Appeal returned to this aspect again, identifying that like the HPPA, the Plan outlines general duties of the Province, but by contrast delineates a specific, practical role for local health agencies:

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

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.”

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

“Public health priorities should be based upon the general public interest. Public health authorities should be left to decide where to focus their attention and resources without the fear or threat of lawsuits.”

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

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41 Supra, para. 25.
42 Supra, para. 27.
43 Supra, para. 27.
44 Supra, para. 33.
a general matter under the HPPA), the Province has primarily an advisory rather than operational role with respect to matters of public health.

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

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

- a breach of the duty 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”\textsuperscript{45}—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.

As noted at the outset of this paper, this area remains a dynamic one. The potential exists for further changes to the legislative landscape in respect to local public board of health liability. Bill 171—the *Health Systems Improvement Act, 2006* which is currently before the Ontario Legislature received first reading on December 12, 2006. Among the changes proposed under this lengthy statute are amendments to s.95 of the HPPA to offer liability protection to the new entities within the public health sphere which are to be created pursuant to Bill 171. I shall

\textsuperscript{45} *Supra*, note 44.
continue to monitor this area (and the progress of Bill 171) and provide further updates to this paper as necessary in the future.

JAL/cig
APPENDIX A

Potential Questions for Board Self-Evaluation

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

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

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

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

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

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

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

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

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

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

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

12. Does the Board establish guidelines for managers that clearly specify their authority?
13. Does the Board micromanage operations or, at the other extreme, does it ignore them and let management handle everything with little Board oversight?

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

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

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

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

alPHa Board of Director Duty of Care Report

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

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

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

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

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

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

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