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Preamble to the 2018 Edition

The Association of Local Public Health Agencies (aLPHA) is pleased to provide the 2018 edition of the Orientation Manual for Boards of Health. The manual brings together in one place key information for board of health members. It includes information about public health and public health units; the structures, roles and responsibilities of boards of health; and relevant legislation.

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

Since the beginning of the new millennium, Ontario’s public health system has undergone several changes, many of which were precipitated by high-profile public health crises such as the 2000 outbreak of E. coli O157:H7 in Walkerton and the Severe Acute Respiratory Syndrome (SARS) outbreak three years later. These tested the capacity and effectiveness of the system and these were in turn carefully analysed through the lens of these events. Detailed, evidence-based recommendations were made for improvements to an under-funded public health system that was revealed to be consistently operating below its mandated standards.

The recommendations of three reports—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)—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.

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 which introduced a number of policy and funding changes. As part of this initiative, the *Final Report of the Capacity Review Committee, Revitalizing Ontario’s Public Health Capacity*, released in May of 2006, included 50 recommendations for the public health work force, accountability, governance and funding, strengthening local service delivery, research and knowledge exchange, strategic partnerships and next steps for the local public health sector. This report remains an excellent reference for understanding public health and illustrating the importance of reinforcing its capacity and many of its recommendations have been implemented.

Another important outcome of the efforts to revitalize our public health system was the replacement of the outdated *Mandatory Health Programs and Services Guidelines* with the
2008 *Ontario Public Health Standards*, a comprehensive set of evidence-based guidelines for the provision of public health services. These were revised in 2018 (*Ontario Public Health Standards: Requirements for Programs, Services, and Accountability*) and they remain the blueprint for the activities of all boards of health throughout the province. They are also the foundation for the Public Health Accountability Framework that sets out the conditions for the receipt of the provincial government’s portion of cost-shared funding. Each of these is further described below.

Finally, and certainly of no small importance, these efforts led to the creation of a public health agency for Ontario with the mandate to focus on the provision of scientific and technical support to the government, public health units and front-line health care workers, similar to the Centers for Disease Control in the United States. In 2007, Public Health Ontario (then known as the Ontario Agency for Health Protection and Promotion, which remains its legal name) was established to “provide the scientific evidence and expert guidance that shapes policies and practices for a healthier Ontario”.

**Introduction**

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

A companion document titled *Governance Toolkit for Ontario Boards of Health*, provides boards of health with practical tools and templates to help them govern more effectively.

**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.

Since the implementation of the Ontario Public Health Standards, public health programs and services have included a stronger focus on the social determinants of health and health equity. It has been more formally recognized that the health of individuals and communities is significantly influenced by complex interactions between social and economic factors, the physical environment, and individual behaviours and conditions. The Ontario Public Health Standards incorporate and address the determinants of health throughout and include a broad range of population-based activities designed to promote the health of the population and reduce health inequities by working with community partners.

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

**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 35 boards of health in Ontario.

**Important Milestones**

1873 The first Public Health Act is passed.
1882 The first board of health is established.

**Determinants of Health**

include:

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

History of Health Units in Ontario
A more comprehensive Public Health Act is prepared by Dr. Peter B. Bryce. This Act establishes the position of the medical officer of health and the relationship with the board of health. Within two years of passage, 400 boards of health are in operation.

The Compulsory Vaccination Act is passed.

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

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

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

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

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

The HPPA was revised as part of Bill 152, the Services Improvement Act. The Mandatory Health Programs and Services Guidelines (the precursor to the present-day Ontario Public Health Standards) are published.

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

The Smoke-Free Ontario Act is introduced, which bans smoking in all enclosed public places. This replaces the patchwork municipal by-laws that provided varying degrees of protection depending on location.
2006  The government of Ontario introduces the Health System Improvements Act, which includes enabling legislation for the Ontario Agency for Health Protection and Promotion, Ontario’s “CDC of the North”.

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

2008  The Ontario Public Health Standards are completed in collaboration with boards of health and Ontario public health professionals. These come into effect on January 1, 2009 and replace the Mandatory Health Programs and Services Guidelines.

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

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

2016  The Patients First Act, 2016 introduces new requirements for Medical Officers of Health (MOHs) and the Chief Executive Officers (CEOs) of Local Health Integration Networks (LHINs) to engage each other in supporting the integration of a population health approach into the broader health system.

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

**Legislation Governing Boards of Health**

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

Several other pieces of provincial legislation are also significant to the activities of boards of health, medical officers of health and their designates. A detailed and comprehensive itemization and description is beyond the scope of this manual, but a list of links to and brief outlines of some of the key public health-related provincial statutes are provided in Appendix 7. The provincial government’s E-Laws Web site provides convenient access to all of Ontario’s Acts and their associated Regulations.

As a BOH member, you are encouraged to keep up to date on current legislation, including announced or proposed changes, as well as opportunities to provide input to consultations.
One of aPHa’s principle roles is to keep its members informed of such changes and opportunities to influence them.

**The Health Protection and Promotion Act**

The *Health Protection and Promotion Act* is the most important piece of legislation for boards of health, as it enables their existence, structures, governance and functions, outlines the authority of the medical officers of health and boards of health, prescribes the broad responsibilities for local public health and serves as the parent legislation for the regulations and guidelines that prescribe the more detailed requirements that serve the purpose of the Act, which is to “provide for the organization and delivery of public health programs and services, prevention of the spread of disease and the promotion and protection of the health of the people of Ontario” (R.S.O. 1990, c. H. 7, s. 2).

There are currently 19 different Regulations made under the HPPA, including those that govern board of health composition, qualifications of staff, food safety, swimming pool health and safety, school health, and communicable disease control. A list of current regulations is included in Appendix 7.

The original Act came into force on July 1, 1984, replacing the *Public Health Act*, the *Venereal Disease Prevention Act* and the *Sanatoria for Consumptives Act*. It has undergone over 40 revisions since that time to keep it aligned with current evidence, best practices and changes to other pieces of legislation. The most recent substantial revision was made in 2017 with enhancements to clauses related to the provision of safe food, public health and safety at recreational camps, pools and spas; and to enhance prevention measures for infectious diseases of public health significance. The previous year, the clause requiring the medical officer of health of a board of health “to engage on issues relating to local health system planning, funding and service delivery with the chief executive officer or chief executive officers of the local health integration network or networks whose geographic area or areas cover the health unit served by the board of health. 2016, c. 30, s. 39 (1)” was added.

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 (see text box).
Section 5 - Mandatory health programs and services
Every board of health shall superintend, provide or ensure the provision of health programs and services in the following areas:

1. Community sanitation, to ensure the maintenance of sanitary conditions and the prevention or elimination of health hazards.
   1.1 The provision of safe drinking water by small drinking water systems.
2. Control of infectious diseases and reportable diseases, including provision of immunization services to children and adults.
3. Health promotion, health protection and disease and injury prevention, including the prevention and control of cardiovascular disease, cancer, AIDS and other diseases.
4. Family health, including,
   i. counselling services,
   ii. family planning services,
   iii. health services to infants, pregnant women in high risk health categories and the elderly,
   iv. preschool and school health services, including dental services,
   v. screening programs to reduce the morbidity and mortality of disease,
   vi. tobacco use prevention programs, and
   vii. nutrition services.
4.1 Collection and analysis of epidemiological data.
4.2 Such additional health programs and services as are prescribed by the regulations.

Section 7 further serves the modern approach by empowering the Minister of Health to publish standards for the provision of these mandatory programs and services. The first Mandatory Health Programs and Services Guidelines were published in 1984, providing minimum province-wide standards for programs and services aimed at reducing chronic and infectious diseases and improving family health. These were revised into the Ontario Public Health Standards (OPHS) that came into effect on January 1, 2009 and were again revised for 2018. In both cases, this was accomplished with extensive support and input from Ontario’s public health professionals. The OPHS are supported by protocols, guidance documents and toolkits that public health staff use to implement effective health promotion and protection programs locally.

The Nine Parts of the Health Protection and Promotion Act

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

Part II - Health Programs and Services
Introduces the requirements for the delivery of basic mandatory health programs and services. This is the section that gives the Ontario Public Health Standards the status of legal requirements. It also authorizes boards of health to provide additional programs and services that may be specific to local needs.
Part III - Community Health Protection
Provisions relating to the monitoring and enforcement activities that are necessary for the prevention, elimination or reduction of the effects of health hazards in the community. These include the traditional duties of public health inspectors (e.g. restaurant inspections, health hazard complaint response) and the types of corrective actions that may be taken to manage risks to health (e.g. issuing orders, seizure and destruction, closing premises). Part III of the HPPA also includes several clauses specifically addressing health hazards in food.

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

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

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

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; 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.

HPPA Part II, Section 9
A board of health may provide any other health program or service in any area in the health unit 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 of the provision of the health program or service. R.S.O. 1990, c. H.7, s. 9.
Part IX - Enforcement
This Part contains the enforcement provisions under the Act and provides for a range of penalties for a range of offences.

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

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

Where Section 5 of the HPPA specifies the areas in which programs and services must be provided the OPHS set out goals and outcomes for both society and boards of health. Requirements for assessment and surveillance, health promotion and policy development, and disease prevention are also laid out. The OPHS are mandatory and they ensure the maintenance of minimum standards for core public health programs and services for all Ontario.

The OPHS set the policy foundation for public health programs and services through 90 outcome-focused requirements spread across 4 foundational standards and 9 program standards. Rather than measuring performance through compliance, they are meant to enable and demonstrate public health’s contribution to population health outcomes through population health assessment and evidence-informed and risk-based approaches to improving it. They are also the basis for the accountability framework that sets out the conditions under which boards of health receive the provincial share of local public health funding.

Policy Framework

The focus of public health is on the whole population. Its work is aimed mainly at addressing the myriad risk factors for poor health outcomes, including ensuring safe food and water, preventing the spread of infectious diseases, reducing environmental threats, creating healthier environments to support and inform healthy choices and behaviours and promoting social conditions that improve health.

Public health’s impact on population health is realized through a multitude of activities on a wide range of issues, often in partnership with other organizations. Clinical service delivery, education, inspection and surveillance, advocacy, policy development and enforcement of
legislation are among the activities undertaken by the sector every day. Each is focused on the upstream prevention poor health outcomes.

Ontario’s public health system reflects the diversity of Ontario’s population, and the OPHS therefore recognizes the disparate demographic, geographic, economic and social conditions under which the 35 boards of health operate and provides the flexibility required for local planning and service delivery.

The following infographic is taken from the 2018 edition of the OPHS. It outlines the core functions of public health (assessment and surveillance, health promotion and policy development, health protection, disease prevention, and emergency management) across four domains (Social Determinants of Health, Healthy Behaviours, Healthy Communities and Population Health Assessment) that are guided by four principles (Need, Impact, Capacity, and Partnership, Collaboration and Engagement). In so doing, it illustrates the contribution of public health to improving population health outcomes.
### Figure 2: Policy Framework for Public Health Programs and Services

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

What Public Health Does: Foundational and Program Standards

**Foundational Standards**

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

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

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

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

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

**Program Standards**

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

2. **Food Safety**: reduction of the burden of food-borne illnesses through detection and response to food-borne illness and associated risk factors, promotion and enforcement of safe food-handling practices, and respond to food-related issues that may arise from floods, fires and power outages.
3. **Healthy Environments**: reduction of exposure to health hazards and promotion of the development of healthy environments that support health and mitigate existing and emerging risks. This includes addressing local needs related to healthy built and natural environments, exposure to hazardous environmental contaminants and biological agents, exposure to radiation including UV light and radon, extreme weather, indoor and outdoor air pollutants and other emerging environmental exposures.

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

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

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

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

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

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

**Strengthened Accountability: Public Health Accountability Framework and Organizational Requirements**

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

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

Detailed expectations, organizational requirements and reporting mechanisms are laid out in section 3 of the OPHS, but the principle obligations are as follow:

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

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

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

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

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

6. The board of health shall comply with all legal and statutory requirements.
The following infographic illustrates the various expectations and reporting mechanisms that are features of the framework:

![Public Health Accountability Framework]

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

In addition to the accountability planning and reporting tools, the 2018 OPHS has embedded a requirement to monitor progress and measure success of boards of health using public health indicators. These are intended to measure the impacts of mandated public health programs and services. Some of these are set at the provincial level to measure outcomes in all public health units. Others will be established by local boards of health for the standards that are aimed at responding to local needs, priorities, and contexts (i.e., Chronic Disease Prevention and Well-Being, Healthy Growth and Development, School Health, and Substance Use and Injury Prevention). The broad categories of measurable population health outcomes include improved health and quality of life, reduced morbidity and premature mortality, and reduced health inequities. The following infographic summarizes the components of this framework:
### Figure 6: Draft Public Health Indicator Framework

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

<table>
<thead>
<tr>
<th>Contribution to Population Health Outcomes</th>
<th>Program Outcomes</th>
</tr>
</thead>
</table>
| **Improved Health & Quality of Life** | **Locally determined program outcome indicators**  
- Indicators will be developed in accordance with locally determined programs of public health interventions |
| **Reduced Morbidity and Mortality** | **# of reported cases of foodborne illness**  
- % reported cases of foodborne illness attributed to exposure settings of (i.e., food premises, daycares, homes, etc.)  
- % of food handlers trained and certified in food safety  
- % foodborne illness caused by unsafe food handling in the home  
- % of the public with knowledge of the impact of climate change locally. Particularly heat-related illness  
- % of the public with knowledge of and positive behaviors related to the impact of air quality on health using the AQHI  
- % of the public with awareness and knowledge about the health risks of radon in indoor air quality  
- % of the public with awareness of the risk of cancer related to exposure to solar ultraviolet radiation  
- % of priority populations who are aware of increased risk for adverse health effects related to high heat events  
- % of doses wasted by publicly funded vaccine annually  
- % of 2 and 17 year olds vaccinated for all ISPA designated diseases  
- % of students with a valid religious or conscience exemption by ISPA designated disease annually  
- % of immunization providers of publicly funded vaccines indicating they have adequate information to support optimal immunization practices  
- % of inspected vaccine storage locations that meet storage and handling requirements  
- % of cases of identified LTBI that are initiating prophylaxis and/or the number completing treatment  
- % of potential rabies exposures investigated by health units annually  
- % of animals investigated that are current on their rabies vaccination  
- % of persons given rabies post-exposure prophylaxis (PEP)  
- % of days that fluoride levels were below recommended levels at municipal drinking water systems that add fluoride  
- % of drinking water advisories (DWA) and boil water advisories (BWA) issued by days advisories were in effect  
- % of the public who use private drinking water supplies (e.g., private wells) who are aware of how to safely manage their own drinking water systems  
- % of small drinking water systems where risk categories change from high risk to moderate or low risk indicating improvement in system performance  
- % of days per season beaches are posted |
| **Reducing Health Inequities among Population Groups** | **# of Ceftriaxone prescriptions distributed for treatment of gonorrhea annually**  
- # and type of IPAC lapse by sector (PSS, dental office, community laboratories or independent health facility)  
- # and rate per 100,000 of new active TB infections annually  
- # of cases of acquired drug-resistance among active TB cases  
- # of patients with LTBI who are initiating prophylaxis and/or the number completing treatment  
- # of potential rabies exposures investigated by health units annually  
- # of animals investigated that are current on their rabies vaccination  
- # of persons given rabies post-exposure prophylaxis (PEP)  
- # of days that fluoride levels were below recommended levels at municipal drinking water systems that add fluoride  
- # of drinking water advisories (DWA) and boil water advisories (BWA) issued by days advisories were in effect  
- % of the public who use private drinking water supplies (e.g., private wells) who are aware of how to safely manage their own drinking water systems  
- % of small drinking water systems where risk categories change from high risk to moderate or low risk indicating improvement in system performance  
- % of days per season beaches are posted |

---

The Indicator Framework is draft and subject to change.

The 2018 OPHS has also embedded a Transparency Framework, which is meant to increase transparency in the public sector and promote public confidence in the public health system. This is achieved through requirements of boards of health to disclose information to the public that supports making informed decisions to protect their health (e.g. restaurant inspection reports, drinking water advisories, infection control lapses) and reports on the activities of boards of health and associated level of investment (e.g. annual reports, strategic plans). The following infographic summarizes the components of this framework:

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Roles and Responsibilities

The Board of Health

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

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

The board should adopt a philosophy and management process that allows it to carry out its mandate in an efficient, effective, and economical manner. This should be complemented with a sound organizational structure that reflects the responsibilities of the component parts. The board of health is the governing body, the policy maker of the health unit. It monitors all operations within the unit and is accountable to the community and to the MOHLTC as described above.

The primary functions of the BOH are to provide good governance and strategic leadership to the organization. More information on good governance and overall BOH functions can be found in the *Governance Toolkit for Ontario Boards of Health* that was released by alPHA in January 2015 (Appendix 9). It is important to note that while the BOH works closely with the MOH/CEO, it is the MOH/CEO’s responsibility to lead the public health unit in achieving board-approved directions. Therefore, the responsibility for the day-to-day management and operations of the health unit lies with the MOH/CEO. The Board of Health

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

The Medical Officer of Health

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

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

In most boards of health (about two-thirds), the MOH serves the dual function of MOH and Chief Executive Officer (CEO) of the board of health. In the others, the MOH and CEO (or CAO in some cases) are separate positions, where the former takes on more responsibility for the administrative and operational aspects of the agency. To ensure that the intent of section 67 of the HPPA is consistently applied across all boards of health (i.e. that the MOH reports directly to the BOH on matters related to public health in all cases) the Ministry requires the following (extracted from the 2018 MOHLTC Policy Framework on Medical Officer of Health Appointments, Reporting, and Compensation, p.4):

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

**Governance**

In general terms, governance can be thought of as the stewardship of the affairs—particularly the strategic direction—of an organization. The BOH, acting in its governance role, sets the desired goals for the organization and establishes the systems and processes to support achievement of those goals. Critical elements of an effective public health unit governance policy framework include:

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

As outlined in the Public Health Legislation section above, each of these elements will be defined within the context of the prescriptive provincial policies that are laid out in the HPPA, OPHS and related documents that each BOH is obliged to follow. alPHa’s [Governance Toolkit](#) (Appendix 9) expands upon the above by giving guidance, practical tools and templates to help BOHs govern more effectively.

**Guidelines for Board of Health Members**

A member of a BOH should:

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

Board of Health Members and Structures

BOH Members

There are three categories of BOH members:

1. Elected Officials. These may be appointed to an autonomous BOH to represent their municipality. In the case of the seven regional boards of health, Regional Council acts as the BOH and all members are elected officials.

2. Public Appointees. The composition of autonomous BOHs is outlined in Section 49 of the HPPA. Section 49(3) provides for the appointment of one or more provincial members by the Lieutenant Governor in Council. Boards of health have the opportunity to participate in the recruitment, nomination and recommendation of individuals for public appointment positions on their boards of health. The guiding principle is that in recognition of unique local demographics, the local BOH is positioned to best determine public representation and geographic characteristics of the area they serve. Applications to be a provincial member on a BOH can be made through an open competition (i.e., advertising) conducted by the BOH or by direct application to the Public Appointments Secretariat (http://www.pas.gov.on.ca).

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

BOH Structures

Autonomous

In autonomous boards of health, the administrative structures of the public health unit and the municipality or municipalities are separate. Most autonomous boards of health have multiple obligated municipalities with representation on the BOH. Some may have citizen representatives appointed by municipalities and/or public appointees. A subset of this
category is known as “Autonomous/Integrated”, where only one municipality appoints representatives and operations are integrated with the municipality’s administrative structure. There are 25 autonomous boards of health in Ontario:

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

*autonomous/integrated

Regional

In this type of BOH, staff operates under the administration of regional government. According to the Association of Municipalities of Ontario, a regional government is a federation of the local municipalities within its boundaries. Regional boards of health have no citizen representatives and no public appointees. The 6 regional boards of health in Ontario are:

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

Single-Tier / Semi-Autonomous

In Single-Tier municipalities, municipal councils serve as the board of health and the staff of the health unit operates under the municipal administrative structure. A subset of this category is “Semi-Autonomous”, in which the municipal council appoints members to a separate board of health but retains authority for budget and staffing approvals. Presently, there are 4 municipal boards of health, two of which are Semi-Autonomous and 2 of which have municipal council acting as the BOH. They have no provincial appointees and the 2 cases where the BOH is independent of municipal council, citizen appointees are possible.

- Haldimand-Norfolk - Council acts as BOH
- Hamilton - Council acts as BOH
- Ottawa - Semi-Autonomous
- Toronto - Semi-Autonomous
The Ministry of Health and Long-Term Care

Minister

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

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

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

The Minister must approve all MOH and Associate MOH appointments, as well as any dismissal of a MOH or an Associate MOH by the BOH. As of 2011, the Minister and CMOH must approve acting MOH appointments that are more than 6 months.

Population and Public Health Division

The Population and Public Health Division (PPHD) has the primary provincial responsibility for public health in Ontario. Its stated mandate includes conducting surveillance for ongoing assessment of public health risks; implementing strategies to ensure continuity of critical Ministry services during an emergency; ensuring that appropriate actions are taken to respond to urgent and/or emergency situations; anticipation, prevention and response to health risks and hazards by designing, implementing, funding and monitoring public health programs; ensuring provincial compliance with national and international obligations; engaging with local, national and international partners in order to shape public health strategies; informing and advising other provincial partners on evidence-based human health impacts of government initiatives; advancing public health in Ontario by providing and supporting education, research, training, and resource tools; and developing the public health sector strategic direction within the broader health system.

It is headed by the Chief Medical Officer of Health (CMOH) and there are six branches within the Division:
Accountability and Liaison Branch: develops policy and plans to support the implementation of divisional programs and priorities for public health. The branch also informs program and divisional priorities.

Health System Emergency Management Branch: serves the entire Ministry and health sector as it responds to urgent and/or emergency situations as well as develops Ministry emergency readiness plans, informs health sector planning and directs, as necessary, health sector emergency response and recovery. It implements strategies to ensure continuity of critical Ministry services during and emergency; and ensures compliance with the Emergency Management and Civil Protection Act and other relevant legislation.

Strategy and Planning Branch: provides central locus for leading enhanced and integrated divisional and public health sector strategic planning and priority setting; research, evidence synthesis, knowledge dissemination and evaluation; as well as the development, implementation and coordination of integrated policies and strategies.

Health Protection and Surveillance Policy and Programs Branch: develops, implements and evaluates Ontario’s public health protection and prevention policies and legislation regarding immunization, environmental health and infectious diseases. The branch also provides oversight of public health programs, identified in the Ontario Public Health Standards, as well as supports public awareness and educational campaigns for public health.

Health Promotion and Prevention Policy and Programs Branch: leads the design/development, funding, implementation and evaluation of strategic population-based policies and programs in the areas of health promotion and prevention.

Health Improvement Policy and Programs Branch: responsible for working with partners to implement policies and programs that keep Ontarians healthy. Main functions include environmental health, addiction and substances policy, and tobacco and smoke policy.

Chief Medical Officer of Health

Appointed for a term of five years by the Ontario Provincial Legislature, the CMOH safeguards the health of Ontarians and provides advice on public health matters to the health sector, the PPHD, and the provincial government. The CMOH also 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 MOH;
• provide, and ensure provision of, required public health programs not being provided by a BOH;
• investigate, advise, guide and, if remedial action is not taken, issue a written direction in cases where the Minister of Health and Long-Term Care is of the opinion that a BOH has failed to comply with the Act, its regulations or provincial program standards. If the BOH fails to comply with the direction, the CMOH may act on behalf of the BOH.
• investigate situations, which, in the opinion of the Minister of Health 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 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. According to the HPPA,

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

(a) the expenses incurred by or on behalf of the board of health of the health unit in the performance of its functions and duties under this or any other Act; and

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

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

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

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

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

**76.** The Minister may make grants for the purposes of this Act on such conditions as he or she considers appropriate. 1997, c. 15, s. 5 (2).
This enables the Province to provide funding for these programs and services, and it has traditionally done so, but is not under the same obligation.

To illustrate, prior to 1997, funding responsibility for public health was shared by the Province (75%) and municipalities (25%). On January 1, 1998, as part of the Local Services Realignment initiative, the Province of Ontario transferred all funding responsibility for public health to municipalities, but this lasted little more than a year. On March 24, 1999, the Province announced that a grant of up to 50 percent would be provided to help offset the costs on the obligated municipalities. The 50/50 cost-sharing arrangement continued until 2005.

As part of Operation Health Protection, the Province announced an incremental increase to its funding share, to 55% in 2005, 65% in 2006, and 75% in 2007, thus returning to the 75-25 cost-sharing arrangement that remains in place today. The Ministry also provides 100% funding for a limited number of public health programs.

It is worth noting that growth limitations imposed by the Province on increases to the Ministry share of the contribution in the intervening years have resulted in an erosion of the total funding envelope and in many cases boards of health have contributed more than 25 percent to offset shortfalls.

**Related Organizations**

**Association of Local Public Health Agencies**

www.alphaweb.org

The Association of Local Public Health Agencies (alPHa) is the not-for-profit organization that provides leadership and services to local public health organizations in Ontario. Members include BOH members of health units, which comprise our Boards of Health Section; medical and associate medical officers of health, who comprise our Council of Ontario Medical Officers of Health (COMOH) Section; and senior managers in nursing, dentistry, epidemiology, nutrition, public health inspection, health promotion and business administration, who are our Affiliate Members.

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’s members and staff act to promote public health policies that form a strong foundation for the improvement of health promotion and protection, disease prevention and surveillance services in all of Ontario’s communities.
alPHa provides benefits to its members in a variety of ways:

- **Advocacy** – alPHa communicates health units’ issues, concerns and solutions on public health matters to government and decision-makers. It facilitates joint meetings between members and decision-makers to share information and expertise to improve Ontario’s public health system.

- **Communications** – To help them do their day-to-day jobs effectively, we keep members informed on latest news and events as well as emerging issues through our website, e-newsletters and group e-mail lists.

- **Education** – alPHa holds timely, relevant and informative sessions and programs to enrich members’ knowledge on issues, developments and challenges affecting the delivery of public health programs and services. Education programs include the Annual Conference, Fall Symposium, and Winter Symposium.

- **Representation** – Through membership in alPHa, our members have the opportunity to work on key issues and represent their public health colleagues on committees, working groups and alliances.

Every member of a BOH that is a member of alPHa is automatically a member of the Association and as such may enjoy the benefits thereof. Please see Appendix 10 for further information.

**Public Health Ontario**

[www.publichealthontario.ca](http://www.publichealthontario.ca)

Public Health Ontario (PHO) was established in 2007 as The Ontario Agency for Health Protection and Promotion. After a name change to Public Health Ontario in 2010, it continues as an arm’s-length government agency that supports the CMOH and provides expert scientific leadership and advice to government, public health units, and the health care sector. The Agency is a centre for specialized research and knowledge of public health, focusing in the areas of infectious disease, infection control and prevention, health promotion, chronic disease and injury prevention, and environmental health.

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

**Ontario Public Health Association**

[www.opha.on.ca](http://www.opha.on.ca)
The Ontario Public Health Association 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 resolutions and advocacy issues for a strengthened provincial public health system. The joint alPHa-OPHA Health Equity Work Group is an important forum for discussion of and advocacy for issues related to public health’s obligations in that area.

**Association of Municipalities of Ontario**

[www.amo.on.ca](http://www.amo.on.ca)

The Association of Municipalities of Ontario 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, including the AMO Health Task Force.

**Local Health Integration Networks**

[http://www.lhins.on.ca/](http://www.lhins.on.ca/)

Local Health Integration Networks 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.

LHINs are mandated to:

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

Public health engagement with LHINs has increased in recent years owing to the increased focus on improving the health system in Ontario informed by a population health approach. There are many examples of local initiatives involve partnerships between public health and LHINs on issues of mutual interest, and in 2016, the *Patients First Act, 2016* legislated formal engagement between the local MOH and the CEO of any LHIN whose territory intersects with the health unit.

Public health remains independent of LHINs, and alPHA’s unequivocal position is that this should remain the case to ensure that the voice of local municipalities remains relevant, that local partnerships with non-health sector entities remain strong and that the public health sector does not have to compete for resources with the much larger health care sector. alPHA will stand by its position that the mandates are substantially different and that there would be no advantage to be gained through any governance or funding relationship.
## Appendix 1 – Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
<th>Description</th>
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<tbody>
<tr>
<td>aPHa</td>
<td>Association of Local Public Health Agencies</td>
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<tr>
<td>AMO</td>
<td>Association of Municipalities of Ontario</td>
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<tr>
<td>AOPHBA</td>
<td>Association of Ontario Public Health Business Administrators</td>
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<td>APHEO</td>
<td>Association of Public Health Epidemiologists of Ontario</td>
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<td>ASPHIO</td>
<td>Association of Supervisors of Public Health Inspectors in Ontario</td>
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<tr>
<td>BOH</td>
<td>Board of Health</td>
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<tr>
<td>CAO</td>
<td>Chief Administrative Officer</td>
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<tr>
<td>CDC</td>
<td>U.S. Centers for Disease Control and Prevention</td>
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<tr>
<td>CMOH</td>
<td>Chief Medical Officer of Health</td>
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<td>COMOH</td>
<td>Council of Ontario Medical Officers of Health</td>
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<td>HPPEA</td>
<td>Health Protection and Promotion Act</td>
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<td>HPO</td>
<td>Health Promotion Ontario</td>
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<td>ISPA</td>
<td>Immunization of School Pupils Act</td>
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<tr>
<td>LHINs</td>
<td>Local Health Integration Networks</td>
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<tr>
<td>MECP</td>
<td>Ministry of the Environment, Conservation and Parks</td>
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<tr>
<td>MOH</td>
<td>Medical Officer of Health</td>
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<tr>
<td>MOHLTC</td>
<td>Ministry of Health and Long-Term Care</td>
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<tr>
<td>O. Reg.</td>
<td>Ontario Regulation</td>
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<tr>
<td>OAHPP</td>
<td>Ontario Agency for Health Protection and Promotion (a.k.a. PHO)</td>
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<tr>
<td>OAPHD</td>
<td>Ontario Association of Public Health Dentistry</td>
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<td>OAPHNL</td>
<td>Ontario Association of Public Health Nursing Leaders</td>
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<td>ODPH</td>
<td>Ontario Dietitians in Public Health</td>
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<td>OHPA</td>
<td>Ontario Health Providers' Alliance</td>
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<td>OPHA</td>
<td>Ontario Public Health Association</td>
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<td>OPHS</td>
<td>Ontario Public Health Standards</td>
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<td>PHO</td>
<td>Public Health Ontario</td>
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<tr>
<td>PHU</td>
<td>Public Health Unit</td>
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<tr>
<td>PPHD</td>
<td>Population and Public Health Division</td>
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<tr>
<td>SARS</td>
<td>Severe Acute Respiratory Syndrome</td>
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<td>SDWA</td>
<td>Safe Drinking Water Act, 2002</td>
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<td>SFIOA</td>
<td>Smoke-Free Ontario Act, 2017</td>
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<td>STDs</td>
<td>Sexually Transmitted Diseases</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>VPD</td>
<td>Vaccine Preventable Disease</td>
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Appendix 2 – Web Sites

Essential Bookmarks

Association of Local Public Health Agencies
www.alphaweb.org

Public Health Ontario
https://www.publichealthontario.ca/en/Pages/default.aspx

Government of Ontario Web Page on Public Health
https://www.ontario.ca/health-and-wellness/public-health-ontario

Public Health Resources and Reports

Make No Little Plans: Ontario’s Public Health Sector Strategic Plan, 2013

Improving the Odds: Championing Health Equity in Ontario: 2016 Annual Report of the Chief Medical Officer of Health of Ontario to the Legislative Assembly of Ontario


The 2018 Smoke-Free Ontario Strategy

Healthy Rural Communities Tool Kit A Guide for Rural Municipalities

aPHa Position Papers and Reports Library
https://alphaweb.site-ym.com/page/PH_Reports
Legislation and Other Governing Documents

Health Protection and Promotion Act
https://www.ontario.ca/laws/statute/90h07

Ontario Public Health Standards

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

Other Organizations

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

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

Ministry of Children, Community and Social Services
http://www.children.gov.on.ca/

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

Local Health Integration Networks
http://www.lhins.on.ca
Appendix 3 – Health Units Map
Appendix 4 – alPHa Board of Health Section Policies and Procedures

Association of Local Public Health Agencies (alPHa)

BOARDS OF HEALTH SECTION POLICIES AND PROCEDURES

Name

1. The name of the organization shall be: “The Boards 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. Honourary membership is for life and honorary members shall have no voting privileges.

(c) An Honourary member, at their own expense, may:
   i. Attend Boards of Health Section meetings or parts thereof subject to approval of the Chair;
   ii. Enjoy discounted registration rates for alPHa Conferences and regular Boards of Health Section meetings;
   iii. Receive periodic updates from the BOHs Section Executive; and
   iv. Represent alPHa/BOH Section on selected internal and external committees and working groups subject to approval of the BOH Section Executive Committee

Meetings and Procedures

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

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

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

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

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

Executive Committee

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

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

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

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

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

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

**Elections**

6. (a) Elections for members of the Section Executive Committee shall be held each year during the aPHa 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 Boards of Health Section Executive shall consist of seven (7) members, elected at the inaugural meeting of the Association, four (4) for two (2) year terms, the remaining three (3) for one (1) year terms. Thereafter, all newly-elected members of the Executive shall serve two (2) year terms. This shall promote continuity of experienced Executive members.

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

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

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

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

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

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

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

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

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

Chair

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

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

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

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

Vice-Chair

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

Amendments and Alterations

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

(b) Notice of proposed amendments shall be circulated to each member board of health and health 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, alPHa
June 10, 2002
Appendix – Ontario Boards of Health by Region

<table>
<thead>
<tr>
<th>North West Region</th>
<th>North East Region</th>
<th>South West Region</th>
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<tbody>
<tr>
<td>NORTHWESTERN</td>
<td>ALGOMA</td>
<td>CHATHAM-KENT</td>
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<td>THUNDER BAY</td>
<td>NORTH BAY PARRY SOUND</td>
<td>GREY BRUCE</td>
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<td>PORCUPINE</td>
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<td>SOUTHWESTERN</td>
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<td>WINDSOR-ESSEX</td>
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<td>Central West Region</td>
<td>Central East Region</td>
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<td>DURHAM</td>
<td>EASTERN</td>
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<td>HKPR</td>
<td>HASTINGS-PRINCE EDWARD</td>
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<td>PEEL</td>
<td>KINGSTON</td>
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<td>PETERBOROUGH</td>
<td>LEEDS-GRENVILLE</td>
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<td>OTTAWA</td>
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<td>WATERLOO</td>
<td>YORK REGION</td>
<td>RENFREW</td>
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<td>WELLINGTON DUFFERIN GUELPH</td>
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**Toronto**: TORONTO
Appendix 5 – aPHa Organizational Chart

Affiliate Members:

- OAPHNL – Ontario Association of Public Health Nursing Leaders
- 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
- OAPHN - Ontario Association of Public Health Dentistry
- ODPH- Ontario Dietitians in Public Health

Members:

- Public Health Units in Ontario
  - Boards of Health Section
  - Council of Ontario Medical Officers of Health

Each Contributes Seven Representatives

Each Contributes One Representative

Board of Directors

Executive Committee

Executive Director

Manager, Public Health Issues

Manager, Administration & Association Services

Executive Assistant

Associate Member:

Ontario Public Health Association (non-voting)
Appendix 6 – Population and Public Health Division Organizational Chart

CLICK HERE FOR FULL MINISTRY OF HEALTH AND LONG-TERM CARE ORGANIZATIONAL CHART
Appendix 7 – Provincial Legislation of Interest

Acts Containing Specific References to Public Health and/or Roles for Public Health Staff

- Health Protection and Promotion Act [https://www.ontario.ca/laws/statute/90h07]

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

Regulations Made under the Health Protection and Promotion Act

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Purpose</th>
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<tbody>
<tr>
<td>O. Reg. 136/18</td>
<td>PERSONAL SERVICE SETTINGS</td>
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<td>O. Reg. 135/18</td>
<td>DESIGNATION OF DISEASES</td>
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<td>O. Reg. 503/17</td>
<td>RECREATIONAL CAMPS</td>
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<td>O. Reg. 502/17</td>
<td>CAMPS IN UNORGANIZED TERRITORY</td>
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<td>O. Reg. 493/17</td>
<td>FOOD PREMISES</td>
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<td>O. Reg. 319/08</td>
<td>SMALL DRINKING WATER SYSTEMS</td>
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<td>O. Reg. 199/03</td>
<td>CONTROL OF WEST NILE VIRUS</td>
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<tr>
<td>O. Reg. 490/97</td>
<td>INTERESTS ON DEBTS UNDER SECTION 86.4 OF THE ACT</td>
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<tr>
<td>O. Reg. 489/97</td>
<td>ALLOCATION OF BOARD OF HEALTH EXPENSES</td>
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<tr>
<td>O. Reg. 338/96</td>
<td>EXEMPTION - SUBSECTION 39 (1) OF THE ACT</td>
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<td>R.R.O. 1990, Reg. 572</td>
<td>WARRANT</td>
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<td>R.R.O. 1990, Reg. 570</td>
<td>SCHOOL HEALTH PROGRAMS AND SERVICES</td>
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<td>R.R.O. 1990, Reg. 569</td>
<td>REPORTS</td>
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<tr>
<td>R.R.O. 1990, Reg. 567</td>
<td>RABIES IMMUNIZATION</td>
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<tr>
<td>R.R.O. 1990, Reg. 566</td>
<td>QUALIFICATIONS OF BOARDS OF HEALTH STAFF</td>
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<td>R.R.O. 1990, Reg. 565</td>
<td>PUBLIC POOLS</td>
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<td>R.R.O. 1990, Reg. 559</td>
<td>DESIGNATION OF MUNICIPAL MEMBERS OF BOARDS OF HEALTH</td>
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<tr>
<td>R.R.O. 1990, Reg. 557</td>
<td>COMMUNICABLE DISEASES - GENERAL</td>
</tr>
<tr>
<td>R.R.O. 1990, Reg. 553</td>
<td>AREAS COMPRISING HEALTH UNITS</td>
</tr>
</tbody>
</table>

- Cannabis Control Act, 2017 [https://www.ontario.ca/laws/statute/17c26]

The purposes of this Act are to establish prohibitions relating to the sale, distribution, purchase, possession, cultivation, propagation and harvesting of cannabis in order to protect public health and safety, protect youth and restrict their access to cannabis, and to deter illicit activities in relation to cannabis. It also provides for youth education or prevention programs, including culturally appropriate programs for Indigenous youth, as an alternative to enforcement and sanctions.
• **Child Care and Early Years Act, 2014**  [https://www.ontario.ca/laws/statute/14c11](https://www.ontario.ca/laws/statute/14c11)

The purposes of this Act are to foster the learning, development, health and well-being of children and to enhance their safety.

• **Healthy Menu Choices Act, 2015**  [https://www.ontario.ca/laws/statute/15h07](https://www.ontario.ca/laws/statute/15h07)

This Act requires that every person who owns or operates a regulated food service display the number of calories of every standard food item that is sold or offered for sale at the regulated food service premise and any other information required by the regulations.

• **Immunization of School Pupils Act**  [https://www.ontario.ca/laws/statute/90i01](https://www.ontario.ca/laws/statute/90i01)

The purpose of this Act is to increase the protection of the health of children against the diseases that are designated diseases under this Act.

• **Mandatory Blood Testing Act**  [https://www.ontario.ca/laws/statute/06m26](https://www.ontario.ca/laws/statute/06m26)

This Act enables a person to apply to a medical officer of health to have a blood sample of another person analysed if the former came into contact with a bodily substance of the other person as a result of being the victim of a crime, while providing emergency care, and other prescribed circumstances.

• **Safe Drinking Water Act, 2002**  [https://www.ontario.ca/laws/statute/02s32](https://www.ontario.ca/laws/statute/02s32)

The purposes of this Act are to recognize that the people of Ontario are entitled to expect their drinking water to be safe and to provide for the protection of human health and the prevention of drinking water health hazards through the control and regulation of drinking water systems and drinking water testing.

• **Skin Cancer Prevention Act (Tanning Beds), 2013**  [https://www.ontario.ca/laws/statute/13s05](https://www.ontario.ca/laws/statute/13s05)

This Act prohibits the sale or provision of tanning services or ultraviolet light treatments for tanning to an individual who is less than 18 years old.

• **Smoke-Free Ontario Act, 2017**  [https://www.ontario.ca/laws/statute/17s26](https://www.ontario.ca/laws/statute/17s26)

The purpose of this Act is to regulate the sale, supply, use and promotion of tobacco, vape and other products as prescribed.
Acts Pertaining to Health Units as Public Bodies

- **Municipal Freedom of Information and Protection of Privacy Act**  
  [https://www.ontario.ca/laws/statute/90m56](https://www.ontario.ca/laws/statute/90m56)

  The purposes of this Act are to provide a right of access to information under the control of institutions in accordance with the principles that information should be available to the public, necessary exemptions from the right of access should be limited and specific, and decisions on the disclosure of information should be reviewed independently of the institution controlling the information. It also provides for the protection of the privacy of individuals with respect to personal information about themselves held by institutions and to provide individuals with a right of access to that information.

- **Personal Health Information Protection Act, 2004**  
  [https://www.ontario.ca/laws/statute/04p03](https://www.ontario.ca/laws/statute/04p03)

  The purposes of this Act are to establish rules for the collection, use and disclosure of personal health information about individuals that protect the confidentiality of that information and the privacy of individuals with respect to that information, while facilitating the effective provision of health care.

- **Fluoridation Act**  
  [https://www.ontario.ca/laws/statute/90f22](https://www.ontario.ca/laws/statute/90f22)

  Where a local municipality or a local board thereof owns or operates a waterworks system, the council of the municipality may by by-law establish, maintain and operate, or discontinue a fluoridation system. It provides for putting the question of doing so to the electorate.

- **Occupational Health and Safety Act**  
  [https://www.ontario.ca/laws/statute/90o01](https://www.ontario.ca/laws/statute/90o01)

  The purpose of this Act is to promote occupational health and safety and the prevention of workplace injuries and occupational diseases through public awareness, education of employers, and workers and regulation.

- **French Language Services Act**  
  [https://www.ontario.ca/laws/statute/90f32](https://www.ontario.ca/laws/statute/90f32)

  A person has the right in accordance with this Act to communicate in French with, and to receive available services in French from, any head or central office of a government agency or institution of the Legislature, and has the same right in respect of any other office of such agency or institution that is located in or serves an area designated in the Schedule.
• Municipal Act, 2001  
https://www.ontario.ca/laws/statute/01m25

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

• Municipal Conflict of Interest Act  
https://www.ontario.ca/laws/statute/90m50

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.

• Accessibility for Ontarians with Disabilities Act, 2005  
https://www.ontario.ca/laws/statute/05a11

Established with the goal to have standards to improve accessibility across the province. The Accessibility Standards for Customer Service is the first of four common standards under the Act. Other common standards that are being developed include: built environment, employment, information and communication.

Appendix 8 – A Review of Board of Health Liability


Appendix 9 – Governance Toolkit for Ontario Boards of Health

WHO WE ARE

The Association of Local Public Health Agencies is the non-profit organization that provides leadership to boards of health and public health units in Ontario. Our members include board of health trustees, medical and associate medical officers of health, and senior public health managers in each of the public health disciplines – nursing, inspections, nutrition, dentistry, health promotion, epidemiology and business administration. alPHA advises and lends expertise to members on the governance, administration and management of public health units. The Association also collaborates with governments and other health organizations, advocating for healthy public policy and a strong, effective and efficient public health system in the province.

OUR RESOURCES

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

Recognizing that health unit resources vary across the province, alPHA’s membership requirements are graded to ensure that any board of health in Ontario can enjoy all of the membership benefits equitably. This is a contribution to the $600,000 that alPHA spends annually on member services such as advocacy, communications, education and professional development.

WHAT WE DO FOR OUR MEMBERS

Promote

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

Represent

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

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

**Support**

alPHa ensures that members are aware of proposed legislation and matters that are of interest to public health units. Further, alPHa facilitates the sharing of member positions, resolutions and discussion documents to encourage broader support for member issues among alPHa’s membership.

alPHa has established the “Current Consultations” page on its web site where information is posted about government consultations. Members are informed and provided links through email and alPHa’s “Information Break” e-newsletter. alPHa has also established a web page for posting existing and proposed health promoting local by-laws, categorized by social determinants of health.

**Connect**

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

**Enrich**

alPHa provides professional development to support excellence in public health leadership and public health unit management and governance. Professional development is delivered through the annual conference, webinars and face-to-face meetings. alPHa holds timely, relevant and informative sessions and programs to enrich members’ knowledge on issues, developments and challenges affecting the delivery of public health programs and services. Education programs include the Annual Conference, Fall Symposium, and Winter Symposium.
HOW WE DO IT

The business of the Association is overseen by a 21-member Board of Directors, consisting of 7 medical officers of health, 7 board of health trustees and representation from each of the 7 public health disciplines listed above. All regions of the province are represented to ensure that all communities’ interests can be served. The Board meets at least 5 times each year to discuss emerging and ongoing issues in public health policy, governance, funding, and programs and services.

alPHa also conducts regular meetings of its Boards of Health Section and Council of Medical Officers of Health (COMOH) to discuss issues particular to their positions. In addition, ad hoc committees are frequently assembled to discuss action plans for Association Resolutions, as well as emerging issues raised by members, public, government or media. These committees often provide the opportunity for wider participation in alPHa business by interested health unit staff with expertise in the operational and programmatic aspects of these issues.

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 day-long workshops on risk management, West Nile virus, drinking water safety, and orientation of new board members. alPHa has also held teleconferences on unexpected policy announcements, and in-services at health units on labour relations and liability issues.

alPHa is regularly invited to appoint official representatives to both ad hoc and standing policy analysis and advocacy committees struck by government, other associations, agencies and coalitions.

Our staff regularly consults with other partners in the health and policy sector, including government ministries, Public Health Ontario, the Association of Municipalities of Ontario, the Ontario Medical Association, the Ontario Public Health Association and Cancer Care Ontario. alPHa also brings the public health perspective to the Ontario Health Providers’ Alliance, the coalition of provincial health service organizations that gives advice and guidance to the Ontario government on health care reform.

VALUE-ADDED BENEFITS OF MEMBERSHIP

❖ Member Services

- **Electronic mailing lists**: interactive e-mail lists where members can seek advice from colleagues and send and receive information instantly throughout the province. It also allows alPHa staff to request and receive broad input from each of its members when formulating its positions.
- **alPHaWeb**: our Web site, [www.alphaweb.org](http://www.alphaweb.org), includes information about alPHa, links to the Web presence of each of its members, job postings and extensive information on current public health issues. Secure Members’ Areas are also available for the posting of non-public material such as meeting information, draft resolutions, salary surveys and collective bargaining agreements.
• **Educational opportunities**: seminars, workshops, and general meetings as described above
• **Membership surveys**, with distribution of results on insurance, board member remuneration, staff salaries, board of health budgets and other topical issues

❖ **Products**
• **Directories**: Every two years, alPHa updates its online *Directory of Public Health Agencies*, which contains contact information for each of Ontario’s health units, including sub-offices and direct lines for senior management staff. This is available at [https://bit.ly/2rjlGLt](https://bit.ly/2rjlGLt)

❖ **Group Affinity Programs**
alPHa will periodically negotiate group rates for member health units and their employees.
  • Teleconferencing
  • Long-distance rates
  • Employee Benefits
  • Group rates on personal home and auto insurance

❖ **A Strong Association**
alPHa’s mission statement is to, through a strong and unified voice, advocate for public health policies, programs and services on behalf of member health units in Ontario. The strength and unity of this voice is best served when all of Ontario’s communities are represented. alPHa is currently enjoying unprecedented recognition and credibility in many public policy discussions, and its voice is strong as the representative of all 35 Ontario health units.

**AT YOUR SERVICE**

The alPHa Staff is small but responsive and capable.

**Executive Director, Loretta Ryan** provides strategic and operational expertise to lead the organization and has overall responsibility for strategic and operational planning, stakeholder relations, budgeting and finance, and human resources. Her primary responsibilities are:

• *Providing strategic leadership in concert with the Board to develop strategic and operating plans for alPHa.*
• *Providing operational leadership and structure to realize the goals of alPHa.*
• *Developing, maintain and leverage relationships with Association members, partner associations, government and other agencies to further the mission of the Association.*
• *Promoting the Association and its members by communicating the positions of the Association and advocating on its behalf.*
• *Keeping informed about and communicate matters that substantively affect the operation of member local public health units.*
• *Developing the annual budget and overall financial management practices that demonstrate fiscal responsibility.*
Manager, Public Health Issues. **Gordon Fleming** provides support and technical services to alPHA's Board of Directors and Committees, with a focus on policy and emerging issues that affect alPHA's members. His primary responsibilities are:

- **Assisting with the development and communication of association positions on matters related to public health programs and services.**
- **Monitoring and tracking developments related to alPHA's active Resolutions**
- **Authoring alPHA correspondence, news releases and other external communications**
- **Representing alPHA's members on external committees and at external meetings as needed**
- **Providing secretariat support for the Council of Medical Officers of Health and its Executive and ad hoc committees**
- **Managing website content and administering alPHA's electronic mailing lists**

Manager, Administrative and Association Services. **Susan Lee** supports the Board of Directors, its committees and association events. Her primary responsibilities are:

- **Planning and coordinating conferences**
- **Providing secretariat support to the following:**
  - alPHA Board of Directors and its Executive
  - Boards of Health Section and its Executive
  - Association ad hoc committees
- **Authoring newsletters, annual report, and other communication pieces**
- **Managing website content**

Administrative Assistant. **Karen Reece** provides support to the Executive Director and other association staff. Her primary responsibilities are:

- **Finances (accounts payables and receivables)**
- **Registration and planning of meetings and conferences**
- **Office management**
- **Updating and maintaining directories**
- **Responding to general inquiries from members and the public**

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