Guarding the Health of Citizens: The Crucial Role of the Medical Officer of Health

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The Ontario Medical Association (OMA) has demonstrated a deep-seated commitment to the promotion of Public Health since its inception in 1881. Some of the Association’s earliest work was conducted by the Committee on Public Health (now the Committee on Population Health) based on concerns that unsanitary conditions were endangering the health of Ontarians. The OMA believes that a robust public health structure, organized to promote and protect health and prevent disease and injury, is a key element of an effective health care system. Furthermore, the OMA believes that only through the combined and coordinated efforts of all agencies and groups involved will we attain a high performance public health system.

The OMA has a long-standing track record of working with government and other stakeholders to improve public health. The Association (1926) supported the Ontario government’s efforts in the appointment of a Minister of Health, the establishment of local health units, the appointment of full-time Medical Officers of Health and the amendment to the Public Health Act that enabled municipalities to combine their efforts in obtaining a Medical Officer of Health. The OMA recognizes the need for both provincial coordination and legislative direction on public health matters in order to protect and improve the health status of the people of Ontario.

The OMA understands that the transformation of the current public health system, in light of recent incidents and recommendations of subsequent inquiries, will fail without a significant investment in the crucial role of the Medical Officer of Health. These expert leaders must be supported if they are to be successful in their mandate to guard the health of Ontario citizens. All other aspects of the reform, while equally important, serve as the supporting foundation for these experts in their mandate to guard the health of citizens.
INTRODUCTION

In the first sentence of The SARS Commission Interim Report, SARS and Public Health in Ontario, Justice Campbell states “SARS showed that Ontario’s public health system is broken and needs to be fixed.” (4)

The success of any effort to fix the system is contingent upon Ontario having a strong and sufficient leadership team of expertly qualified and properly credentialed public health physicians. These Medical Officers of Health are the backbone of the public health system.

Justice O’Connor stated
“The existing legislative scheme that requires every board of health to appoint a full-time Medical Officer of Health is a provision that enhances the security and independence of the office.” (2)

Justice Campbell stated
“Local Medical Officers of Health and public health units, the backbone of Ontario public health, require in any reform process a strong focus of attention, support, consultation and resources.” – Principles for Reform #6 (4)

Dr. Naylor stated
“In short, on multiple levels, be it staffing for core public health functions, or at the interface of clinical and public health activities, there is an acute shortage of highly qualified personnel.” (6)

Graham Scott, Assessor Muskoka-Parry Sound Health Unit stated
“The MOH position is both demanding and pivotal in the provincial–municipal interface.” (9)

The Government of Ontario stated in the Health Protection and Promotion Act that every board of health shall appoint a full-time medical officer of health and may appoint one or more associate medical officers of health. (1)

Despite the findings of expert inquiries over the last five years, and despite provincial legislated requirements, one-third of all health units in the province are without a full-time Medical Officer of Health in 2005. (10) “Furthermore, acting MOH positions are not considered vacant by many boards of health.” (10)

These vacancies are especially disquieting when put into context. There are currently 36 health units in the province of Ontario, which, by legislation, must have a full-time Medical Officer of Health. Given this small number, the reduction of one-third has had a staggering impact that goes beyond individual community needs. There is a danger that the current critical mass of Medical Officers of Health is insufficient to be viable and sustainable. The foundation has been so eroded over time that, if not protected and fortified, it will disintegrate and seriously imperil the province’s health.

The Ontario Medical Association has, throughout recent years, urged the government to address the issues identified by inquiries and voiced by the Medical Officers of Health. Today, critical fundamental issues persist, however, the OMA believes that the provincial government has never before been so well informed and strategically positioned to address these issues.
In this paper we will systematically summarize our concerns. We will discuss the lack of capacity in the system and capture the many challenges facing practising Medical Officers of Health. We will highlight the changing role of the MOH and the changing expectations of the public. We will provide a compelling case to act on the issues facing Medical Officers of Health as identified in both Interim Campbell Reports. (4,5) We will urge the government to enforce its own legislation by insisting on full-time, properly credentialed Medical Officers of Health throughout the province of Ontario.

In summarizing the issues, this paper will emphasize both the gravity and the urgency of the situation. It will leave no room for misinterpretation, and at no point in the future can it be said that decision-makers were unaware.
PART I. BACKGROUND

Over the last five years Ontario has been faced with a number of public health emergencies. Some were highly publicized while others drew less media attention. We will use these disasters, and other public health incidents in Ontario, as examples of how policy decisions have had a profound and long-term impact on the health of citizens. Each example is linked to the bigger picture of a provincial public health system with an inadequate number of properly qualified experts to manage even typical public health needs.

In 1997, the Ontario government passed Bill 152, Schedule D, the Services Improvement Act amending the Health Protection and Promotion Act (HPPA). The amendments allowed for the downloading of public health to the municipalities. At that time, Ontario Medical Association President Dr. John Gray, and other health care leaders, expressed serious concerns that such amendments, without offsetting safeguards, would compromise the health and safety of Ontarians. Three specific concerns were presented to government:

1. Decisions on public health would be undertaken by municipal administrators who had no requisite training or expertise to be publicly accountable for public health services.
2. Existing programs that were funded entirely by the provincial government would be vulnerable given a historical perspective that municipalities had refused to support some of those important initiatives.
3. The privacy of confidential health information could be compromised.

The following is taken directly from remarks made by Dr. Gray in October 1997, to Committee Hearings at Queen’s Park, addressing Bill 152:

"I cannot emphasize enough that the downloading of public health is a very serious health-care issue. The health of families, friends and entire communities is in the balance. Water supply contamination, outbreaks of diseases like tuberculosis, hepatitis and meningitis may become difficult to track and treat under a fragmented system. In light of the emergence of new antibiotic resistant bacteria these are frightening prospects."

The OMA was successful in bringing about some amendments to the original Bill that secured the direct reporting relationship between Medical Officers of Health and local health boards, and ensured confidential medical information remained solely with qualified health professionals. However, Bill 152, as predicted, by removing the executive officer powers and duties of the Medical Officers of Health, has had the devastating impact of transferring responsibility for public health to some governing bodies whose employees lack the qualifications, insight, and commitment to public health to make the best strategic choices. Concurrently, it has eroded the leadership and independence of Medical Officers of Health at a time when it was urgently needed.
PART II. EXAMPLES OF A BROKEN PUBLIC HEALTH SYSTEM

The following examples of recent public health crises in Ontario may be viewed by the public as unrelated incidents. They are recognized, however, by public health experts as closely knit events with a common underlying thread – a broken public health system.

1. Contaminated Water in Walkerton Ontario

In Ontario, people trusted the safety of their drinking water. That changed in May 2000, when the drinking water in Walkerton became contaminated with *Escherichia coli* O157:H7 (commonly referred to as E. coli).

By the end of this disaster, seven people died as a result of this contamination. More than 2,300 became ill. The loss to the community was enormous, both in terms of morbidity and mortality, as well as economic losses. It raised questions across Ontario about the safety of drinking water, and left this previously quiet community with a legacy that continues to this day.

In Walkerton, once the Medical Officer of Health was alerted, the local health unit began to investigate. A boil-water advisory was issued and, at the urging of the Medical Officer of Health, the Ministry of the Environment began its own investigation of the Walkerton water system.

A Medical Officer of Health, in his/her duty to the public, must be kept fully informed and must be able to act independent of political pressure.

In 1996, Cabinet approved budget reductions of Ontario’s public laboratory system despite warnings of increased risk to the environment and human health. This led to the discontinuation of government laboratory water testing services for municipalities. (2) No regulation was implemented at that time to notify the MOH of adverse results. Only after the events in Walkerton did the government enact such a regulation.

2. SARS Outbreak in Toronto Ontario

The most profound and widespread public health crisis in Ontario’s recent history was that of SARS.

SARS is a viral illness that originally emerged in China in November 2002 and spread to different parts of the world over a period of a few weeks. Globally, approximately 8,500 people were diagnosed as probably having SARS, although differential diagnosis is a challenge with SARS as it resembles many other respiratory infections. Over 900 people died. The two regions of the world most impacted were Asia and Canada. In Canada, SARS was concentrated in Toronto and the greater Toronto area (GTA), where, by August 2003, there were 438 suspected cases including 44 deaths. Roughly 100 of those diagnosed were health care workers, of whom three died.

SARS put unprecedented demands on the public health care system and the Medical Officers of Health, both individually and collectively. In Toronto, during SARS, the
volume of work included approximately 2,000 case investigations (9 hours each). More than 23,000 people were identified as contacts and 13,374 were quarantined. Over 200 staff responded to over 300,000 calls on the SARS hotline. (5)

In addition to highlighting this issue of capacity and surge capacity, SARS also drew attention to the complexities of controlling an outbreak of disease, and the skills required by Medical Officers of Health in responding to those complexities. The impact of SARS on Medical Officers of Health will be discussed further, and is well documented in the first and second interim SARS Commission (Campbell) reports.

3. Rubella Outbreak In Oxford County

In order for information to be useful, it must be interpreted by public health experts who have an understanding of their community and can put that information into context.

An example where absence of expertise at the local level resulted in a missed opportunity is a rubella outbreak in Oxford County. Important information prior to the event was not interpreted within the context of the community, therefore no action was taken prior to the event. There is no suggestion here that the outbreak could have been prevented as this community had a relatively low immunization rate due to religious beliefs and affiliations that do not support immunization. However, at the time, the Municipality had hired a part-time acting Medical Officer of Health who did not have the credentials that are required by the HPPA of full-time Medical Officers of Health. As a result, the skill required to carry out the needed public health activities for an outbreak of communicable disease was absent.

Prior to the rubella outbreak, the Ministry of Health’s Public Health Division alerted Medical Officers of Health of a rubella outbreak in the Netherlands. This community had a sizeable Netherlands Reformed population. Recognition of the risks of imported rubella would have allowed greater and more active surveillance opportunities, more timely diagnosis of rubella cases, and more prompt institution of outbreak control measures that could have resulted in a reduction of the intensity and duration of the outbreak.

As a result of the outbreak, the Chief Medical Officer of Health appointed two temporary Medical Officers of Health. They developed and assured a coordinated and comprehensive set of outbreak investigation, control and communication measures, at the same time linking with provincial and federal expertise to address rubella outbreak issues that challenged our previous practices and understanding of rubella outbreaks, leading to new standards of practice and guidelines for the management of rubella in numerous health care and community settings.

4. Ineffective Governance in Muskoka-Parry Sound

The following example further illustrates that problems continue in spite of recommendations made by Justices O’Connor and Campbell and reinforces the need to act immediately.

Muskoka-Parry Sound Health Unit has had a history of grappling with the issue of effective governance. In July 2004, the Chief Medical Officer of Health appointed an
Assessor for the Muskoka-Parry Sound Health Unit, based on growing concerns regarding governance and operations. Several changes had already taken place to try to alleviate some of the issues.

Despite the changes, there was little noted improvement. Some of the specific deficiencies cited were a lack of strategic planning, insufficient Board orientation, and a poor understanding on the division of roles between the Board and management.

The following observations are taken from the Assessor’s (Scott) report (9):

- “The Board does not respect the role of the MOH and is divided on the issue of the duties and responsibilities of the MOH.”
- “The Board does not require or expect the MOH to attend all Board meetings and report regularly.”
- “There has been a constant upheaval in the office of the MOH for the MPSHU.” (Muskoka-Parry Sound Health Unit)
- The Board ignores the governing legislation when convenient.”

At the time of the report, the current MOH was “largely unknown to the new Board as he has not been able to attend Board meetings due to a well-understood timing conflict that the Board has not addressed.” (9)

Scott’s report described the MPSHU Board as chronically dysfunctional and recommended that it be dissolved. The situation had existed over a sustained period of time and made vulnerable a portion of the population in Ontario. This Board was given authority under Bill 152 to make decisions impacting the health of its citizens. It is an example of what cannot be allowed to continue.

Since 1997, Ontario has seen the profound effects on families and communities brought about by the contamination of the water supply in Walkerton. The world watched as we struggled to contain the SARS outbreak, a disease unheard of in 1997. An outbreak of rubella occurred in an Ontario community that did not have public health physician expertise and leadership to manage the event. Each of these outbreaks challenged the public health system in different ways. Deficiencies related to capacity, accountability, governance, a fragmented system, and the interpretation of information by not properly credentialed acting MOHs came to light. While each of these system deficiencies surfaced, a single underlying issue was evident in every case. Managing the health of the public demands a highly skilled, adequately resourced team of experts empowered to act in the interest of the public.

Recommendations:

1. The OMA urges the Ontario government to enforce its own existing legislation by insisting that all health units in Ontario have a full-time, properly credentialed Medical Officer of Health.

2. The OMA supports recommendation 1 of Part One Report of the Walkerton Inquiry which states: The Health Protection and Promotion Act should be amended to require boards of health and the Minister of Health, acting in concert, to expeditiously fill any vacant Medical Officer of Health position with a full-time Medical Officer of Health.
3. The OMA supports recommendation 7 of the Position Paper of the Community Medicine Residents of Ontario which states: As a precaution to protect the public’s health, the MOHLTC should ensure that any person being appointed by a board of health as an Acting MOH, be assessed in accordance with the College of Physicians and Surgeons of Ontario (CPSO) Policy on “Requirements when Changing Scope of Practice” (Policy #13-00).

4. The OMA strongly supports the following recommendations of the first and second Campbell reports:

So long as the local boards of health remain in place: the local Medical Officer of Health should have full chief executive officer authority for local public health services and be accountable to the local Board. Section 67 of the Health Protection and Promotion Act should be enforced, if necessary amended, to ensure that personnel and machinery required to deliver public health protection are not buried in municipal bureaucracy {Principle of Reform #9}.

The Health Protection and Promotion Act be amended to provide for every local Medical Officer of Health a degree of independence parallel to that of the Chief Medical Officer of Health. This would include:

a. Giving the local medical officers of health the same reporting duties and authority as the Chief Medical Officer of Health....
b. Protecting the independence of the local Medical Officer of Health by providing that no adverse employment action may be taken against any Medical Officer of Health in respect of the good faith exercise of those reporting powers and duties.
PART III. THE CHANGING ROLE OF THE MEDICAL OFFICER OF HEALTH

“A strong central body will never compensate for weak local capacity in infection control in the local public health system.”
Walker

“Community medicine specialists serve as medical officers of health in local public health agencies, and provide specialized expertise for the provincial and federal governments.”
Naylor

The scope of public health has changed dramatically. The emergence of new diseases and the re-emergence of traditional ones bring new sets of challenges. Global travel increases the likelihood of large-scale outbreaks. An emphasis on prevention has led to highly successful public health education programs. The use of technology both as an enabler of data transfer and as a vehicle for surveillance increases the speed with which public health information can be shared and therefore acted upon. These changes impact on every aspect of public health, including the more traditional health protection regulatory roles (e.g. food and water safety, communicable disease control).

The expectations of public health have also changed dramatically. Perhaps a victim of its own success, public health is expected to play a lead role in communicable and non-communicable disease prevention and control, and in health promotion. Public health work ranges from grassroots community development initiatives to top-down enforcement activities. It is increasingly expected to play a first responder role and to lead local health-emergency preparedness planning. This latter role has evolved since 9/11 to include bioterrorism and, with extreme weather events and hydro shortages, to also include natural disaster response.

Correspondingly, the role of the Medical Officer of Health has also changed dramatically over the last several years. Even within the last five years, the specialist and leadership expectations of the MOHs have grown exponentially, imposing increased accountabilities and liabilities on the already complex role. Unfortunately, in Ontario these developments come at a time of increased MOH vacancies and decreased executive authority as a result of Bill 152.

More than ever, the effective functioning of the Medical Officer of Health requires a broad range of specialist core competencies.

Clinical Expertise

The SARS example demonstrates the need for the Medical Officer of Health to interpret and act on emerging information about potential health threats. With SARS, the required core competencies included clinical, epidemiological, scientific, risk management, and communication skills, to name a few. Knowledge and skills in all of these areas must be constantly updated to maintain competence within the scientific parameters of the job.
**Clinical Leadership and Engagement**

Clinical and epidemiological information must be organized in a manner that allows the Medical Officer of Health to give direction and make recommendations to the scientific and local public health and general community. She/He must orchestrate local response to public health issues with all key stakeholders (e.g. CCACs, hospitals, family physicians). The ability to accomplish this, especially during times of crisis, is based on a solid foundation of credibility and ongoing engagement with the clinical community. This relationship cannot be instantly conjured up during times of crisis. It is the result of a constant presence in the community of a full-time, properly credentialed MOH.

**Community Leadership and Engagement**

In order to support health and enhance compliance with measures to protect health, public health issues must be communicated to local communities in the context of the unique needs of each community (e.g. cultural, religious, socioeconomic). As the “voice” of the public health system at a local level, the Medical Officer of Health must work with schools and community agencies. During a public health outbreak/emergency the MOH must have the confidence of the community. The local Medical Officer of Health must be able to apprise the public of complex issues in a way that is locally effective and be available to respond to unique community needs.

**Management and Team Building**

The Medical Officer of Health, in addition to being a clinical expert, must be an excellent manager and organizational leader. She/He is responsible for staff that is entrusted with the health of the community. The MOH must establish and lead an effective team of public health experts and administrative personnel. Leadership skills are required to work with multiple stakeholders, multiple layers of government, politicians, the Chief Medical Officer of Health, Health Canada and others.
PART IV. SYSTEM CAPACITY

“One of the most striking and urgent issues raised in our Initial Report related to human resource shortages, especially in public health.” Walker (7)

Public health, like many other health care specialties, must be ready to go “from 0-60” at any given time – and that time is unpredictable. Similar to an Emergency Department or an Intensive Care Unit, volumes and the nature of cases can be trended over a period of time, using historical data, current trends and an understanding of the environment. However, activity levels can change quickly and the system must be properly resourced with skilled professionals for the unexpected at any and all times.

The outcomes of a well thought out public health strategy may not be obvious for years, and, like many examples in life, it only looks easy when it is well done. While long-term outcomes impacting morbidity and mortality are quantifiable, they may not receive the public attention that occurs during a crisis. The capacity to respond in a public health emergency is immediate and obvious.

The Investment in Medical Officers of Health

The value of a full-time, properly credentialed Medical Officer of Health in each community is one part of the equation. However, equally important is the issue of adequate coverage – capacity.

The current legislation requires a full-time Medical Officer of Health for every health unit. This underestimates the capacity needed to provide 24/7 coverage. The number of MOHs essential to manage the system must account for extended hour coverage, vacation, sick time, and educational time needed to remain professionally current. It requires a calculation based on full-time equivalents (FTEs). This method of determining staffing levels is the standard within hospitals and health care agencies, and should be adopted as the method to determine human resource requirements for Medical Officers of Health.

Recommendations:

5. The OMA recommends that the Ontario government requires that Boards of Health employ, in addition to a full-time Medical Officer of Health, a sufficient number of properly credentialed full-time equivalents (FTE’s) to ensure adequate public health coverage at all times.

6. The OMA recommends that Ontario factor into the calculation of full-time equivalents (FTE’s) sufficient Human Resources to meet surge capacity.

Currently in Ontario, there is an insufficient number of Medical Officers of Health to meet even baseline needs. Vacancies, and temporary positions with unqualified personnel have created serious gaps in service to communities.
Cross-coverage is currently extensive and includes routine vacation coverage and coverage of boards of health during recruitment periods. In situations where an MOH is asked to assess, cover, and intervene in another health unit (e.g. rubella outbreak) their own community is left underserviced and vulnerable, while the MOH bears the additional responsibility of managing two communities. This is the inadequacy that exists within the current system most of the time – that is, during usual times. Add to this the potential of an outbreak of disease and we have a crisis – there is no surge capacity in the system.

Every example of a public health outbreak in Ontario’s recent history required more than one Medical Officer of Health to contain the outbreak and manage the community public health issues. We raid medical resources from one community, putting it at risk, to assist the community in greatest current need. This is clearly shortsighted and inadequate.

MOH staffing, based on an FTE calculation, would benefit the entire public health system by ensuring that the province could manage a full range of public health incidents, whether contained in one community or dispersed across the province. In the absence of health emergencies the investment of these additional medical resources would allow adequate coverage for baseline needs and for investment in public health initiatives. It would provide the Medical Officer of Health adequate time for continuing education, ensuring currency and professionalism. This has significant implications for recruitment and retention.

The investment that would be required is modest and would yield a significant pay off as we, as a society, shift from a model of illness to one of health and disease prevention.

**Human Resource Capacity**

**Recommendation F: “A review of recruitment and retention strategies for Medical Officers and Associate Medical Officers of Health, including remuneration.”** Walker (7)

We have learned many lessons from SARS, but one of the most profound was the corroboration of what we already knew – SARS was only an example of an outbreak of disease – it was destined to happen, and it is destined to happen again. For those health care professionals who worked in the greater Toronto area, this knowledge has been transferred from an intellectual understanding to a chilling reality at a visceral level. We have not increased our Medical Office of Health capacity since the SARS outbreak and do not currently have an adequate number of public health experts to respond effectively to another outbreak.

In October 2003, four months after the SARS epidemic ended, the report of the National Advisory Committee on SARS and Public Health noted that it is difficult to know how many doctors in Canada are involved in the practice of public health. Public health human resources have not been well characterized by the Canadian Medical Association, the Canadian Institute for Health information (CIHI), and studies sponsored by Human Resources & Skills Development Canada have not focused on Public Health.(6) It does appear, through a survey of the Chief Medical Officers of Health across Canada, that while many doctors have been trained in community and/or public health, a much smaller number are working in that specialty.
“... less than one percent of graduating medical students in Canada choosing Community Medicine as a specialty.” (10)

A summary of public health physician positions across Canada does not provide sufficient information. Vacancy data are not particularly reliable because physicians working part-time or without formal qualifications occupy many of the filled positions. (6) At the time of the SARS Report, for example, eight of the then existing thirty-seven health units in Ontario (since reduced to 36 on dissolution of Muskoka-Parry Sound Health Unit) did not employ a full-time Medical Officer of Health and municipalities have had long standing difficulties filling vacancies for Medical Officers of Health.

**Recommendation D:** “The development of re-entry training positions in community medicine such that practitioners currently practicing in other specialties can become qualified to work in public health.” Walker(7)

Although Ontario has gone so far as to legislate formal public health qualifications, insufficient access to these professionals has resulted in acting Medical Officers of Health, who may not have the requisite education and experience. While these professionals are filling the gap to the best of their abilities, Canada, and Ontario specifically, has a shortage of well-qualified public health specialist physicians.

**Recommendation:**

7. **The OMA recommends that the Ontario government develop a Human Resource Strategy for Medical Officers of Health that includes surge capacity provisions and incentives to attract and retain properly credentialed Medical Officers of Health.**

**Educational Capacity**

Increasing the number of training positions is an important ingredient in increasing the future capacity to manage public health. However, there must also be incentives to attract our best and brightest into community medicine with an emphasis on rewarding careers within the public health specialty. Dr. Naylor points out in his report Learning from SARS, Renewal of Public Health in Canada, “Compensation is frequently cited as a barrier to recruitment and retention of public health physicians. Whether compensation-related or not, interest in this specialty is limited.” (6) He goes on to conclude that, “Relatively poor remuneration is not the only drawback to working as a public health physician. Other potential disincentives are the challenges of working in a political and bureaucratic environment and bearing ultimate responsibility for the health of thousands of citizens in a particular region.” (6)

Linkages between Medical Officers of Health and other public health professionals with universities, teaching hospitals, and research opportunities are examples of designing a strong and integrated network of public health for the province. “Teaching health units” (6) have been described as critical to a well credentialed, well resourced, public health system.
We must scrutinize our educational processes for public health practitioners in light of what we have learned. The number of programs and the curricula should be reviewed. We must also examine continuing education opportunities to maintain clinical expertise and to engage a broad number of physicians in a number of roles that support healthy Ontarians.

**Recommendations:**

8. The OMA recommends that an Educational Strategy, including necessary funding, be developed to graduate well qualified physicians in sufficient numbers to address current and growing needs, and to absorb the attrition of medical officers of health who are nearing retirement.

9. The OMA supports Recommendation D of the Walker report: “The development of re-entry training positions in community medicine such that practitioners currently practicing in other specialties can become qualified to work in public health.”
PART V. ACCOUNTABILITY

With sufficient numbers of properly credentialed Medical Officers of Health, the province of Ontario will be well positioned to meet the health needs of the public. However, the transformation of the system must then include the supports necessary to allow these experts to fulfill their mandate.

An efficient and effective public health infrastructure must have clear and simple lines of accountability. Those accountabilities must lie with professionals who have the knowledge, experience, judgment, and independence to act in the best interest of Ontarians in a crisis. Strategy, planning, operations, and funding must be organized to support the system. There is no place for “silo” thinking and political agendas during an emergency. Those who will lead a strong public health system in Ontario must understand and be passionate about the need for accountability.

The Accountability of the Medical Officer of Health

While the outbreak in Walkerton highlighted several deficiencies, the knowledge, judgment, and actions of a highly skilled Medical Officer of Health resulted in a quick assessment and appropriate intervention.

Despite such examples there has been considerable resistance by many Boards of Health and/or obligated municipalities in complying with legislation requiring a full-time, properly credentialed Medical Officer of Health. On January 1, 1998, funding for the provision of public health in Ontario was downloaded to local obligated municipalities. At the same time, some Medical Officers of Health were stripped of their Executive Officer and administrative powers and duties. It is inappropriate, as outlined above, for municipal governments to fill that void, thus widening the responsibility-authority gap of Medical Officers of Health.

In the late 1990’s and into the year 2000, at least seven municipalities employed a part-time acting MOH, with no intention to change. The government, after the experience in Walkerton, insisted on enforcing the legislation. Some Boards of Health and municipalities were highly opposed to this, noting that:

a. There was no need for a full-time MOH
b. The added expense was unnecessary

To state that a full-time Medical Officer of Health is not required demonstrates a lack of knowledge and insight into the role of the MOH. The outcomes of expert public health care touch the lives of citizens daily. It ensures that the food in the local restaurants is safe and that children are protected through vaccination programs. Education on issues such as obesity, teen pregnancy, and risk factors of heart disease have a deep and long-term health and economic impact on the community.

The Medical Officer of Health is a key contributor to an effective public health system. Legislative responsibilities for Medical Officers of Health are cited in over 80 provincial and federal statutes\(^1\). A full-time Medical Officer of Health knows the

\(^1\) Public Health in Ontario: health practice or social service? , Dr. David Williams, Ontario Medical Review, April 1999, p.33
community and acts as a key liaison with hospitals, clinics, physicians, schools, and citizens and directs the provision of clinical services (e.g., immunizations). She/He is able to work with these stakeholders, developing a well-networked relationship and a level of trust. Physicians, especially family physicians, depend on public health units and the MOH as an essential resource. In a public health crisis, the Medical Officer of Health is “the glue that holds it together.”

However, some obligated municipalities, struggling to manage expanded mandates with reduced budgets, determine that compliance with legislated requirements to employ a full-time MOH is an unnecessary expenditure. The Walkerton and SARS experiences and an example of a rubella outbreak make obvious the gross miscalculation of that argument.

The provision of public health cannot be a matter of local popular vote and cannot be so fragmented that each municipality can leave Ontarians vulnerable based on financial decisions with a relatively small cash value. Microbes know no borders and the inability to adequately fund public health in one community has major implications for other communities throughout the province.

**Recommendations:**

10. The OMA recommends that the government immediately upload the funding and control of public health to the province.

11. The OMA recommends that the government remove municipalities from governing public health.

**The Accountability of Governing Bodies**

Clearly, the impact of decisions on the part of government going back to 1996 contributed to the circumstances leading up to the Walkerton disaster. In 1997, the OMA noted that, historically, a significant number of municipalities had been reluctant to support public health services. We asked why, in an exercise supposedly committed to greater accountability, would the government hand municipalities responsibility for those services without sufficient safeguards?

In Walkerton, we saw the outcome of insufficient safeguards and fragmented accountability. A well-governed, and accountable public health infrastructure must clearly outline who is responsible and accountable for what. Whatever governance model exists, the Medical Officer of Health must have the autonomy and independence to speak in the public’s interest without political caution. She/He must be accountable for the health of those in the community.

We know without question that all regions of the province are entitled to safe and healthy communities and we also know that until every part of the province meets an acceptable standard, we are vulnerable.

We concur with Justice Campbell’s observations that “Ontario’s 36 local health units are the front line of protection against infectious disease. That chain of protection is only as strong as its weakest link. Some health units are well governed, some poorly. Because viruses respect no boundaries, it is of little comfort that some are well
governed. It takes only one dysfunctional health unit out of 36 to incubate an epidemic that brings the province to its knees within weeks.” (5)

We appreciate Justice Campbell’s decision to wait until 2007 to make a change in the governance structure, given that the scope of the Commission was limited to the SARS experience. However, when combined with findings by Justice O’Connor on Walkerton (2,3) and Graham Scott, QC, on the Muskoka-Parry Sound Health Unit (9), we believe this is too generous. We respectfully suggest that the time to wait has passed. While viruses respect no boundaries, they have equal disregard for the calendar. If a virus can indeed bring the province to its knees within weeks, we cannot wait an additional two years to begin a process to improve governance. Such a delay is the equivalent of collectively “crossing our fingers” in the hope that the next crisis will wait until we are ready.
“It is troubling that Ontario ignored so many public health wake-up calls: from Justice Krever in the blood inquiry, from Mr. Justice O’Connor in the Walkerton Inquiry, from the Provincial Auditor, from the West Nile experience, from pandemic flu planners and others. Despite many alarm calls about the urgent need to improve public health capacity, despite all the reports emphasizing the problem, the decline of Ontario’s public health capacity received little attention until SARS. SARS was the final, tragic wake-up call. To ignore it is to endanger the lives and the health of everyone in Ontario.” Campbell (5)

Clearly, a comprehensive and coordinated approach is crucial to building a public health system that Canadians, including Ontarians, can look to with pride and confidence. It must be built at all levels. A National Public Health Strategy must provide an overarching approach that enables a Provincial Public Health Strategy. However, the public health system must be built upon an iron clad local foundation. It is at the local level that:

- Data can be provided in a clear and consistent manner;
- Information can be interpreted to become more than data;
- Information can be applied through the lens of qualified public health professionals to start to form a picture – to alert us of possible scenarios.

Locally, we can most efficiently impact the health of Ontarians through initiatives such as education for immunization and liaison with family physicians and other health care professionals and the community.

We must include community public health as an equal partner with the federal and provincial levels in the overall design of a public health strategy.

On September 11, 2001, the attack on the United States caused nations such as Canada to rethink its strategy on protecting citizens from potential hazards that can cross borders throughout the world. Since that time, people have been trained to identify threats: Technology has been put into place to assist them in their efforts, funding has been allocated to support new practices and public opinion has supported those in the public and private sectors in these initiatives.

However, some of the greatest threats to the survival and health of citizens exist at a microscopic level and pass freely through even the most elaborate security systems. It is imperative that, in the same way we learned from the 9/11 disaster, we learn from the public health outbreaks that Ontario has experienced.

**Lessons Learned**

The Walkerton experience provides an opportunity to examine and learn important lessons relating to accountabilities within the public health system. The incident draws our attention to the need for sound governance, properly credentialed full-time Medical Officers of Health, strong, independent leaders with executive authority, and a system that empowers the Medical Officer of Health to perform his or her fiduciary role without constraint or influence from the political arena.
The SARS outbreak highlighted many concerns relating to Ontario’s ability to respond to an outbreak of disease. However, no issue was more visible than that of capacity – will we have the capacity to manage a large-scale outbreak when it happens? Can our capacity be robust enough to meet the foreseeable and perhaps unforeseeable demands? We must, through funding and incentives, build the intellectual capacity to plan for and manage any and all threats to public health. We must insist that funding at the federal, provincial, and local levels are sufficient and protected from budgetary cutbacks.

The rubella outbreak demonstrated some of the weaknesses in the interpretation and chain of information flow.

In the inquiries that were held subsequent to the SARS outbreak, the health care providers were described as heroes and it was acknowledged that their dedication was a key factor in containing the outbreak. We observed the heroism of our colleagues and concur with this finding. However, we can never again gamble the health of Ontarians on the heroism of those in the field.
1. The OMA urges the Ontario government to enforce its own existing legislation by insisting that all health units in Ontario have a full-time, properly credentialed Medical Officer of Health.

2. The OMA supports recommendation 1 of Part One Report of the Walkerton Inquiry which states: The *Health Protection and Promotion Act* should be amended to require boards of health and the Minister of Health, acting in concert, to expeditiously fill any vacant Medical Officer of Health position with a full-time Medical Officer of Health.

3. The OMA supports recommendation 7 of the Position Paper of the Community Medicine Residents of Ontario which states: As a precaution to protect the public’s health, the MOHLTC should ensure that any person being appointed by a board of health as an acting MOH, be assessed in accordance with the College of Physicians and Surgeons of Ontario (CPSO) Policy on "Requirements when Changing Scope of Practice" (Policy #13-00).

4. The OMA strongly supports the following recommendations of the first and second Campbell reports:

   So long as the local boards of health remain in place: the local Medical Officer of Health should have full chief executive officer authority for local public health services and be accountable to the Local Board. *Section 67 of the Health Protection and Promotion Act* should be enforced, if necessary amended, to ensure that personnel and machinery required to delivery public health protection are not buried in municipal bureaucracy {Principle of Reform #9}.

   The *Health Protection and Promotion Act* be amended to provide for every local Medical Officer of Health a degree of independence parallel to that of the Chief Medical Officer of Health. This would include:
   a. Giving the local medical officers of health the same reporting duties and authority as the Chief Medical Officer of Health...
   b. Protecting the independence of the local medical officer of health by providing that no adverse employment action may be taken against any Medical Officer of Health in respect of the good faith exercise of those reporting powers and duties.

5. The OMA recommends that the Ontario government requires that Boards of Health employ, in addition to a full-time Medical Officer of Health, a sufficient number of properly credentialed full time equivalents (FTE’s) to ensure adequate public health coverage at all times.

6. The OMA recommends that Ontario factor into the calculation of full time equivalents (FTE’s) sufficient Human Resources to meet surge capacity.
7. The OMA recommends that the Ontario government develop a Human Resource Strategy for Medical Officers of Health that includes surge capacity provisions and incentives to attract and retain properly credentialed Medical Officers of Health.

8. The OMA recommends that an Educational Strategy, including necessary funding, be developed to graduate well-qualified physicians in sufficient numbers to address current and growing needs, and to absorb the attrition of Medical Officers of Health who are nearing retirement.

9. The OMA supports Recommendation D of the Walker report: “The development of re-entry training positions in community medicine such that practitioners currently practicing in other specialties can become qualified to work in public health”

10. The OMA recommends that the government immediately upload the funding and control of public health to the province.

11. The OMA recommends that the government remove municipalities from governing the business of public health.
## Appendix 1
### Medical Officers of Health (September, 2005)

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<tr>
<th>HEALTH UNIT</th>
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