Assessors Report on the Muskoka-Parry Sound Health Unit

Pursuant to Section 82(3)
Health Protection and Promotion Act

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SECTION A – APPOINTMENT AND PROCESS OVERVIEW

1. Appointment

On July 12, 2004, I was appointed Assessor for the Muskoka-Parry Sound Health Unit pursuant to Section 82(3) of the *Health Protection and Promotion Act*, R.S.O. 1997, c.30 Schedule D, s. 11.

The assessment was requested as a result of growing concern with regard to governance and operations of the Muskoka-Parry Sound Health Unit. The Terms of Reference set out the objectives of the assessment and are found in Appendix A.

2. Process of Assessment

I interviewed most Board Members, some former Board members, the Acting Medical Officer of Health, former Acting Medical Officers of Health, the former full-time Medical Officer of Health, neighbouring Medical Officers of Health, senior staff of the Muskoka-Parry Sound Health Unit ("MPSHU"), MOHLTC officials, other health officials and interested citizens. I attended at the new offices of MPSHU on July 19, 20, 27, 28, August 17 and 19, 2004 for the bulk on my interviews. The remaining interviews were done by telephone (see Appendix B). I reviewed the relevant legislation, regulations, previous reports on the MPSHU, reports commissioned by the MPSHU, minutes of MPSHU Board meetings, aspects of the Walkerton Report, and The SARS Commission Interim Report: SARS and Public Health in Ontario.

3. The Balancing of Interests in the Delivery and Funding of Public Health

The Health Protection and Promotion Act ("HPPA") attempts to create a regime which constitutes a fine balancing act between the role of the government in establishing a comprehensive public health program for the province, while at the same time devolving the funding requirements and program delivery to the municipalities.

The purpose of the HPPA 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. [s. 2]

Accountability for the discharge of these crucial public services is divided among:

- the provincial government which determines mandatory programs and services which must be delivered by every local public health unit;

- the Chief Medical Officer of Health for Ontario;
- the Medical Officer of Health for each health unit who has extensive statutory powers and responsibilities quite independently of any reporting relationship with the local Board of Health and who is required under s. 67 to report directly to the Board on issues relating to public health concerns and to public health programs and services under the HPPA and all other provincial statutes; and
- the local Boards of Health

The local municipalities served by the Board must pay the expenses of the Board of Health. While the province generally pays an estimated 50% or more of the approved costs of a health unit's operations through a combination of a grant and specifically designated 100% funded programs, the size of the budget is an important consideration for the municipalities in striking their tax requirements.

While the budget is a particularly significant factor in smaller jurisdictions such as Muskoka-Parry Sound, the fact remains that the principal role of the Board of Health is to oversee effective delivery of public health programs. Through this process of balanced responsibility, the province ensures the delivery of its mandatory programs and the municipalities are seen to be protected because they have the majority of appointees to the local health Board, which approves the budget and ensures the effectiveness of the health programs to protect their communities.

The key to the success of this relationship lies in the effectiveness of the Board of Health. The municipally dominated Board must recognize that they are responsible for the quality and success of the mandatory health programs and in the execution of these duties they are largely reliant on their Medical Officer of Health ("MOH"). The MOH is responsible to the Board for both medical and administrative matters under the HPPA (Section 67). The MOH position is both demanding and pivotal in the provincial-municipal interface. The MOH must ensure the development of a budget that is sufficient to meet the public health needs while administering a health unit that is efficient, and cost effective. This leadership by the MOH and the policy and approval oversight by the Board should provide the local municipalities and their residents with assurance that the public health is protected and that their public health programs are delivered at a reasonable cost to their taxpayers.

Like all balancing acts, there must be both a reasonable measure of respect and understanding between the parties particularly the relationship between the MOH and the Board.

SECTION B – THE STRUCTURE OF THE MPSHU

1. Structure of Board Appointments

The Board of Health consists of twelve members. The regulations provide for ten municipally appointed members:

- Six from the District Municipality of Muskoka;
- One from the Municipal Councils of the Townships of Seguin and The Archipelago;
- One from the Town of Parry Sound and the Councils of the Townships of McDougall, Whitestone, and McKeller and the Corporation of the Town of Carling;
- One from the Municipal Councils of the Town of Kearney, the Village of Burk's Falls, and the Townships of Armour, McMurrich-Monteith, Perry and Ryerson;
- One from the Municipal Councils of the Village of Sundridge, and the Councils of the Townships of Joly and Strong and the Corporation of the Municipality of Magnetawan.

In addition, the Province may appoint provincial representatives under the Act. The Board now has two provincial appointees. While the province has the discretion to appoint additional provincial representatives, the HPPA (Section 49) requires that the number shall be less than the number of municipal members.

2. Changes in Appointment Strategy by the District of Muskoka

Following the municipal elections in November 2000, municipal representatives were appointed to the Board by the various councils and only one of the appointees was a Mayor and there was no District Chair on the Board. Following the November 2003 municipal elections, there was a conscious decision to encourage a number of the Mayors to take a seat on the Board arising out of concerns that the Board had not being well run by the previous Board and that costs were not under proper control. As a result, six of the ten municipal Board members were Mayors and the District Chair. This has resulted in considerable change in the municipal make-up of the Board, with 2/3 of the Members from Muskoka being Mayors and the District Chair. Half of the four Parry Sound representation consists of Mayors, both are new to the Board.

3. Governance and Orientation

The governance and accountability of public corporations has been a topic of major concern for several years. It has become more and more common for Boards to have regular retreats and strategic planning sessions with outside speakers and consultants to establish priorities, measure and consider the state-of-the-art of their governance processes, their relationship with their management, knowledge of relevant governing

legislation and effective orientation for Board members. The last meaningful retreat was held about five years ago and the last reference to strategic planning in the Board minutes was on February 21, 2002. Indeed, there is no current strategic plan in place to guide the Board.

Although the Board Manual contains useful information on governance matters, roles etc, most Board members readily admitted that their orientation process was limited and not a priority. Board members had little exposure to governance practices, and had had no contemporary discussion on the division of roles between Boards and their management.

SECTION C – THE STATE OF THE MPSHU

1. Overview

The MPSHU covers a very large geographical area and embraces two jurisdictions – the District of Muskoka and part of the District of Parry Sound. This marriage of convenience tries to serve the purpose of creating a jurisdiction large enough to provide a population sufficient to support a public health unit. It should be noted that even the combination of the two leaves the MPSHU with one of the smallest populations in the province to support its work.

The MPSHU has a permanent population of roughly 83,000 which can rise seasonally to as high as 900,000 people. The health unit includes approximately 900 water systems, 70 camps and 1,032 food premises. There are six long-term care facilities and three hospitals.

In this report, the use of the word "Board", except where one Board is specifically singled out, is intended to cover the overall effectiveness of two Boards, the first serving from the 2000 municipal election and the second serving since the 2003 municipal election. The actions of both Boards are the subject of this report, as both have carried the ultimate responsibility for the performance of the MPSHU since 2000. It would, however, be misleading to suggest that the problems identified in this assessment originated solely during the 2000 timeframe and beyond. Indeed, the Agora Report in 1999 made it obvious that the Board preceding the 2000 Board had problems. The Agora Report provided the opportunity for the subsequent Boards to get it right.

The current Board and the predecessor Boards in recent years have not been effective in their stewardship of the MPSHU. They have not been successful in balancing the health delivery responsibility and the budgetary responsibility. Obviously not all Board members share the same positions on issues but all must share responsibility for the failures and successes of the Board. Some members over the years have been very committed to public health as their primary reason for serving on the Board, but there is overwhelming evidence that the majority have been serving with a view to managing costs with little apparent interest in their health policy responsibilities in the delivery of public health.

2. Dysfunctional Governance

One word that has been used extensively to describe the overall governance and operation of the Board and Health Unit and that word is: "dysfunctional".

The word dysfunctional has, from a limited beginning, recently enjoyed a more common usage to describe organizations that are abnormal or impaired in their relationships. The

word originally arose in a medical context. Webster's New World Dictionary, Third College Edition, defines "dysfunction" as *"abnormal, or incomplete functioning, as of a body or part."*

The state of corporate governance is not only dysfunctional, but chronically dysfunctional. Those I interviewed suggested that the problems in the MPSHU are not recent but have been at play for several years, and that the current Board quickly became entangled in the established environment. MPSHU is chronically dysfunctional because:

- The roles and responsibilities as between the Board and the medical/technical/ administrative arm of the operation are undefined to poorly defined;
- The Board is dominated by concerns about cost at the expense of addressing the raison d'être of the MPSHU as a health delivery organization;
- 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 constant upheaval in the office of the MOH for the MPSHU;
- The Board ignores the governing legislation when convenient;
- There is little mutual respect between the Board and its employees;
- There is no clear leadership structure at the senior levels of the MPSHU;
- There has been no qualified Director of Finance or Human Resources for over a year, particularly notable when control of costs is the number one concern of the majority of the Board;
- Communications between Board and staff follow unconventional routes;
- Some municipal Board members acknowledged that being on the Board of Health had not been a matter of choice and that they would have preferred another Board or appointment;
- Many Board members lack certainty as to whether the MPSHU has the ability to function effectively in the face of a major crisis;
- Many Board members are aware of these problems and seem unable to resolve the issues to the point that they question whether they should continue on the Board; and
- Dysfunctionality was identified as a major concern in a consultant's report to the Board over five years ago and remains unresolved.

A health Board that cannot maintain a quality working relationship with its operational leadership, that cannot act on major decisions that they identify as important, that has no strategic outlook and that spends little time on its health services mandate, cannot be seen as anything other than chronically dysfunctional.

Indeed, in mid-1999, the Agora Group from Markham, Ontario was retained by the Board to do a governance review. The report concentrated primarily on options for geographic

reconfiguration of the MPSHU but the report did briefly address Organizational Effectiveness in Section 11. While acknowledging that both the Board and staff showed goodwill in wishing to address the organizational issues it went on to state:

> *"Yet each group seems to find it difficult to identify, in each other, a sense of common understanding and mutual support. Each ascribes less than positive motivations to the other."*

The report goes on to state:

> *"The consultants believe that Board/staff relations and overall organizational effectiveness have suffered as a result of misconceptions and negative expectations rooted in long standing practices and patterns of inaction that are barriers to communication."*
>
> *…"However, the "dysfunctional" attitudes, perceptions and behaviours are of such long standing that they have almost become reflexive for some among Board and staff."*[1]

There is no consensus on the future for the MPSHU at either the Board or staff level. The lack of consistent leadership has had a very damaging impact on the operations of the MPSHU. The Board is divided on a number of issues, and is perceived as having a negative view of the staff, and decisions on leadership have been delayed with the inevitable result that Public Health is not being well served in Muskoka-Parry Sound. The whole operation is so dysfunctional that it cannot be allowed to continue in the same vein; however, because many of the attitudes are entrenched, any turnaround within the existing geographical boundaries will be far from simple.

3. Board Members

Thirteen Board members were interviewed some of whom had served more than one term. They were for the most part very co-operative and constructive in their responses.

1) Role

The Board members were almost unanimous in their understanding that the proper role of the Board is policy leadership and strategic direction. While recognizing this, most acknowledged that the Board had not adhered to that role over the years, and had and continues to get involved in micro-management. There seemed to be a resignation to the view that as they attempted to address various problems, they

[1] healthy public health…… a governance review of the Muskoka-Parry Sound Health Unit, November 1999, page 48

became necessarily more involved in micro-management. The principal rationale given for micro-management was the belief that it was unavoidable due to the need for better administration and operation of the health unit. The counterpoint given by other Board members was that the actions and inactions of the Board on management matters relating to the MOH position and the Director of Finance and Human Resources created unstable circumstances encouraging more micro-management. The Board clearly recognizes that it has and continues to operate as a micro-manager of the administration function of the HPSHU rather than as a policy leader providing broad strategic direction. More importantly, the Board has been unable to correct the situation.

Costs and Accountability

The majority of members interviewed were of the view that both Boards since 2000 were more focused on the costs of the public health program than on their responsibilities of ensuring the delivery of effective public health programs. The agendas and discussions were and are disproportionately focused on the financial matters. This is an almost unanimous view of the Board members interviewed. The rationale provided for this phenomenon is that most of the Board members came to the office with a municipal focus that was to keep costs down and that in the last few years, there was a close to unanimous belief that both the finances and general administration of the MPSHU required serious attention. That being said, most Board members were of the view, that to a large extent, the Board's actions helped create the negative administrative environment and that, in any event, the Board had a duty to provide a much greater proportion of its time for health policy matters. The municipal members of the Board are appointed by their councils and some Board members noted that they and some other members of the Board would have preferred other municipal committee appointments and consequently they served with little natural commitment to public health issues. Of those municipal members who acknowledged they wanted to be on the Board as a matter of choice, almost half served solely out of a desire to address their concerns about costs and management with little interest in the public health program aspect of their duties. Indeed, many of the 2004 Board chose to serve primarily because they believed that the MPSHU costs were too high and not well managed. It was this latter concern that led to the sharp increase in number of Mayors appointed to the current Board. While a legitimate rationale for wishing to serve, it was not helpful in balancing the responsibilities of a Board already weak in its interest in health policy and effective program delivery.

2) Morale

The overwhelming majority of members felt that MPSHU staff morale was very poor and most accepted that the blame rested with the Board. The reasons included interventional behavior of the Board Chairs, pay equity and differences with the unions. The only Board members who were not sure of the state of morale were two

recent appointments who felt any morale issues were being driven by the dispute with the unions over the on-call arrangements.

3) Status of Service Delivery

Most Board members displayed a lack of certainty with regard to the capability of the MPSHU to meet the needs of the community. Many believed that the staff was well qualified but questioned whether there was enough depth. Others believed that services were too stretched and that it was doubtful they could manage a crisis, but still others were confident that the staff was good enough to identify a crisis and that the province could back them up when called upon. This failure of the Board to have a handle on the ability of the MPSHU to carry out its responsibilities is perhaps best explained by the failure of the Board to ask for and receive regular status briefings and reports at each Board meeting from their MOH or acting MOH. The tenure of the various MOHs over the years is outlined below.

It is notable in the minutes that the Board was regularly briefed on and sometimes discussed public health issues during the period that Dr. Pfaff was MOH. Otherwise, the minutes demonstrate that the Board did not generally engage in meaningful public health policy discussions. There was little enthusiasm shown by the Board in recent years to have the MOH play a role at Board meetings. This was an issue with both Dr. Pfaff and Dr. Hemens and indeed the current acting MOH, Dr. Stern, is 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. This absence of regular reporting in part arises from differences on the Board with regard to significance of the role they attribute to the MOH.

5) The Two Boards

There are some substantial policy differences between the first Board, appointed after the 2000 election and the current Board, appointed after the 2003 election. The first Board was seen by many of the new members as having done a poor job in managing the costs of the MPSHU. These differences surfaced quickly after the 2003 elections. The tradition was for the Chair position to alternate between Districts. The only candidate for Chair from Parry Sound was a provincial appointee identified closely with the leadership of the previous Chair from Muskoka. This was opposed by many of the new members who favoured a Co-Chair arrangement to ensure that the new members' agenda was addressed. The result was the election of Co-Chairs, even though it is not provided for under the HPPA. They have not worked out as Co-Chairs and have not adopted a co-operative approach. The Co-Chairs have different positions on some key issues and their lack of co-operation has contributed to the dysfunction of the current Board. It is notable that the acceptance of Co-Chairs is consistent with the attitude of both Boards to ignore the HPPA where convenient, as it has in its treatment of the MOH position.

4. The MOH and the Revolving Door

The last time the MPSHU had stability in the office of the MOH was during the period Dr. Nancy Cameron served as MOH from 1991 to July 7, 2000. The situation at the time of her departure was not positive. While she was seen as an effective MOH, her relationship with some members of the Board was difficult. Dr. James Pfaff followed Dr. Cameron as Acting MOH on a part-time basis on July 21, 2000 and became full-time on August 1, 2002. He stepped down on May 9, 2003. Dr. Pfaff was replaced by Dr. William Hemens, who became Acting MOH on May 26, 2003. Dr. Hemens departed as Acting MOH on Tuesday, August 19, 2003 and was replaced by Dr. Ronald Stokes as Acting MOH who served until January 2, 2004. On December 22, 2003, Dr. Dennis Stern was appointed as Co-Acting MOH and became Acting MOH on January 2, 2004. Not listed are the Acting MOHs who covered off short intervening periods between the above.

All the MOHs since 1991 share the view that the Board has been difficult to deal with and while they differ on some matters, some of the common observations are that:

- The Board does not understand that it is a policy body and attempts to micro-manage the MPSHU;
- Most Board members believe that physicians are incapable of handling administrative matters and don't acknowledge the importance of the MOH role under the Act;
- The Board did not see much value in having the MOH at Board meetings and does not generally accommodate their attendance;
- The Board sees itself as having a mandate to control costs and does not understand or focus on their responsibility to protect public health;
- The Board does not devote the time necessary to learn or promote public health in the community.

These perceptions by the MOHs are supported both by staff, and indeed by a number of Board members. In fact, a number of Board members are firm in their views that physicians cannot manage and are opposed to them having any administrative responsibilities. This is in spite of the reality that many MOHs in the province have effective operations under their management and that fully qualified MOHs are trained in administration as part of their fellowship training.

5. Staff of MPSHU

1) Morale

The staff is demoralized. The poor morale is evident, not only from the limited interviews with staff, but is acknowledged by most members of the Board. Interviews with senior staff and representatives of ONA and CUPE paint a consistent picture:

- They believe that the Board, for the most part, does not respect the work that they do and consistently fails to take any interest in the roles they fulfill in the community;
- They believe the Board is interested only in financial matters and is, for the most part, resistant to devoting time to learning more about the public health function and taking time to support it publicly;
- Meetings concentrate on financial issues, briefing packages are often opened for the first time at the meeting and little or no time is set aside for Board education/orientation on health matters;
- Stress leave is a problem and there have been a number of departures by staff for positions elsewhere;
- MPSHU staff daily face a number of issues that either require or would benefit from qualified medical advice that has often not been readily available, putting many of them at professional risk in giving advice;
- The breakdown of the on-call system made it difficult to access needed expertise which resulted in unqualified administrative staff having to find ways to reroute important questions that they were not qualified to address;
- Unresolved differences related to pay equity have created internal tensions.

2) Leadership

The staff is aware that the Board has little interest in hearing from the MOH. The senior staff has been working without effective or consistent policy and administrative leadership from either an MOH or the Board. This lack of leadership has been very damaging for two principal reasons. First, on the public health programs and services side of matters they have:

- suffered from insufficient staffing;
- been subject to several external reviews and been reviewed by Board appointed consultants;
- been without a readily available MOH to provide guidelines on professional judgment matters when they arise;
- been required to go to the Board for routine decisions, such as changes in job descriptions, that are consistently delayed;
- not had any programs such as emergency preparedness and SARS III planning completed;
- been without human resources/financial leadership;
- not had clear management channels, resulting in direct involvement of Board chairs in administrative matters.

Secondly, the lack of clear leadership and the direct involvement of the Board Chairs and some Board members in staff issues have altered the appropriate flow of interaction between the Board and the staff. Board members have overstepped their

appropriate authority in dealing with staff and staff has gone to sympathetic Board members to get support for their programs. This breakdown in appropriate management roles is destructive of both management and policy governance.

3) Operational Readiness

Significantly, the senior staff does not have confidence that they are ready for a health crisis. Unlike the Board that had mixed views on the subject, they do not believe that they are ready to handle a major problem on their own due to:

- the lack of a fully certified MOH to provide leadership and professional guidance;
- key staff are too stretched by carrying multiple responsibilities;
- turnover of staff and levels of stress related leave;
- understaffing of Communicable Diseases;
- outdated job descriptions;
- on-call problems;
- being behind on education/training programs/not retrained for SARS III and Communicable Disease control; and
- divisiveness among the staff over the interpretation and functioning of the pay equity plan in the unit.

6. Support of Neighbouring Health Units

The MPSHU has been unsuccessful in obtaining dependable back-up support from neighbouring health units. This is notable, as it is common across the province for MOHs in nearby health units to support each other when issues arise that require additional advice and assistance. The rationale is quite straightforward. It is in the interest of public health that neighbouring units provide assistance to each other when it becomes difficult to manage a problem without additional assistance. Further, it is of mutual benefit to be able to provide advice to cover for any short-term problems that may arise when that advice is not readily available in a particular unit. Such support is particularly valuable to MPSHU given the lack of a full-time, fully qualified MOH. The Board of MPSHU was aware that support was not readily available from either the North Bay District Health Unit or the Simcoe County District Health Unit. The MOHs of both units had and continue to have concerns with policies and procedures of the MPSHU that had not been developed and approved by a fully qualified MOH and were reluctant to address issues on a piecemeal basis as it could expose them to considerable professional liability. This lack of confidence by the adjacent MOHs did not seem to have much impact on the MPSHU in pursuing solutions and left the health unit in a vulnerable position as they were without either a fully qualified MOH or any assurance of readily available professional advice from other experienced MOHs.

SECTION D – CURRENT ISSUES

1. Role of the MOH and Unit Administration

1) Dual Reporting

The most divisive and problematic issue over the past few years has been the view of the Board on the roles of the MOH as the medical authority and administrative authority. The previous Board adopted the view that the administrative role should be removed from the authority of the MOH and replaced with a dual reporting arrangement. MOH would be responsible to the Board for all medical matters and an independent chief administrator or CEO would report to the Board on all administrative matters. This majority view established the policy direction of the previous Board and influenced its attitude toward the succession of MOH and to oversight of administrative matters. This position on the role of the MOH was clearly at odds with the intention of the HPPA.

It was apparent they had little concern for Section 67, which gives the MOH authority for public health programs and services and places the employees under the MOH's direction. Further, the current Board continued to struggle with the issue and it is apparent it gave little attention to Mr. Justice Campbell's interim report, which stated:

> *"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 the municipal bureaucracy".*[2]

Little effort was obvious in pursuing a full time MOH and in considering the role and authority of the MOH the previous Board was concentrating on establishing a separate reporting authority for administrative matters. This restricted view was resisted by some of the MOHs and led to the Board working around the MOH with regard to leadership on administrative matters. The Board's intervention in administrative matters led it to the view that new administrative leadership was required, which subsequently resulted in the Board taking a direct hand in the departure of the Director of Finance and Human Resources from office in 2003. That decision was taken independently from the MOH, even though no obvious action plan was in place to find adequate replacement.

[2] *The SARS Commission Interim Report; SARS and Public Health in Ontario*, The Honourable Mr. Justice Archie Campbell, Commissioner, April 15, 2004, p. 206.

The current Board that assumed office in January 2004 shared the concern of its predecessor that the administration of the MPSHU needed attention but introduced some new members that did not subscribe to the dual reporting concept as devised by the previous Board. Nonetheless, the majority of the current Board favoured administration being handled by the District of Muskoka and except when spurred by external reports, showed little interest in rapidly pursuing their duty to find a full-time MOH. This difference on the MOH role contributed to the failure of the current Board to get on with the job of finding an MOH due to disagreements within the Board on the Terms of Reference governing the role of the MOH. Those differences obviously also hampered the pursuit of a solution to address the lack of leadership in the finance and human resources area.

2) Finance and Human Resources Administration and the Morley Report

The most surprising element of the assessment is the failure of both Boards to effectively address the finance and human resources issues. Both Boards, by their own admission, are more driven by their concerns about costs than about public health issues and yet they did not find a resolution to the management of this crucial area. With their commitment, by default or otherwise, to micro-management and given the absence of either their concept of a chief executive or an MOH to provide action, they have only themselves to blame for over a year of inaction. Boards were not designed to micro-manage and the job faced by the current Board has probably been even more difficult with so many of the Board members carrying other major responsibilities outside the MPSHU.

Regardless of whether the decision to replace the Director of Finance and Human Resources was warranted or not, the previous Board decided that a change in personnel was required but acted without having an alternative plan in place. The decision was controversial and absorbed much of the Board's attention, leaving the administration without a substantial knowledge-base important to the effective day-to-day management of the MPSHU. The result has been to weaken the operations of the MPSHU, both internally and externally, in managing administrative matters. The principal excuse given by the previous Board was that the matter went into abeyance due to the fall municipal elections. Even accepting this excuse, there can be no better example of a problem self-imposed by a Board engaging in micro-management. In any event, the previous Board left the MPSHU with out effective administrative organization.

The make-up of the membership of the current Board was influenced, at least in part, by the views of many of the new members, that the MPSHU had been mismanaged by the previous Board. While the new Board arrived with the belief that matters were not being well managed it was not until late March 2004 that they acted by retaining Morley & Associates[3], to assess the financial and budgetary processes of the

[3] Morley Report.

MPSHU. Their first report to the Board on April 15th, not surprisingly, found substantial gaps in leadership, administration and the budget process. In their second report to the Board on April 23rd, they proposed a second mandate which included inviting proposals from the District of Muskoka and the Parry Sound District Social Services Administration Board ("PSDSSAB") concerning the outsourcing of leadership. Their presentation to the Board on May 20th covered an expansion of their mandate to consider the feasibility of moving the administration building into another entity and to assess the District of Muskoka and PSDSSAB outsourcing option.

Subsequently, in June 2004 the Board decided in principle to award the outsourcing to the District of Muskoka. The counterproposal from the PSDSSAB was not addressed. Not surprisingly, there has been municipal opposition from the District of Parry Sound to the proposal to turn over the administration to the District of Muskoka.

Effectively, the Board was making the management plans for the MPSHU from meeting to meeting guided by the work of the Morleys as they proceeded with their expanding mandate.

Outsourcing of administration would bind the hands of an incoming MOH and result in reports to the Chair of the District who is also the Co-Chair of the Board of Health. It is difficult to imagine that that the proposed arrangement would not turn out to be yet another de facto form of dual reporting, as well as creating a potential conflict of interest for the Co-Chair.

3) Muskoka and Parry Sound

There has been an uneasy relationship between the two jurisdictions. There has been a view in the MPSHU that there has been a long-standing desire by the District of Muskoka to assume administrative control of the MPSHU. Indeed, there are files going back more than 20 years addressing the issue. The fact that the MPSHU's financial and human resource administration was in poor shape provided an opportunity for the District to step in. The Morley Report established the groundwork and certainly an outsourcing solution was one that merited consideration. While the Board invited both PSDSSAB and Muskoka to put in a joint submission, the former declined and made a counter-proposal. It is not at all clear that the Board was fully aware of, or debated, options including the counter-proposal from the PSDSSAB. The vote did not divide along District lines. Nonetheless, the decision to go to a single source without wider consideration of options predictably elicited a negative response from a number of communities, other health providers and the District of Parry Sound Municipal Association.

The Assessor, in response to a question from the Chief Administrative Officer of the District of Muskoka, advised against the District investing the time in a detailed proposal to the Board pending the release of this report.

2. On-Call Dispute

The Mandatory Programs and Service Guidelines mandate an on-call system to ensure 24-hour availability of Board of Health staff to respond to reports of health hazards. Historically, the MPSHU had a long-standing on-call system covered by management staff, rotating on a weekly basis. The manager received the first call and if the issue was beyond that manager's scope and expertise, the manager would contact other individuals on the emergency telephone list who had the appropriate expertise. This system had worked in the past due, in no small part, to the presence of a full-time MOH, competent to handle a wide range of issues.

The Walkerton tragedy and the recommendations flowing from it created a much more demanding environment. This, combined with the subsequent insistence of the Acting MOH, Dr. Hemens, that the old system was not adequate, resulted in the decision that the Public Health Inspectors ("PHIs") should be on on-call. Agreements that provided for a weekly stipend were reached with the PHIs for weekly rotation commencing in July 2003 with an expiry date of June 2004.

The Assessment of the Muskoka-Parry Sound Health Unit Communicable Disease Programs and Activities carried out at the direction of the MOHLTC by Dr. Charles Gardner and Dr. Beth Henning and reported on March 22nd, 2004[4] recommended that the CD nurses should be incorporated into the on-call system. This reopened the debate at the Board on the desirability of the on-call agreement that had been put in place by the previous Board. The current Board, with a number of new members who had joined the Board primarily because of budgetary concerns, saw the on-call agreement for the PHIs as providing too generous a stipend and ordered it to be renegotiated. The union refused and the on-call for PHIs ended on June 20th, 2004.

Management was then put on-call, including the executive secretary for the MOH. This put considerable strain on management who had to make many additional calls for assistance due to their lack of expertise in relation to a specific call. This situation was exacerbated by the limitations of the Acting MOH in non-infectious disease issues such as water quality. The ending of the PHI on-call arrangement coincided with the period of greatest demand in the area served by the MPSHU, given the huge influx of summer residents, tourists and the opening of camps and resorts.

This matter has been temporarily resolved as a result of the intervention of the MOHLTC in the appointment of an MOH and an Assessor. The Board agreed to a request by the MOH, Dr. Hukowich, to reinstate the PHI on-call agreement and the union agreed to co-operate pending the final report of the Assessor.

[4] *The Assessment of the Muskoka-Parry Sound Health Unit Communicable Disease Programs and Activities*, Dr. Charles Gardner and Dr. Beth Henning, reported on March 22nd, 2004.

The on-call dispute and rhetoric surrounding it deepened the already serious mutual lack of confidence between the Board and staff. On the surface, the on-call stipend appeared to be very generous and that presumably created political problems for Board members openly dedicated to controlling MPSHU costs. The reality is that looked at in isolation the on-call appeared generous but when considered as part of the total compensation for PHIs, it did not appear to be out of line with total compensation for PHIs in other health units. While the misunderstanding could be written off as "packaging", the reality is that the problem was further complicated by a lack of a real understanding of all the circumstances, including the perceived limitations of the MPSHU's pay equity plan.

3. New MPSHU Offices

Morley & Associates Inc. was retained by the Board in 2004 to carry out a review of budget, the status of the MPSHU office building and the management of finance and human resources.

The MPSHU had leased office space from the District of Muskoka. The Board built new offices in Gravenhurst and vacated the District premises in 2002 for their new facilities. The province contributed one-time cost shared funding amounting to $775,000 and held 50% equity in the building as of the date of the building's completion. The new premises have proven to be more expensive than anticipated and Morley & Associates Inc. were contracted "to assess the feasibility of moving the building into another entity to allow for reserves and modernize the use of the provincial funding rules."[5]

The Report looked at three alternatives:

1. Status Quo
2. Maximize the Municipal Equity Share
3. Sale and Leaseback

The Report recommended the second, which was to repay the provincial one-time funding, and fully fund the mortgage payments over the next 15 years so the municipalities would have 100% ownership. The municipal owners charge rent to the MPSHU that covers the operating costs, capital costs and provides a return on investment.

If followed, this would provide the municipalities with ownership and control of the premises. The interest of the province was not a consideration notwithstanding the substantial provincial funding of the MPSHU and its contribution to the ongoing subsidization of the rental cost.

[5] Morley Report to MPSHU Board meeting, May 30, 2004.

4. Board Leadership

The chairs of both Boards, while adopting different styles, must bear the brunt of the responsibility for Board leadership, as they are responsible for guiding the Board and for the Board interface with the administration. Both failed to appreciate the importance of the MOH to the operations and policy development of the Board. The Chair of the previous Board contributed to the current problems by ignoring written advice from the MOHLTC as to the role and responsibilities of the MOH. This was compounded by attempting to create a dual role for the MPSHU leadership, in micro-managing the operations of the administration, and in taking a direct hand in the removal of the Director of Finance and Human Resources. The current Board has Co-Chairs. The Co-Chairs have not been successful in finding consensus in addressing Board issues. The Co-Chair concept is not working and provides the opportunity for each Co-Chair to frustrate the interests of the other in seeking solutions.

SECTION E – FINDINGS

Individual Board Members

None of these findings should be taken as personal criticism of any individual Board member. There is no evidence of intentional wrongdoing by any Board member. They did the job as they thought it should be done as opposed to what they should have done. They were all members of a Board that collectively lost its way in the manner described in this report.

Most Board members, as noted above, agreed that there were longstanding problems in the Board's governance of the MPSHU. Clearly, some of the practices they adopted pre-dated the appointment of the members appointed after the 2000 and 2003 elections. Individual Board members cannot be faulted for the institutional inability of the Board as a whole to change its underlying organizational culture that proved, in hindsight, to be dysfunctional.

I am satisfied that most Board members on reflection would agree, for the reasons given above, that it is time for a fresh start, with no adverse reflection on their individual attempts to do what they thought best in the circumstances.

Has the Board of Health of MPSHU failed to ensure the adequacy of the quality of the administration or management of its affairs?

Yes, I am satisfied that the Board of Health has failed to ensure the adequacy of the administration and management of its affairs.

The Board has failed to carry out the expected basic governance tasks of a Board in that:

1) There is no strategic plan.

2) There is no regular overview of the program performance of the MPSHU.

3) The Board has little apparent commitment to understanding and monitoring the performance of health programs.

4) The Board, when it found it convenient, has ignored certain provisions of the HPPA.

5) The Board does not have the benefit of a regular flow of public health advice from the MOH and does not have a current appreciation of the ability of the MPSHU to deal with major health events.

6) There has been little or no follow–up by the Board on the performance of the MPSHU following the SARS event and the assessment carried out by Dr. Gardner and Dr. Henning.

7) The Board did not have the Acting MOH available for most Board meetings prior to the appointment of Dr. Hukowich by the Chief Medical Officer of Health.

8) The Board does not have an agreed concept on how the MPSHU should be led and managed.

9) The Board has permitted the MPSHU to operate for a year without a leadership structure in place and without competent expertise in finance and human resources.

10) The Board has become involved in micro-management without the time, ability, technical expertise or mandate to manage.

Has the Board of Health failed to comply in any other respect with the HPPA, the regulations and guidelines?

Yes, I am satisfied that the Board has shown little interest in meeting the requirements of the legislation where it is inconvenient. For example:

1) The Board has been without a full-time MOH for most of the time since 2000 and consequently has not met the requirements of Section 62 (1) of the HPPA, which require it to appoint a full-time MOH.

2) The last time an MOH reported regularly to the Board was during the tenure of Dr. Pfaff. The Board has, at best, been passive about the presence of the MOH at Board meetings and is clearly outside the intent of Section 67 (1) of the HPPA.

3) The Board's actions with regard to personnel matters have circumvented and frustrated the intent of Section 67 (2) and (3) which provide that employees are subject to the direction of, and responsible to, the MOH.

4) The Board has, by procedural means, made it difficult for the MOH to exercise the right in Section 70 to attend each meeting of the Board and every committee meeting.

5) The current Board has appointed Co-Chairs of the Board notwithstanding that they were aware that the HPPA has no provision that permits the appointment of Co-Chairs.

While there is no evidence to suggest nor do I believe that either the previous Board or the current Board were acting in any intentional manner to prevent the effective delivery of public health programs, the fact remains that in my view they have not ensured the adequacy of the quality of administration or management of the MPSHU.

SECTION F – CONCLUSIONS

The problems plaguing MPSHU are deeply rooted. The fault lies not with any one individual but with an entrenched governance culture that is focused, not on the delivery of public health programs and their adequacy, but on the cost of public health. Efficient and effective management of the costs of public health is obviously important, but the primary responsibility for the Board is the delivery of public health programs and services to ensure the protection of the residents of the two Districts.

The failure of the Board in not engaging fully in the public health role is overwhelmingly evidenced by the lack of strategic consideration to public health issues and the low regard for the role of the MOH within the MPSHU. Further, the Board, in its attempts to address costs has become a micro-manager of the MPSHU. The Board has no role in management of the MPSHU. Even if it were appropriate for a Board to engage in management, it is an assignment that they are not capable of discharging given their limited experience in public health administration, as well as the other demanding responsibilities that require their time in meeting their responsibilities, particularly those serving as councillors and Mayors.

Indeed the evidence is clear that they have failed to bring either sound organization or stability to the MPSHU. This is true even on the administrative and cost side that has been their declared area of priority. On the health side, notwithstanding a previous assessors report, a SARS case in 2003 and the interim report of Justice Campbell, they have not carried out any serious health program or performance review at the Board level, which as a minimum would seem an essential response to critical external reviews.

The Board requires a complete overhaul.

The question of Board geography and structure has long been a matter of debate and discussion and in recent time this has been evidenced by both the Agora Report and the Morley Report. The Agora Report dealt at length with possible merger with one or more neighbouring health units. The concept of merger was also raised by a number of people I interviewed as desirable to constructively address the dysfunctionality of the Board.

I believe that the most effective outcome of my assessment would be to dissolve the existing Board and merge the District of Muskoka operations with the Simcoe County and District Health Unit and merge the portion of the health unit within the District of Parry Sound operations with the North Bay District Health Unit. This would result in a complete break with the culture that has plagued the last two Boards and provide a larger catchment area.

Every public health unit in Ontario is a crucial part of our front line defence against disease and health risk. Any health unit that is dysfunctional puts at risk, to the extent it

weakens that defence, the health of its citizens. Anything less than the measures outlined above will weaken our front line defence.

While management and the employees of the MPSHU have operated reasonably in difficult circumstances, the failure of the Board to ensure consistent leadership at the management level at least raises questions as to the need for a thorough review of management operations. The reconstruction of the Board should not obscure the need for a thorough review of operations. The most glaring problem is the lack of any leadership in assessing and managing both the financial and human resources requirements of the MPSHU that have been without direction for over a year.

SECTION G – RECOMMENDATIONS

1. The Board of the MPSHU should be dissolved and the Muskoka District operations should be merged with the Simcoe County District Health Unit and the Parry Sound District operations should be merged with the North Bay District Health Unit.

2. While the Board of Health of the MPSHU should remain in place pending the transfer of authority through the merger process proposed in recommendation #3, the business of the MPSHU should be managed under the policy direction of the Chief Medical Officer of Health by the exercise of her powers under the HPPA.

3. The MPSHU should be merged with neighbouring health units as follows:

   (a) The Lieutenant-Governor–in-Council should act to amend the regulations under the HPPA to permit the MPSHU to be absorbed into a larger health unit, either in accordance with any planned provincial realignment of health organizations, or divided – with the portion of the health unit within the District of Parry Sound operations becoming part of the North Bay & District Health Unit ("NBDHU") and the District of Muskoka operations becoming part of the Simcoe County District Health Unit ("SCDHU").

   (b) The process should begin immediately to commence the merger of the MPSHU into its new regional alignment.

   (c) A merger Transition Team should be created to oversee the merger of the MPSHU with the new health alignment and two Transition Teams appointed, one for the merger of the District of Muskoka and the SCDHU, and one for the merger of the District of Parry Sound and the NBDHU.

   (d) The following process is suggested for transition:

      - The Transition Team for the Muskoka District and SCDHU merger should consist of one representative from the District of Muskoka and one representative from the current Board of the SCDHU, the Acting Medical Officer of Health from MPSHU and the Medical Officer of Health from the SCDHU and a Chair appointed by the Chief Medical Officer of Health.

      - The Transition Team for the Parry Sound District and NBDHU merger should consist of one representative from the District of Parry Sound and one representative from the current Board of the NBDHU, the Acting Medical Officer of Health from MPSHU and the Medical Officer of Health from the NBDHU and a Chair appointed by the Chief Medical Officer of Health.

(e) The Transition Teams would make recommendations to the Chief Medical Officer of Health to address all the issues including but not limited to:

   i. The redeployment of employees between the health units and all related labour issues;

   ii. The realignment of management positions;

   iii. The allocation of assets and liabilities between the health units including the resolution of the equity rights of the province and the Districts of Muskoka and Parry Sound in the Gravenhurst office and other physical assets of the MPSHU;

(f) To minimize the disruption in the SCDHU, the Lieutenant-Governor-in-Council should amend the regulations in the HPPA to maintain the current formula for the membership of the Board originating in Simcoe County and add two members from the District of Muskoka.

(g) To minimize the disruption in the NBDHU, the Lieutenant-Governor-in-Council should amend the regulations in the HPPA to maintain the current formula for the membership of the Board originating in North Bay and District and add three members from the District of Parry Sound.

(h) The same chair should be appointed for both Transition Teams to ensure continuity in addressing the issues in the division of assets and human resources of the MPSHU.

(i) The full costs of the transition process should be assumed by the MOHLTC.

4. For continuity, it is recommended that Dr. Alex Hukowich, the Acting Medical Officer of Health remain as MOH for the MPSHU. Should this not be possible, another Acting MOH should be appointed by the Chief Medical Officer of Health until recommendation #3 is completed.

5. The Chief Medical Officer of Health should take immediate action to authorize the appointment of an interim Transition Director for the MPSHU to address the financial and human resources organization of the MPSHU to facilitate the merger of organizations under recommendation #3 and to provide assurance that the administration of the MPSHU meets provincial standards.

6. The current on-call arrangement should remain in place until the MPSHU is realigned in accordance with recommendation #3. If realigned in accordance with #3 on-call would be subsequently renegotiated in accordance with the legislation governing the merger of the staff of the units involved.

Appendix A

TERMS of REFERENCE

ASSESSMENT by the Ministry of Health and Long-Term Care

Of the Muskoka-Parry Sound Board of Health

Report to: Dr. Sheela Basrur, Chief MOH and ADM, Public Health Division, Ministry of Health and Long-Term Care.

Liaises with Senior Managers and staff at the Public Health Division.

Objectives:

1. To assess the quality of the management or administration of the affairs of the Muskoka-Parry Sound Board of Health under s. 82(3) (c) of the Health Protection and Promotion Act ("HPPA");

2. To ascertain whether the board of health is complying in all other respects with the Act the regulations and the guidelines under s. 82(3) (b) of the HPPA; and

3. To make a written assessment report for the Chief Medical Officer of Health that makes recommendations respecting the Board of Health and/or the Ministry about any issue relating to the assessment's purposes in 1. and 2. above, including but not limited to the Board's:

   a) governance and administration
   b) public health leadership and program management
   c) human resource management
   d) protection of assets
   e) quality assurance and risk management.

Responsibilities:

1. Carry out the assessment of the Board of Health in accordance with the rights, duties and powers of an assessor under s. 82 of the HPPA.

2. Review relevant materials compiled by Public Health Division staff and examine or demand the production of any other record or document of the board of health, including but not limited to, financial and bookkeeping records and minutes and by-laws of the Board of Health that is relevant to the assessment.

3. Interview members of the Board of Health, selected staff, current and former Medical Officers of Health for Muskoka-Parry Sound (including those who have served in acting capacities), municipal officials and other key stakeholders.

4. Assess the structure and function of the Board of Health in relation to:

   a) Membership
   b) Committee structure
   c) Bylaws, Policies and Procedures
   d) Decision-making process
   e) Role and responsibilities (including recruitment process and position description) for the Medical Officer of Health (MOH)
   f) Delegation of responsibility for the management of public health programs and services to the MOH
   g) Delegation of responsibility for the management of business affairs to other Health Unit staff as well as existing outsourcing agreements
   h) Mechanisms for monitoring the achievement of objectives, quality assurance, risk management, conflict of interest and other issues
   i) Management and/or disposition of fixed assets, i.e. the sale of the Board of Health's main office building
   j) Internal and external Board communications
   k) Any other matter that, in your opinion, is appropriate given the objectives of this assessment.

5. Prepare a written report with key findings and recommendations for areas of improvement, including action steps to be considered by the Board of Health, the MOHLTC, and other applicable stakeholders.

6. Determine whether, in your opinion as an assessor under s. 82 of the HPPA, the Board of Health has,

   a) failed to ensure the adequacy of the quality of the administration or management of its affairs;
   b) failed to comply in any other respect with the HPPA, the regulations or the guidelines.

Timelines and Deliverables:

Wk of July 5th: agreement on terms of reference and related matters
Wk of July 12th: initiate assessment and meetings with PHD
Wk of July 19-30th: completion of initial interviews and information gathering
Wk of August 23rd: completion of draft report for discussion with PHD
Wk of September 7th: submission of final report

July 6, 2004
Public Health Division

Appendix B

Interviews

Past and Current Board Members

Mr. Gord Adams, Co- Chair of the Board and Chair of the District of Muskoka
Mr. John Boyd, Co-Chair and Appointment
Mr. Bill Core, Board Member and Mayor of Perry Twp
Ms Adele Fairfield, Board Member and District Councillor, Twp of Muskoka
Mrs. Julia Fraser, Board Member, Seguin Twp and Archipelago Twp
Mr. Mike Kennedy, Board Member and Mayor, Georgian Bay Twp
Mr. Ted Knight, Board Member and Mayor Parry Sound
Mr. Hugh Mackenzie, Board Member and Mayor of Huntsville
Mr. Turner Montpetit, Board Member, Joly Twp, Magnetawan Twp, Strong Twp and Sundridge
Mr. Scott Young, Board Member and District Councillor, Bracebridge
Mr. Ben Boivin, Past Chair and Board Member, Muskoka
Mr. John Murphy, Past Board Member, Parry Sound
Mrs. Debbie Zulak, Past Board member, Parry Sound

Past and Current Medical Officers of Health for Muskoka-Parry Sound

Dr. Nancy Cameron
Dr. Bill Hemens
Dr. James Pfaff
Dr. Ron Stokes
Dr. Dennis Stern

Staff of MPSHU

Dr. Salwa Bishay, Acting CEO
Dr. Terry Hicks, Dental Consultant
Mr. Peter Jekell, Director of Infectious Diseases
Marilee Keonderink, Director of Family Health
Jackie Shaughnessy, Executive Assistant
Norma Van Alstine, Operations Manager
Debbie Wight, Program Manager, Sexual Health and Vaccine Preventable Diseases

Union Bargaining Units

Diane Baranik, PHN and representative of ONA
Bill Martin, PHI and representative of CUPE

Neighbouring Medical Officers of Health

Dr. George Pasut, MOH, Simcoe County District Health Unit
Dr. Penny Sutcliffe, MOH, Sudbury and District Health Council
Dr. Cathy Whiting, MOH, North Bay and District Health Council

Other Interested Parties

Anne Collins, Chair, Algonquin Health Services Board
Jim Green, Chief Administrative Officer, District of Muskoka
G. Michael Hepinstall, Chair, South Muskoka Memorial Hospital
Janet Patterson, Chief Administrative Officer, Parry Sound District Social Services Administration Board
Rick Zanussi, Chair, Parry Sound District Social Services Administration Board