6. Improvements since SARS

After many years of decline in Ontario's public health infrastructure, SARS has finally focused the attention of the government and the public on the public health systems that protect us from infectious disease. SARS exposed the weaknesses in these systems. If we are to learn lessons from SARS these weaknesses cannot be ignored. The problems in our public health system must be fixed. If the next outbreak of infectious disease strikes Ontario as unprepared as it was for SARS, with a public health infrastructure as weak as it was during SARS, the province will be in serious trouble.

It is beyond the Commission's mandate to monitor the implementation of government initiatives designed to address the public health problems that emerged during SARS. The Ministry has reported to the Commission on various reforms that it is presently undertaking and it is therefore appropriate to note them at this time. The Commission of course is in no position to evaluate these pending and proposed initiatives or to predict whether they will all be successfully implemented. Decisions in respect of their implementation are entirely a matter for the government and beyond the scope of the Commission's mandate.

Some system improvements have been made since SARS, including the recruitment of a new Chief Medical Officer of Health. The appointment to that office of Dr. Sheila Basrur, who ably led the Toronto response, is hopefully a signal that the government is serious about public health renewal.The Ministry of Health has announced changes that involve both internal organizational enhancements and external system collaboration. Some of those changes are noted below.

Some of these changes by the former and the present governments respond to problems that are not addressed in this interim report but will be addressed in the final report.

An example of internal organizational change is the creation of an Emergency Management Unit (EMU) to coordinate the development of a Ministry emergency preparedness program, integrate it into Ministry business planning, identify the infrastructure requirements for its maintenance and develop a quality improvement program for emergency readiness. The Ministry's plan calls for the EMU to work

with the Public Health Branch, other Ministry divisions, other ministries and local public health units on policies, procedures and protocols. It has been identified as the Ministry's principal link for broad government collaboration on emergency management and pandemic preparedness.

Another Ministry organizational change involves the creation by the Public Health Branch of a Surveillance and Outbreak Management section housing an Epidemiology Centre, an Epidemiological Investigation and Policy Unit, Rapid Response Teams and a Public Health Call Centre. With the creation of this section, the Ministry seeks to improve its surveillance, surge capacity, information flow and its capacity to analyze data. Other changes to the federally funded Integrated Public Health Information System (iPHIS) are expected to improve data collection and transmission substantially and to support outbreak management with improved contact, case and quarantine management.

An example of the Ministry's new approach to system collaboration is the creation of task forces made up of representatives from Health Canada, organized labour, other ministries and colleges that regulate medical professionals to develop and refine infection control and surveillance standards for acute care facilities and community health care settings. In addition, the Ministry is leading a standing, integrated coordinating committee of senior provincial government officials from all relevant ministries created to address emergency preparedness issues.

On the national and international fronts, there are signs that progress is underway. This was signaled in the November 20, 2003 Speech from the Throne:

> Your new government . . . is keeping its commitment to work cooperatively with the federal government on heath care, in the interests of Ontarians . . .
>
> [Y]our new government will continue to work with Ottawa to fix health care, instead of merely affixing blame.

To this end, the Ministry has begun to work closely with Health Canada in connection with the incorporation of World Health Organization requirements relating to SARS surveillance and management. The Ministry has adopted certain public health measures from Health Canada and put them in place in the event of SARS re-emergence and has revised quarantine protocols to reflect Health Canada guidelines.

As was noted above, although some work has been done post-SARS to develop a provincial pandemic flu plan, it is not yet completed. However, the Ministry has held workshops with a wide range of internal and external stakeholders from both health and non-health sectors to assist in the development of the plan. Representation was included from emergency management, labour, municipal affairs, community safety and correctional services, agriculture and food and community and social services. The current draft plan is aligned with the Canadian Pandemic Influenza Plan, released in February 2004, to be consistent in language, format and definitions. Drafting efforts continue in order to ensure clarity of roles and responsibilities between provincial and local levels and within each level as well as to identify roles and responsibilities by position. The current draft is aligned with the structure of the national plan and incorporates full acceptance of the WHO phasing of a pandemic. The Ministry has indicated to the Commission that its target is to have a consolidated plan for use in the field ready to be released by the end of May 2004. Once the Ontario Pandemic Influenza Plan is developed, planning across all provincial ministries can move forward.

In order to address the serious problem of the lack of a sufficient supply of personal protective equipment for health care workers, patients and others that arose at the outbreak of SARS I, the Ministry has begun to stockpile and secure its supplies. The Ministry reported that a two-month stockpile of personal protective equipment, including masks, gloves, gowns, eye protection and other clinical supplies, for a community the size of Toronto is available and could be distributed quickly through a central distribution system.

Insufficient human resources at the public health unit level not only impeded efforts to gather and analyze important data relating to the spread of SARS but also made effective contact tracing and the application of quarantine management procedures almost impossible. The Ministry has taken some steps to assist local public health units to acquire more staff with the necessary expertise in managing infectious diseases by allocating funding for 180 positions at the local health unit level. It remains to be seen how long this will be maintained.

The Ministry has informed the Commission that it distributed SARS Outbreak Directives to all provincial acute-care facilities in October 2003 and to all other health care facilities in December 2003. The Directives relate to infection control and surveillance procedures for all health-care sectors in the event of another SARS outbreak. The Ministry has indicated that the Directives can quickly be adapted for use during an influenza pandemic or other infectious disease/public health emergency. The Ministry required that all acute-care hospitals confirm that all staff members have been trained in the Directives as of March 31, 2004. Non-acute care

facilities and Community Care Access Centres have been asked to provide confirmation of training by May 1, 2004.

A febrile respiratory illness (FRI) screener has been distributed to health-care providers across the province in order to assist in assessing patients/clients who present with a febrile illness. In addition, the Ministry has reported to the Commission that it has developed infection control and surveillance standards for febrile respiratory illness for non-outbreak conditions. The Ministry has requested the professional colleges to identify strategies to incorporate the guidelines into their respective professional practice standards by July 1, 2004.

The Ministry has advised the Commission that a number of initiatives have been undertaken to facilitate a more effective local response to public health emergencies. The strategies include the following: a 20-bed mobile critical care unit, known as the Emergency Medical Assistance Team (EMAT), that can be deployed on 24 hours notice anywhere in the province in situations where a health emergency is overwhelming local resources; a Designated Hospital model is being finalized to respond to situations in which local health resources are overwhelmed by an infectious disease outbreak such as SARS; the Patient Transfer Authorization Centre (PTAC) has been set up with appropriate authorization protocols to provide a provincial patient tracking system that will facilitate surveillance of patients with FRI who are being transferred between facilities or discharged home; negative pressure rooms, that are used in the treatment of air-borne infectious diseases, across the province have been identified by region, site and type on the CritiCall database which can be accessed by all acute-care facilities; rapid discharge protocols have been developed to facilitate patient discharge from acute-care hospitals to long-term care facilities or home in the event of a health emergency.

The Ministry advised the Commission that it has taken steps to address compliance with the Directives through hospital infection control audits. Every Ontario hospital has confirmed to the Ministry that it has done a thorough review of its infection control procedures and has put proper infection control measures in place. In the future, rigorous infection control audits will become part of each hospital's ongoing monitoring and reporting to the Ministry and the public.

As has already been noted, Ministry communication with health-care providers and the public was neither timely nor clear during the SARS crisis. The Ministry has reported to the Commission that it has enhanced its capacity to rapidly communicate with health-care providers and with the public in a health emergency. It has indicated that "Important Health Notices" and other critical information docu-

ments can be distributed to all health-care providers in the province through an integrated email/fax/postal system that will facilitate the distribution of timely and accurate information. These Notices can also be used to communicate appropriate infection control and surveillance measures, including directives and standards, during a health emergency. The Ministry has reported to the Commission that it has its own multi-media web server that will support the communication of webcasts with 24-hour notice. It also has the capacity to broadcast live from Queen's Park with international news conferencing capability (including satellite). Within the Ministry, the Emergency Management Unit, the Public Health Branch and the Communications and Information Branch have established notification protocols in the event of a potential health emergency. The Ministry also advises that it has modified and enhanced its crisis and risk communications strategy by adopting the CDC model.

To begin to address a weakness identified by the Provincial Auditor, the Commission has been informed that the Ministry has started to undertake spot audits to determine whether local health units are meeting mandatory infection control guidelines.

Other strategies being employed to deal with public health human resource needs include: a protocol for emergency out-of-province recruitment and licensure has been put in place; a registry has been established through the Registered Nurses Association of Ontario to facilitate access during an emergency to healthcare workers, including nurses and respiratory therapists; a system of on-call infectious disease specialists to support clinical diagnosis of patients with suspected illnesses has been put in place; and a plan is in development to provide psychological assistance to health care workers and to the public during and after a health emergency.

The measures implemented and contemplated evidence a laudable determination to address the many public health weaknesses identified in this report. These problems, however, are deeply ingrained and systemic. They can only be addressed through a sustained commitment that may take years to bear fruit. History has shown that governments, no matter how well intentioned, do not always have the stamina to oversee changes that require a long-term dedication. This was recently expressed in an audit of the management and planning functions at the CDC. The audit, by the highly regarded U.S. General Accounting Office, underlines the challenge of making fundamental, long-term change. It stated:

> Experience shows that successful major change management initiatives in large private and public sector organizations can often take at least 5 to 7 years. This length of time and the frequent turnover of political leader-

> ship in the federal government have often made it difficult to obtain the sustained and inspired attention to make needed changes.[143]

These pending and proposed improvements exemplify an obvious present desire to fix the public health problems revealed by SARS. It is beyond the Commission's mandate to evaluate or monitor these initiatives. The government's efforts to ensure the province will not again be confronted by the same problems that arose during SARS, will be effective only if it dedicates adequate funds and makes a long-term commitment to reform of our public health protection systems. As in most areas of human endeavour, actions speak louder than words. Only time will tell whether the present commitment will be sustained to the extent necessary to protect Ontario adequately against infectious disease.

143. U.S. General Accounting Office, *Centres for Disease Control and Prevention: Agency Leadership Taking Steps to Improve Management and Planning, but Challenges Remain,* (Washington, D.C., January 2004), pp. 2-3.