Appendix A: First Interim Report Summary of Recommendations

A Broken System

SARS showed that Ontario's public health system is broken and needs to be fixed. Despite the extraordinary efforts of many dedicated individuals and the strength of many local public health units, the overall system proved woefully inadequate. SARS showed Ontario's central public health system to be unprepared, fragmented, poorly led, uncoordinated, inadequately resourced, professionally impoverished, and generally incapable of discharging its mandate.

The SARS crisis exposed deep fault lines in the structure and capacity of Ontario's public health system. Having regard to these problems, Ontario was fortunate that SARS was ultimately contained without widespread community transmission or further hospital spread, sickness and death. SARS was contained only by the heroic efforts of dedicated front line health care and public health workers and the assistance of extraordinary managers and medical advisors. They did so with little assistance from the central provincial public health system that should have been there to help them.

These problems need urgently to be fixed.

Reasons for Interim Report

The work of this Commission will continue until I am satisfied that the necessary evidence has been reviewed. Because government decisions about fundamental changes in the public health system are clearly imminent, this interim report on the public health lessons of SARS is being issued at this time instead of awaiting the final report. This interim report is based on the evidence examined to date and is not intended as the last word on this aspect of the Commission's investigation.

The fact that the Commission must address public health renewal on an interim basis is not to say it is more important than any other urgent issue such as the safety and

protection of health care workers. It is simply a case of timing. The Commission continues to interview health care workers, SARS victims, the families of those who died, and those who fought the outbreak. Their story and the story of SARS will be told in the Commission's final report.

For an update on the Commission's ongoing work see Appendix A.

Twenty-One Principles for Reform

The lessons of SARS yield 21 principles for public health reform:

1. Public health in Ontario requires a new mandate, new leadership, and new resources.

2. Ontario public health requires renewal according to the principles recommended in the Naylor, Kirby, and interim Walker reports.

3. Protection against infectious disease requires central province-wide accountability, direction, and control.

4. Safe water, safe food, and protection against infectious disease should be the first priorities of Ontario's public health system.

5. Emergency planning and preparedness are required, along with public health infrastructure improvements, to protect against the next outbreak of infectious disease.

6. 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.

7. Reviews are necessary to determine if municipalities should have a significant role in public health protection, or whether accountability, authority, and funding should be fully uploaded to the province.

8. If local boards of health are retained, the province should streamline the processes of provincial leadership and direction to ensure that local boards comply with the full programme requirements established by the province for infectious disease protection.

9. 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.

10. Public health protection funding against infectious disease should be uploaded so that the province pays at least 75 per cent and local municipalities pay 25 per cent or less.

11. A transparent system authorized by law should be used to clarify and regularize the roles of Chief Medical Officer of Health and the local medical officer of health in deciding whether a particular case should be designated a reportable disease.

12. The Chief Medical Officer of Health, while accountable to the Minister of Health, requires the independent duty and authority to communicate directly with the public and the Legislative Assembly whenever he or she deems necessary.

13. The operational powers of the Minister of Health under the *Health Protection and Promotion Act* should be removed and assigned to the Chief Medical Officer of Health.

14. The Chief Medical Officer of Health should have operational independence from government in respect of public health decisions during an infectious disease outbreak. Such independence should be supported by a transparent system requiring that any Ministerial recommendations be in writing and publicly available.

15. The local medical officer of health requires independence, matching that of the Chief Medical Officer of Health, to speak out and to manage infectious outbreaks.

16. The operational powers of the local medical officer of health should be reassigned to the Chief Medical Officer of Health, to be exercised locally by the medical officer of health subject to the direction of the Chief Medical Officer of Health.

17. An Ontario Centre for Disease Control should be created as support for the Chief Medical Officer of Health and independent of the Ministry of Health. It should have a critical mass of public health expertise, strong academic links, and central laboratory capacity.

18. Public health requires strong links with hospitals and other health care facilities and the establishment, where necessary, of an authoritative hospital presence in relation to nosocomial infections. The respective accountability, roles and responsibilities of public health care and health care institutions in respect of infectious outbreaks should be clarified.

19. Ontario and Canada must avoid bickering and must create strong public health links based on cooperation rather than competition to avoid the pitfalls of federal overreaching and provincial distrust.

20. The Ontario government must commit itself to provide the necessary resources and leadership for effective public health protection against infectious disease.

21. Public health requires strong links with nurses, doctors and other health care workers and their unions and professional organizations.

It is expected that the final report of the Walker expert panel will recommend a detailed prescriptive blueprint for many of the operational details of a renewed system. Such operational details are beyond the scope of this interim report. Some of the issues that will drive these details are discussed in the report.

Hindsight

Everything said in this report is said with the benefit of 20-20 hindsight, a gift not available to those who fought SARS or those who designed the systems that proved inadequate in face of a new and unknown disease.

It is important to distinguish between the flaws of public health systems and the skill and dedication of those who worked within them. To demonstrate the weakness of Ontario's public health infrastructure is not to criticize the performance of those who worked within systems that proved inadequate in hindsight. The Commission recognizes the skill and dedication of so many individuals in the Ontario public health system and those

volunteers from Ontario and elsewhere who worked beyond the call of duty. Twenty-hour days were common. They faced enormous workloads and pressures in their tireless fight, in a rapidly changing environment, against a deadly and mysterious disease.

It is my hope that those who worked on the front lines and in public health in Ontario during SARS will accept that I have approached the flaws of the system with the utmost respect for those who gave their all to protect the public. We should be humbled by their efforts.

In this interim report I have attempted to avoid, and I invite the reader to avoid, the unfair use of hindsight to judge the actions of those who struggled so valiantly in the fog of battle against the unknown and deadly virus that is SARS.

What Went Right

The litany of problems listed below reflect weaknesses in central public health systems. These weaknesses hampered the work of the remarkable individuals who eventually contained SARS. The problems of SARS were systemic problems, not people problems. Despite the deep flaws in the system, it was supported by people of extraordinary commitment.

The strength of Ontario's response lay in the work of the people who stepped up and fought SARS. What went right, in a system where so much went wrong, is their dedication. It cannot, however, be said that things went right because SARS was eventually contained. It does nothing for those who suffered from SARS or lost loved ones to SARS to say that the disease which caused their suffering was ultimately contained. For the families of those who died from SARS and for all those who suffered from it, little if anything went right. This enormous toll of suffering requires that the Ontario government commit itself to rectify the deep problems in the public health system disclosed by SARS.

The Decline of Public Health

The decline of public health protection in Ontario began decades before SARS. No government and no political party is immune from responsibility for its neglect.

It is troubling that Ontario ignored so many public health wake-up calls from Mr. Justice Krever in the blood inquiry, 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.

Lack of Preparedness: The Pandemic Flu Example

When SARS hit, Ontario had no pandemic influenza plan. Although SARS and flu are different, the lack of a pandemic flu plan showed that Ontario was unprepared to deal with any major outbreak of infectious disease.

Had a pandemic flu plan been in place before SARS, Ontario would have been much better prepared to deal with the outbreak. The failure to heed warnings about the need for a provincial pandemic flu plan, and the failure to put such a plan in place before SARS, reflects a lack of provincial public health leadership and preparedness.

Lack of Transparency

Because there was no existing plan in place for a public health emergency like SARS, systems had to be designed from scratch. Ad hoc organizations like the epidemiological unit (Epi Unit) and the Science Committee were cobbled together. Procedures and protocols were rushed into place including systems like the case review, or adjudication process, that grew up to determine whether a particular case should be reported as SARS. Because SARS was such a difficult disease to diagnose, there were no reliable lab tests and knowledge about the disease was rapidly evolving, there were disagreements from time to time as to whether a particular case was SARS.

Although well meaning, this system lacked clear lines of accountability and in particular it lacked transparency.

To avoid this problem in the future the Commission recommends that the respective roles of the Chief Medical Officer of Health and the local medical officers of health, in deciding whether a particular case should be designated as a reportable disease, should be clarified and regularized in a transparent system authorized by law.

Lack of Provincial Public Health Leadership

Few worked harder during SARS than Dr. Colin D'Cunha, the Chief Medical Officer of Health for Ontario and Director of the Public Health Branch in the Ontario Ministry of Health and Long- Term Care. He demonstrated throughout the crisis a strong commitment to his belief of what was in the public interest. Dr. D'Cunha is a dedicated professional who has devoted his career to the advancement of public health. For the brief reasons set out in the report Dr. D'Cunha turned out in hindsight to be the wrong man in the wrong place at the wrong time.

While it may be due to misunderstandings or a simple difficulty on the part of Dr. D'Cunha to communicate effectively, there is a strong consensus on the part of those colleagues who worked with him during the crisis that his highest and best public calling at this time is in an area of public health other than direct programme leadership. This general concern has undoubtedly been reflected in the government's decision to provide him with other opportunities within his area of expertise.

Because Dr. D'Cunha no longer holds the office of Chief Medical Officer of Health it might be asked why it is necessary in this interim report to deal with his leadership during SARS. The answer is that the public has a right to know what happened during SARS and that obliges me to make whatever findings I am taken to by the evidence. The story of what happened during SARS cannot be told without some reference to the difficulties that arose in respect of Dr. D'Cunha's leadership.

I cannot fairly on the evidence before me make any finding of misconduct or wrongdoing by Dr. D'Cunha. The underlying problems that arose during SARS were systemic problems, not people problemMs. Because the underlying problems were about inadequate systems and not about Dr. D'Cunha, it would be unfair to blame him or make him a scapegoat for the things that went wrong.

It is impossible to say, in the end result, that Dr. D'Cunha's difficulties made any ultimate difference in the handling of the crisis. Although his colleagues were frustrated by his approach to things, the crisis was to a large extent managed around him. It is hard to say that the overall result of the SARS crisis would have been different with someone else at the helm.

Lack of Perceived Independence

The Commission on the evidence examined thus far has found no evidence of political interference with public health decisions during the SARS crisis. There is, however, a perception among many who worked in the crisis that politics were at work in some of the public health decisions. Whatever the ultimate finding may be once the investigation is completed, the perception of political independence is equally important. A public health system must ensure public confidence that public health decisions during an outbreak are free from political motivation. The public must be assured that if there is a public health hazard the Chief Medical Officer of Health will be able to tell the public about it without going through a political filter. Visible safeguards to ensure the independence of the Chief Medical Officer of Health were absent during SARS. Machinery must be put in place to ensure the Actual and apparent independence of the Chief Medical Officer of Health in decisions around outbreak management and his or her ability, when necessary, to communicate directly with the public.

Lack of Public Health Communication Strategy

The problems of public communication during SARS are addressed thoughtfully in the Naylor Report and the Walker Interim Report. The Commission endorses their findings and their recommendations for the development of coherent public communication strategies for public health emergencies.

There is no easy answer to the public health communications problems that arose during SARS. On the one hand, if there are too many uncoordinated official spokespeople the public ends up with a series of confusing mixed messages. On the other hand, as Mr. Tony Clement the Minister of Health during SARS pointed out to the Commission, any attempt to manage the news by stifling important sources of information will not only fail but will also lead to a loss of public confidence and a feeling among the public that they are not getting the straight goods or the whole story. What is needed is a pre-planned public health communications strategy that avoids either of these extremes.

Poor Coordination with Federal Government

Problems with the collection, analysis and sharing of data beset the effort to combat SARS. While many factors contributed to this, strained relations between the three levels of government did not help matters.

The lack of federal-provincial cooperation was a serious problem during SARS. This lack of cooperation prevented the timely transmission from the Ontario Public Health Branch of vital SARS information needed by Ottawa to fulfill its national and international obligations. Although recollections differ as to the responsibility for this lack of cooperation, the underlying problems were the lack of pre-existing protocols, agreements, and other machinery to ensure the seamless flow of necessary information and analysis, combined with a possible lack of collaborative spirit in some aspects of the Ontario response.

The inherent tensions between the federal and provincial governments must be overcome by a spirit of cooperation around infectious disease surveillance and coupled with the necessary machinery to ensure in advance that the vital information will flow without delay. It is clearly incumbent on both levels of government to ensure that the breakdown that occurred during SARS does not happen again.

A Dysfunctional Public Health Branch

The Commission has heard consistent reports that the Public Health Branch of the Ministry of Health had become dysfunctional both internally and in terms of its relationships with the local public health units.

A lack of respect for the Public Health Branch was evident in the responses from outside Ontario and from elements of the Ontario public health system at the local level. When SARS hit, leadership was not forthcoming from a Public Health Branch that turned out to be dysfunctional.

Lack of Central Public Health Coordination

Under the *Health Protection and Promotion Act*, local medical officers of health were responsible for the local response to SARS. It was to the province however, to the Public Health Branch in the Ministry of Health, that the local public health units looked for guidance. Unfortunately many medical officers of health felt there was no coordinated effort at the Public Health Branch to facilitate the SARS response at the local level. For many in the field it seemed as though the Branch was a silo, disconnected from the field, rather than a partner or a resource.

Many local medical officers of health felt abandoned during SARS, devoid of support and guidance. The Branch's failure to coordinate and guide the local health units was

already a big problem before SARS. It turned out to be a harbinger of the problems that arose during SARS.

Lack of Central Expertise

The outbreak was managed, of necessity, around the Public Health Branch of the Ministry of Health and Long-Term Care rather than through it. The critical mass of professional expertise one would expect in a crucial branch of government in a province the size of Ontario simply did not exist, either in the number of experts or their depth of experience. Key operational groups had to be put together on the run and individual experts had to be recruited from the field to fill this void. Machinery such as the Science Committee and the Epi Unit were run on almost a volunteer drop-in basis because there was no depth of expertise in the Branch itself.

SARS demonstrated that our most valuable public health resources are human resources and that Ontario lacked a critical mass of expertise at the provincial level. It is crucial to the success of any public health reform initiatives in Ontario that there be a high level of expertise at both the local and central levels of public health. Ontario cannot continue to rely on the goodwill and volunteerism of others to protect us during an outbreak. Many of those who came forward to work at the provincial level during SARS were disheartened by the problems they saw and a few expressed doubts whether they would be willing to come forward again, particularly if the problems are not addressed. Examples abound of centres of excellence for disease control: British Columbia, Quebec, and Atlanta, among others. Ontario needs to learn from their example. Without a critical mass of the right professionals public health reform, no matter how well-reasoned and well-resourced, has no chance of success.

No Established Scientific Backup

In March 2003, the Public Health Branch in Ontario had neither the capacity nor the expertise to handle an outbreak of the magnitude of SARS. Neither was there any provincial plan to rapidly bring together the necessary experts to provide scientific advice to those managing the outbreak. One outside expert, brought in to help manage the crisis, noted that Ontario simply didn't have the machinery, people or the leadership at the central level:

> It was abundantly clear to everyone who sat in on teleconferences that Ontario was scrambling, didn't have the infection control expertise, at

> least the amount of expertise. There were superb infection control people there … it's clear they were unable to pull together the data that was required for them and us to try to understand what's going on. It was abundantly clear that there was no obvious concerted leadership of the outbreak at least as we could see … It was obvious to all of us that Ontario was in substantial trouble.

Consequently, the Ministry of Health had to turn to experts outside of government for advice and direction. While it is not unusual that outside experts would be consulted during an outbreak, the lack of planning meant that the core expert groups had to be thrown together in haste without adequate planning or organization.

Lack of Laboratory Capacity

Before SARS, concerns had been raised about the capacity of the Ontario Central Public Health Laboratory (provincial laboratory). Despite these warnings, it was not prepared to deal with an outbreak of this magnitude. There were only two medical microbiologists in the laboratory, who were responsible for the entire province.

To make it worse, the Ministry of Health and Long-Term Care, in the fall of 2001, had laid off its PhD level scientists at the provincial laboratory. These scientists were engaged in the diagnosis and surveillance of new and emerging infections as well as research and development.

Within government, there seemed to be a complete lack of understanding of the importance of the work done by scientists at the provincial laboratory. At the time of the layoffs, a Ministry of Health spokesman was quoted as saying:

> Do we want five people sitting around waiting for work to arrive? It would be highly unlikely that we would find a new organism in Ontario.

It is unnecessary, in light of SARS, to bring the irony of this statement to the attention of the reader. Less than two years later, SARS struck Ontario. The provincial laboratory did not have the capacity to deal with SARS.

Despite earlier warnings, the Ontario Central Public Health Laboratory proved inadequate during SARS. It is essential that the provincial laboratory be revitalized with the necessary physical and human resources.

No Provincial Epidemiological Unit

When SARS hit Ontario, the Ministry of Health's Public Health Branch was totally unprepared to deal with an outbreak of this nature. To start with, it had no functioning epidemiological unit (Epi Unit).

The Science Committee needed epidemiological data about the transmission of the disease and whether control measures were effective. It needed answers to a number of vital questions: How was the outbreak progressing? What was the incubation period? How long were people infectious? What were the risks in hospital?

Although an Epi Unit was cobbled together as the outbreak unfolded, its work was hampered by the lack of planning and support systems.

It was a major failure of Ontario's public health system that no such unit was in place when SARS struck. The development of fully resourced epidemiological capacity is vital to protect Ontario against outbreaks of infectious disease. In the absence of major reform, Ontario may not be able in a future outbreak to draw on the extraordinary volunteer resources that helped so much in the spring of 2003.

Inadequate Infectious Disease Information Systems

The fight against SARS was hampered by the lack of an effective reportable disease information system. When SARS hit Ontario neither the provincial Public Health Branch nor the local public health units had any information system capable of handling a disease like SARS. The existing system, known as Reportable Disease Information System, or RDIS, was disease-specific and not flexible enough to handle new diseases.

Until the Epi Unit was up and running, there was no way to coordinate the work of local public health units into a common reporting structure. This delay turned out to be a critical problem. By the time the Epi Unit was established, individual health units were married to their own individual methods of collecting and reporting data. As a result, they were unable and disinclined to change their systems mid-stream, despite problems created by the diverse manner in which the data was being collected and reported.

Because of systemic weaknesses, the Toronto Public Health unit, which had the majority of the SARS cases, relied on a paper-based system of case tracking. This

nightmarish system generated cardboard boxes spilling over with paper, all of which had to be collated and analyzed by hand.

The Commission endorses the specific recommendations in the Naylor Report and the Walker Interim Report to address the deficiencies in the federal and Ontario infectious disease information systems.

Should SARS or some other infectious disease hit Ontario tomorrow, the province still has no information system, accessible by all health units, capable of handling an outbreak. The first unheeded wake-up call was the Provincial Auditor's report in 1997. The second unheeded wake-up call was West Nile. If it takes Ontario as long to respond to SARS as it did to those earlier wake-up calls, the province will be in serious trouble when the next disease strikes.

Overwhelming and Disorganized Information Demands

The problem of information flow was not restricted to the lack of the necessary information technology systems. Confusion, duplication, and apparent competition prevailed in the work of those in the central apparatus who sought information from local public health units and hospitals. These unfocused demands consumed valuable time of public health and hospital staff, distracted them from urgent tasks at hand, and impaired their ability to get on with the work of fighting the disease.

SARS caught Ontario with no organized system for the transmission of case information to those who needed it to fight the outbreak. There was no order or logic in the frenzied, disorganized, overlapping, repetitious and multiple demands for information from hospitals and local public health units. Requests would go out simultaneously to many people for the same piece of information. The work of front line responders in hospitals and health units was seriously impaired by this constant and unnecessary harassment.

Inadequate Data

The data produced by the jerry-built system through the frenzy of information demands often proved to be inadequate. Accurate data of high quality was vital to the experts on the Science Committee who had to provide evidence- and science-based direction for the management of SARS. Because so much about the disease was unknown, case-specific information was vital and sound decisions could not be made

without adequate data of the necessary quality.

The Science Committee never reached the point where it received adequate data in a timely manner, including information about contacts of those with SARS. Consequently, it was difficult to judge the effectiveness of control measures such as quarantine.

The Epi Unit and the local health units were often unable to provide adequate and timely data. While there is disagreement among those involved as to the amount of data being provided, what is clear is that the experts and officials who needed the data did not get what they needed when they needed it. The information systems and support structures were simply not in place. In the absence of this necessary machinery, not even the hardest work and greatest expertise of those who came forward to staff the Epi Unit and the Science Committee could overcome the obstacles

Duplication of Central Data Systems

Because there was no standard information system for the Public Health Branch and all the local public health units, each individual health unit developed their own data collection system during SARS. The lack of a single, effective, accessible information system, combined with a constant, intense demand for information from a number of different people and groups, resulted in chaos.

Duplicate data systems sprung up at the Ministry of Health. For example, one group in the Ministry ran a system intended to track the situation in hospitals. This group collected data separate from the Epi Unit, but the numbers reported by this Ministry group often differed widely from the numbers reported by the Epi Unit.

The proliferation of data systems, and the confusion and burdens it created, was an inevitable consequence of Ontario's lack of preparedness for a major outbreak of infectious diseases.

Failure to priorize public health emergency preparedness, and to devise one central system for the collection and sharing of infectious disease data was a major problem during SARS. Although work has been done since SARS to improve the situation, there is no such system now in place to protect us from a future outbreak. Unless this problem is addressed, duplicate systems will spring up again as people scramble to devise their own information systems in the absence of systems put in place before the next outbreak hits.

Blockages of Vital Information

There was a perception among many who fought SARS that the flow of vital information to those who urgently needed it was being blocked or delayed for no good reason.

What is striking is that the various groups appear honestly to believe that they communicated the information to each other. Yet clearly there were significant gaps in the transfer of information between Toronto Public Health and the province, between the provincial Epi Unit and the Science Committee, and between Ontario and the Federal government. It is impossible to determine the precise source of the data blockages.

It does not matter whose perception, in the fog of battle against the disease, was correct. The bottom line is that the lack of clarity around the flow of communication and the reporting structure, the absence of a pre-existing epidemiological unit coordinated with the local health units and the absence of clear public health leadership above the Epi Unit provided an environment in which the crucial elements of the fight against SARS were disconnected from each other. Despite the best efforts of individuals attached to all of the groups involved, they simply could not connect effectively.

Legal Confusion

The fight against SARS was marked by the lack of clarity of existing laws that impacted on the public health system. Although the Commission cannot at this interim stage make specific recommendations for legislative reform in Ontario, a few things should be said about the general need for work in this area. Areas of concern include the following:

- Who legally was in charge of the outbreak?
- Who had the ultimate responsibility for the classification of a case: the local jurisdiction or the province?
- What was the legal authority for issuing directives to hospitals?
- What were the consequences of not following those directives?

- What specific information had to be transmitted, by whom, when and to whom?

- To what extent could public officials and private experts share data and for what purpose?

- Who was obliged to notify relatives that a family member was classified as a suspect or probable case?

- Did privacy rights prevent the sharing of information necessary to fight the outbreak?

While protection of patient confidentiality is a key consideration in any data sharing agreement or legislation, it should not in the future hinder the vital communication of data to the extent it did during SARS. Notwithstanding the strong privacy concern demonstrated by many of those who fought the outbreak, a number of families affected by SARS reported that they felt their privacy had nonetheless been violated because personally identifying information somehow made it into the media. It is ironic that although privacy concerns restricted the flow of vital information between agencies fighting the outbreak, they were not always effective to keep personal information from the media.

Whatever the precise path of legislative reform, privacy, while vital, should not impede the necessary sharing between agencies and governments of information required to protect the public against an outbreak of infectious disease.

The Commission during the course of its investigation will continue to address issues around the need for legislative changes identified in the lessons learned from SARS.

Public Health Links With Hospitals

SARS was largely a hospital spread infection. Although there was some spread in households and doctors offices, and a limited element of community spread, most of the transmission took place in hospitals.

There are significant weaknesses in the links between public health and hospitals and there is lack of clarity as to the respective accountability and authority of public health and hospitals in a hospital-based outbreak.

Public health should have strong links with hospitals and establish where necessary an authoritative hospital presence in relation to nosocomial infection. The respective accountability, roles and responsibilities of public health and health care institutions in respect of infectious outbreaks should be clarified.

Public Health Links with Nurses, Doctors and Others

Public health links with nurses, doctors, other health care workers and their unions and professional organizations were often ineffective during SARS.

This section of the report illustrates specific problems that arose from this general failure and points to the need for a better system to ensure that public health develops better links and communication systems with the key participants in the health care system.

Lack of Public Health Surge Capacity: The Toronto Example

The sudden demands imposed by SARS on local public health units were overwhelming. The hardest hit jurisdiction was Toronto, where the cases snowballed with each passing day of the outbreak. While the same was true of other public health units, Toronto is selected as an example because it had the greatest number of cases.

Despite the reassignment of public health staff from other jobs, and despite the influx of workers from other health units to help out, Toronto public health was at times overwhelmed by the staggering workload which included:

- Approximately 2,000 case investigations. Each took an average of nine hours to complete.
- More than 23,000 people identified as contacts.
- Of these, 13,374 placed in quarantine.
- More than 200 staff working on the SARS hotline.
- Over 300,000 calls received on the hotline.
- On the highest single day, 47,567 calls.

Despite the best efforts of so many, the systems for redeployment proved inadequate. SARS demonstrated the need to create surge capacity by planning in advance so that every available worker can be redeployed where necessary.

The Case of the Federal Field Epidemiologists

The federal government sent a number of Health Canada employees to work in the field to help with containment efforts. In the early days of the outbreak they sent three federal field epidemiologists to Toronto, often referred to as the field epi's, who brought a badly needed level of expertise to the provincial response. Unfortunately, the lack of clarity concerning their deployment and, from time to time, the tasks that they were asked to perform led to problems and ultimately contributed to the decision by Health Canada to pull them back from Ontario.

The case of the federal field epidemiologists demonstrates many of the underlying problems of Ontario's SARS response noted above: poor coordination among levels of government, poor coordination of Ontario's public health response, and above all a lack of any advance plan for outbreak management.

Improvements Since SARS

This section of the report describes the steps taken to fix the problems disclosed by SARS.

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.

Naylor, Kirby, Walker

These three reports share a common vision for the renewal of our public health

systems through increased resources, better federal-provincial and inter-agency cooperation, and system improvements. They bear close study and great consideration. Their methodology and approach are sound and their recommendations are solidly based in their respective expertise. Based on the evidence it has seen, the Commission endorses the major findings and recommendations of all three studies.

Federal-Provincial Cooperation

Too many good ideas in this country have been destroyed by mindless federal-provincial infighting. The most noble and appealing proposals for reform falter so often in Canada simply because of the inherent bureaucratic and political mistrust between the two levels of government. If a greater spirit of federal-provincial cooperation is not forthcoming in respect of public health protection, Ontario and the rest of Canada will be at greater risk from infectious disease and will look like fools in the international community. While there are hopeful signs that more cooperation will be forthcoming, it will take hard work from both levels of government to overcome the lack of coordination demonstrated during SARS.

Ontario and Canada must avoid bickering and must create strong public health links based on cooperation rather than competition, avoiding the pitfalls of federal overreaching and provincial distrust

Independence And Accountability

There is a growing consensus that a modern public health system needs an element of independence from politics in relation to infectious disease surveillance, safe food and safe water, and in the management of infectious outbreaks.

Whatever independence may be required by the Chief Medical Officer of Health for public health decisions during an outbreak and for the right to speak out publicly whenever necessary, he or she should remain accountable to the government for overall public health policy and direction and for the expenditure of public funds.

The proposed power to report directly to the public, combined with independence in relation to the management of infectious outbreaks, provides a significant measure of independence to the Chief Medical Officer of Health. It ensures that on important public health issues the Chief Medical Officer of Health cannot be muzzled and that the public can get a direct sense of emerging public health problems without passing

through any political filters. It ensures both the reality and the public perception that the management of infectious disease outbreaks will be based on public health principles and not on politics.

The Commission therefore recommends:

- Subject to the guarantees of independence set out below, the Chief Medical Officer of Health should retain a position as an Assistant Deputy Minister in the Ministry of Health and Long-Term Care.

- The Chief Medical Officer of Health should be accountable to the Minister of Health with the independent duty and authority to communicate directly with the public by reports to the Legislative Assembly and the public whenever deemed necessary by the Chief Medical Officer of Health.

- The Chief Medical Officer of Health should have operational independence from government in respect of public health decisions during an infectious disease outbreak, such independence supported by a transparent system requiring that any Ministerial recommendations be in writing and publicly available.

- The local medical officer of health should have the independence, matching that of the Chief Medical Officer of Health, to speak out and to manage infectious outbreaks.

The Public Health Ping-Pong Game

Public health in Ontario including protection against infectious disease is delivered primarily through 37 local Boards of Health, which are largely controlled by municipal governments. Public health funding has gone back and forth like a ping-pong ball between the province and the municipalities.

So long as the municipalities fund public health to a significant degree, public health will have to compete with other municipal funding priorities. Communicable disease control is a basic public necessity that can affect the entire province if a disease gets ahead of the controls. Infectious disease control should not have to compete against potholes for scarce tax dollars.

There is no scientific way to determine the appropriate degree of provincial funding upload for infectious disease surveillance and control. Although a case can be made

for 100-per-cent funding upload, the persuasive views of a number of local Medical Officers of Health suggest that it would be sensible to upload infectious disease control to a provincial contribution of at least 75 per cent.

Opinions will differ as to how the funding formula should be changed, and whether and how much coordinating or direct power over public health should be uploaded to the province. The one thing on which everyone will agree is that the shifting of funding and accountability back and forth between the province and the municipalities has impaired the stability of Ontario's public health system. It is time to stop the ping-pong game and to begin an era of stable public health funding relationships between the province and the municipalities.

One Local Funding Problem

This section of the report demonstrates in exquisite detail the problems that can arise through the present system of local funding of public health and the disinterest shown by some municipal politicians in the public interest in effective public health protection.

This story painfully reveals the importance of ensuring that funding for local health activities is not left to the mercies of any intransigent local council that fails to live up to its legal responsibilities in respect of public health protection. Basic protection against disease should not have to compete for money with potholes and hockey arenas. Even if most municipalities respect their public health obligations under the *Health Protection and Promotion Act*, it only takes one weak link to break the chain of protection against infectious disease. Should an infectious disease outbreak spread throughout Ontario, the municipality that cannot or will not properly resource public health protection may be the weak link that affects the entire province and beyond.

The Municipalities' Funding Dilemma

All municipalities are affected by the underlying difficulty of funding any provincial programme from the local municipal property base. SARS and West Nile showed that infectious disease protection has to be approached at a provincial level. It is anomalous to fund a provincial programme like infectious disease control from the limited municipal tax base. In a submission to the Commission, the Association of Municipalities of Ontario makes a persuasive case for the province and the municipal-

ities to sit down together and agree on the best structure to fund infectious disease protection and the best process for getting there.

One Local Story: Parry Sound

SARS was not restricted to Toronto. This section outlines the response to SARS by the local hospital, the West Parry Sound Health Centre and the local public health unit. It demonstrates the lack of provincial public health support to a local community faced with SARS and the difficulties caused by the inability of many local public health units to attract and retain permanent a medical officer of health.

If the present system of local control over public health and infectious disease is to be maintained, it is essential that machinery be put in place to ensure continuous unbroken oversight and authority in every public health unit in Ontario supported by the necessary cadre of public health professionals.

An Ontario Centre for Disease Control

A consensus has developed that some kind of separate "CDC Ontario" is needed, with strong academic links, in order to provide a critical mass of medical, public health, epidemiological, and laboratory capacity and expertise. Structural models abound for such an organization, from the British Columbia Centre for Disease Control (B.C. CDC), to the Institut national de santé publique du Québec, to the federal model proposed in the Naylor Report, and even to the United States Centres for Disease Control (CDC) itself. It is expected that the final Walker Report will make detailed and prescriptive recommendations for the structure and mandate of such an organization.

While it is beyond the scope of this interim report to address this issue in the detailed fashion expected from the final Walker report, a few observations are in order.

First, the structure of the new agency or centre, which will combine advisory and operational functions, must reflect the appropriate balance between independence and accountability whether it is established as a Crown corporation or some other form of agency insulated from direct Ministerial control.

Second, it should be an adjunct to the work of the Chief Medical Officer of Health and the local medical officers of health, not a competing body. SARS showed that

there are already enough autonomous players on the block who can get in each other's way if not properly coordinated. There is always a danger in introducing a semi-autonomous body into a system like public health that is accountable to the public through the government. The risk is that such a body can take on a life of its own and an ivory tower agenda of its own that does not necessarily serve the public interest it was designed to support.

Third, it must be made clear from the beginning that the agency is not an end in itself but exists only to support public health.

The success of centres such as the CDC in Atlanta and the CDC in British Columbia flows largely from a widespread recognition that these institutions house the very best of the best. The authority they have comes from their recognition as centres of excellence that can be counted on to work collaboratively with local agencies. To achieve this authority and success an Ontario Centre for Disease Control will require considerable resources and a strong commitment from government to maintain those resources. It will only work if it has the resources to attract recognized experts and to provide them with the best technology and equipment and optimal support to perform their work. It will take years to build a reputation for excellence and anything less than a 100 per cent commitment to this long-term goal will surely result in failure.

Public Health Restructuring

Whenever a system proves wanting it is tempting to blame its problems on structure and to embark on a course of reorganization, or centralization, or regionalization, or decentralization. It must be remembered that organizational charts do not solve problems. The underlying problems of public health in Ontario have to do with a lack of resources, years of neglect, and lack of governmental priority. These problems developed during the regimes of successive governments and no government or political party is immune from responsibility for the decline of public health protection. These problems will not be fixed by drawing boxes on paper around public health units and moving them into other boxes. The underlying problems will only be solved by a reversal of the neglect that has prevailed for so many years throughout the regime of so many different governments headed by all three political parties.

That being said some attention must be given to the best way to structure and organize the delivery of public health in Ontario. This section discusses the respective

merits of different approaches to the restructuring of Ontario's system of public health protection.

Greater Priority for Infectious Disease Control

SARS made it clear that our public health system must give greater priority to protection against infectious disease. It is equally clear, however, that our entire public health system cannot be reorganized around one disease like SARS. Many diseases produce more sickness and mortality than SARS, and the task of plugging the holes demonstrated by SARS cannot be permitted to detract public health from the task of preventing those afflictions that comprise a higher burden of disease than SARS and other infectious diseases.

While it would be wrong to downgrade the long-term importance of health promotion and population health, the immediate threat posed by any infectious outbreak requires that a dominant priority must be given to protecting the public against infectious disease. It does not disrespect the advocates of health promotion to say that the immediate demands of public safety require that public health, as its first priority, looks after its core business of protecting us from infectious disease.

The tension in public health, between priority for infectious disease control and priority for long-term population health promotion, including the prevention of chronic lifestyle diseases, is not going to go away. There is no point in arguing which is more important, because they are both important. There are however five basic reasons why protection against infectious disease should be the first basic priority of our public health system.

The first is that the threat from infectious disease is direct and immediate. The second is that an outbreak of infectious disease, if not controlled, can bring the province to its knees within days or weeks, a threat not posed by lifestyle diseases. The third is that infectious disease catches the direct attention and immediate concern of the public in a way that long-term health promotion does not. It is essential in an infectious disease outbreak that the public be satisfied that they are getting solid information from the government and that everything possible is being done to contain the disease. The fourth is that infectious disease prevention requires an immediate overall response because it moves rapidly on the ground and spreads quickly from one municipality to another and from province to province and country to country, thus engaging an international interest. The fifth is that health promotion depends largely on partnerships outside the health system between public health and local community agencies

like schools and advocacy groups, allies and resources not available to infectious disease control which must stand largely on its own.

For these five reasons safe water, safe food, and protection against infectious disease should be the first priorities of Ontario's public health system.

Central Control Over Health Protection

An uncontrolled outbreak of infectious disease could bring the province to its knees. The province-wide consequences of a failure in infectious disease control are simply too great for the province to delegate infectious disease protection to the municipal level without effective measures of central provincial control. There is little machinery for direct central control over infectious disease programmes. The existing machinery to enforce local compliance with provincial standards is cumbersome and underused. Better machinery is needed to ensure provincial control over infectious disease surveillance and control.

During a disease outbreak the international community and organizations like the World Health Organization look for reassurance and credibility to the national and provincial level, not to the particular strength of any local public health board or the particular credibility of any local Medical Officer of Health. Viruses do not respect boundaries between municipal health units. The chain of provincial protection against the spread of infectious disease is only as strong as the weakest link in the 37 local public health units. A failure in one public health unit can spill into other public health units and impact the entire province and ultimately the entire country and the international community. When dealing with a travelling virus, concerns about local autonomy must yield to the need for effective central control.

If the *Health Protection and Promotion Act* were amended to provide that:

- The powers now assigned by law to the medical officer of health are reassigned to the Chief Medical Officer of Health, and

- The powers reassigned to the Chief Medical Officer of Health shall be exercised by the medical officer of health in the local region, subject to the direction of the Chief Medical Officer of Health,

it would leave to the local medical officers of health a clear field to exercise the same powers they have always exercised, subject to ultimate central direction.

Under the old system, such a re-arrangement of powers might raise serious concerns of loss of autonomy on the part of the local medical officer of health including the spectre of political influence from Queen's Park on local public health decisions. While concerns about local autonomy will never go away in any centralized system, the new independence of the Chief Medical Officer of Health and the medical officer of health should go a long way to allay such concerns.

A further sensible measure to allay these concerns, and to further protect against the perception of political interference with public health decisions, would be to remove from the Minister of Health under the Act the direct operational power in cases of health risk, such powers to be assigned to the Chief Medical Officer of Health.

These measures are proposed to strengthen provincial control over public health protection with adequate safeguards to ensure the political independence of the Chief Medical Officer of Health and the local medical officer of health in relation to infectious disease control.

Without stronger measures to ensure central provincial control of infectious disease control whenever necessary, Ontario will be left with inadequate protection against potential public health disasters.

Political Will

A reformed public health system requires a major injection of resources. The Naylor, Kirby, and interim Walker reports analyzed the need for a critical mass of scientific and medical expertise, more capacity to educate, recruit, and retain public health professionals, increased laboratory capacity, and improved technology. Further recommendations are expected in the final Walker report. Significant financial resources will be needed to give Ontario's public health system any reasonable capacity for protection against infectious disease.

The decline of public health protection in Ontario reflects a consistent lack of political will, over the regime of many successive governments and all three political parties, to bring up to a reasonable standard the systems that protect us against infectious disease.

Competition for tax dollars is fierce. It is not easy in a time of fiscal constraint for any government to make additional funds available for any public programme. It will require significant political will on the part of the Minister of Health and the Ontario

government to commit the funds and the long-term resolve that are required to bring our public health protection against infectious disease up to a reasonable standard.

It would be very easy, now that SARS is over for the time being, to put public health reform on the back burner. It is a general habit of governments to respond to a crisis by making a few improvements without fixing the underlying problems responsible for the crisis. It would be a tragedy if that turned out to be the case with SARS. As the Naylor Report pointed out:

> SARS is simply the latest in a series of recent bellwethers for the fragile state of Canada's … public health systems. The pattern is now familiar. Public health is taken for granted until disease outbreaks occur, whereupon a brief flurry of lip service leads to minimal investments and little real change in public health infrastructure or priorities. This cycle must end.[490]

Ontario, as demonstrated in this interim report, slept through many wake-up calls. Again and again the systemic flaws were pointed out, again and again the very problems that emerged during SARS were predicted, again and again the warnings were ignored.

The Ontario government has a clear choice. If it has the necessary political will, it can make the financial investment and the long-term commitment to reform that is required to bring our public health protection against infectious disease up to a reasonable standard. If it lacks the necessary political will, it can tinker with the system, make a token investment, and then wait for the death, sickness, suffering, and economic disaster that will come with the next outbreak of disease.

The strength of the government's political will can be measured in the months ahead by its actions and its long-term commitments.

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490. National Advisory Committee on SARS and Public Health, *Learning from SARS: Renewal in Public Health in Canada* (Health Canada: October 2003) p. 64. (Subsequent footnotes will refer to this report as the Naylor Report.)

Appendix B: What Has Been Done

In June 2004, two months after the release of the Commission's first interim report and of the Walker panel's final report, the government unveiled Operation Health Protection, a three-year plan to fix the weaknesses in the public health system exposed by SARS.

The Ministry has recently updated the Commission on the status of efforts to revive the public health system. While this Appendix summarizes the Ministry's information on the progress to date in implementing key initiatives, it is beyond the Commission's mandate or resources to monitor their implementation.

Operation Health Protection announced that a new Health Protection and Promotion Agency will be created by 2006/7. It stated:

> Within two years, Operation Health Protection will be anchored by an independent health protection and promotion agency similar to those operating in British Columbia, Québec and at the Centers for Disease Control and Prevention in Atlanta. This new Ontario Health Protection and Promotion Agency will support the CMOH and provide expert scientific leadership.
>
> Its responsibilities will include:
>
> - Specialized public health laboratory services that will ensure that all health practitioners receive timely and relevant information to support health surveillance;
>
> - Infection control and communicable disease information and centralized support for professionals in "the field";
>
> - Emergency preparedness assistance and support in the form of scientific and technical advice, and a modern and timely alert system;

- Risk communications that will enhance the rapid exchange of information between health care practitioners, institutions and the Ministry about potential health crises;

- Research and knowledge transfer through linkages with research, academic and health care institutions; and

- Reporting through the CMOH on the health status of Ontarians, and emergent health threats and risks.[491]

The Ministry advises the Commission that a task force to help design and develop the agency has been struck, and its terms of reference confirmed and approved. The task force is expected to present initial recommendations to the Ministry by the spring of 2005 and make final recommendations by the fall of 2005.

One of the key weaknesses identified during SARS was the woeful lack of public health laboratory capacity in Ontario, a shortcoming that seriously hampered the response to the deadly outbreak. After years of neglect, SARS demonstrated that the Central Public Health Laboratory was severely under-staffed, poorly resourced, inadequately equipped, and badly led.

In response, Operation Health Protection stated that the Ministry intended to address the staffing issues, modernize the public health laboratory system and integrate it into the new Health Protection and Promotion Agency: It stated:

> Central to the establishment of the Agency is the modernization of Ontario's Central Public Health Laboratory and the public health laboratory system. Laboratories are a key element of an effective public health system. They are often the first indication of evidence of a reportable or communicable disease, a point of verification in the diagnosis of many diseases for which surveillance is essential, including infectious diseases.
>
> The Agency Implementation Task Force will also guide an operational review of the public health laboratory system to align the available testing services with what is required. This will also help determine the functional and procedural enhancements needed to ensure that the system performs at optimal levels on a daily basis as well as during an outbreak.

491. Operation Health Protection, p. 5.

> This review will be completed over the next few months. Formal linkages are already being strengthened and technological infrastructure has recently been created within the Ministry and the Central Public Health Laboratory to improve communication and information exchange.
>
> Our goal is to ensure a state-of-the-art public health laboratory system in Ontario. In order to strengthen the province's laboratory capacity and to prepare for co-locating appropriate functions of the Central Public Health Laboratory with the Agency, we will enhance the medical capacity of the public health laboratory system, beginning with the addition of a senior medical director and additional medical microbiologist.[492]

The Ministry has advised that it has issued a Request for Proposals for an operational review of the public health laboratory system. The review is to have a number of key areas of focus including corporation organization and infrastructure and business practices and policies. With regards to staffing levels, the Ministry also advises that approval has been given for the recruitment of medical microbiologists and a medical director for the Central Public Health Laboratory. Recruitment is at the interview stage. In addition, the Ministry has advised that the Public Health Division is developing a closer functional relationship with the public health laboratory system.

The Commission's first interim report and the Walker panel's final report both recommended increasing the role and independence of the Chief Medical Officer of Health.

Operation Health Protection stated:

> As the most senior public health official in Ontario, the CMOH must be able to provide leadership while at the same time be able to speak publicly about public health issues. In addition, the CMOH must have an appropriate level of independent authority to act quickly and decisively in situations that pose risks to the health of Ontarians. To this end, over the coming year we will initiate legislative changes to increase the independence of the CMOH. Furthermore, the CMOH will be given the responsibility of providing an annual report on the health of Ontarians.[493]

492. *Ibid*, p. 13.
493. *Ibid*, p. 14.

On October 14, 2004, Bill 124, aimed at strengthening the role and independence of the Chief Medical Officer of Health, was introduced in the Ontario Legislature. It received Royal Assent on December 16, 2004. Under Bill 124, the Chief Medical Officer of Health can only be removed from office for cause on the address of the Legislative Assembly; some operational powers in the *Health Protection and Promotion Act* were reassigned from the Minister to the Chief Medical Officer of Health; the Chief Medical Officer of Health was given the authority to issue any reports on public health issues that he or she felt were appropriate; and the Chief Medical Officer of Health was mandated to issue one report each year on the state of public health in Ontario. The first report is expected in the 2005-6 fiscal year.

The SARS Commission and the Walker Panel both commented on the Public Health Division's lack of internal resources and capacity. In addressing these concerns, the Ministry has advised that an external organizational review has been completed. To strengthen the Division's internal capabilities, recruitment has begun for an Associate Chief Medical Officer of Health and Director of the Division's Infectious Diseases Branch (formerly known as the Division's Public Health Branch), and for six senior medical consultants. The Ministry indicates that a commitment has been made to rebuild public health capacity through the promotion of public health careers, the enhancement of training for public health professionals, the development of models for the effective utilization of human resources during an emergency and supporting strategies to increase full-time employment for nurses and other health care workers.

A committee has been created to review the capacity of local public health units. An interim report is expected in the summer of 2005 with the final report released in December 2005. Chaired by Dr. Susan Tamblyn, former medical officer of health for the Perth District Health Unit, the Capacity Review Committee is to advise the Chief Medical Officer of Health on the following:

- Core capacities required (such as infrastructure, staff, etc.) at the local level to meet communities' specific needs (based on geography, health status, health need, cultural mix, health determinants, etc.) and to effectively provide public health services (including specific services such as applied research and knowledge transfer);

- Issues related to recruitment, retention education and professional development of public health professionals in key disciplines (medicine, nursing, nutrition, dentistry, inspection, epidemiology, communications, health promotion, etc.);

- Identifying operational, governance and systemic issues that may impede the delivery of public health programs and services;

- Mechanisms to improve systems and programmatic and financial accountability;

- Strengthening compliance with the *Health Protection and Promotion Act*, associated Regulations and the Mandatory Health Programs and Services Guidelines;

- Organizational models for Public Health Units that optimize alignment with the configuration and functions of the Local Health Integration Networks, primary care reform and municipal funding partners; and staffing requirements and potential operating and transitional costs.

The government says it expects to fully implement the Capacity Review Committee's recommendations by the 2006-7 fiscal year.

Adequate funding for local public health was an important issue raised in the wake of SARS. To address this, the province's share of local public health funding rose in January 2005 from 50 per cent to 55 per cent. It will rise to 65 per cent in 2006 and to 75 per cent in 2007.

Responding to numerous concerns about the Mandatory Health Programs and Services Guidelines, the Public Health Division intends to conduct a review of the Mandatory Health Programs and Services Guidelines. The review will consider emerging health issues, best practices, new science, as well as lessons learned from Ontario's experiences with Walkerton, West Nile virus and SARS.

SARS demonstrated the need to have a permanent panel of experts to advise the Chief Medical Officer of Health on the prevention and containment of infectious disease outbreaks. In an effort to fill this need, Operation Health Protection stated:

> The Ministry is creating a permanent central expert body – the Provincial Infectious Disease Advisory Committee (PIDAC) – to continue the development of standards and guidelines for health professionals and organizations faced with infectious disease outbreaks. Membership of the committee will bring together broad expertise from across the health care sector. The Committee will also advise on research priorities, emergency preparedness and immunization programs. PIDAC will help create

> regional networks for infection control and communicable disease that will coordinate infection control activities at the local level.[494]

The Ministry recently advised that the Provincial Infectious Diseases Advisory Committee (PIDAC) has been established. Its key role will be to advise the Chief Medical Officer of Health on prevention, surveillance and control measures necessary to protect the people of Ontario from infectious diseases. PIDAC also provides the Chief Medical Officer of Health with advice on issues such as standards and guidelines for infection control, emergency preparedness for an infectious disease outbreak, protocols to prevent and control infectious diseases, and immunization programmes. Subcommittees have been created for surveillance, immunization and infection control. PIDAC has completed a best practice manual for the prevention and control of *Clostridium difficile* in health care facilities. PIDAC is currently co-chaired by Dr. David Williams, Medical Officer of Health for Thunder Bay District, and Dr. Dick Zoutman, Chief of the Department of Medical Microbiology and Medical Director of Infection Control Services, Kingston General Hospital.

The Ministry advises that foundational work is also under way to implement and assess a small number of regional infection control networks. Implementation of networks across the province is expected to be completed by the fiscal year 2006-7. As well, a steering committee has been created to develop tools for standardized and accessible infection control education to front line health care workers.

In the view of many, including the Commission, the fight against SARS was hampered by a lack of an effective reportable disease information system. To address this issue, the Ministry has pledged to implement a federally funded outbreak management system called the Integrated Public Health Information System or iPHIS. Operation Health Protection stated:

> A key component of this comprehensive public health information system is the Ministry's integrated Public Health Information System (iPHIS). This system builds on the federal initiative to integrate public health information and data systems across Canada, and will enhance both Public Health Unit reporting of reportable diseases and ability to manage outbreaks. Through iPHIS, health units will forward information on cases of reportable diseases to the Ministry, where it will be collected and quickly analyzed and interpreted to identify unusual and

494. *Ibid*, p. 6.

> unexpected instances of infectious disease. This analysis will then be provided back to the Public Health Units to guide their activities and follow-up. Phase 1 (Testing and Evaluation) of the iPHIS implementation plan is complete and Phase 2 (Outbreak Management and Ontario Enhancements) will begin in November of this year. Within one year, iPHIS will be fully implemented in all Public Health Units for communicable disease reporting, contact tracing, and quarantine management.[495]

We are informed by the Ministry that full deployment of the iPHIS system is expected to be completed by the end of 2005.

The Emergency Management Unit (EMU) is overseeing the development of the Ontario Health Pandemic Influenza Plan, which was first issued in May 2004. The Commission understands that a steering committee, and a number of subcommittees and working groups, have been established to refine the plan. The Public Health subcommittee and related working groups, for example, have developed draft guidelines for laboratory surveillance during a pandemic. The Operations subcommittee and related working groups, for their part, are developing a provincial framework for the delivery of necessary health services during a pandemic.

The Ministry has told the Commission that efforts are also under way to develop a pan-governmental approach to pandemic planning. A series of exercises are planned in 2005 in collaboration with Health Canada and the other provinces and territories to test parts of the Canadian Pandemic Influenza Plan.

Additionally, the EMU is working on a smallpox emergency response plan, business continuity plans, the health component of the Foreign Animal Disease Plan and a radiation health response plan. It has also participated in a number of emergency management exercises. EMU also participated in a number of emergency management exercises in 2004.

In January 2005, the government announced a $13.5 million programme to help hospitals respond to chemical, biological, radiological and nuclear emergencies. Funds will be used to purchase self-contained decontamination tents, build emergency stockpiles of equipment and supplies, train staff and conduct emergency exercises.[496]

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495. *Ibid*, p. 22.
496. Canada News Wire, Operation Health Protection' Giving Hospitals Improved Training And Emergency Supplies, January 13, 2005.

Efforts are also being made to improve accountability and enforcement in the delivery of public health services and programmes.

In a newly released financial planning and accountability guide for boards of health and health unit staff, the Ministry's Public Health Division has advised that it will actively enforce compliance with the Mandatory Health Programs and Services Guidelines.

According to the guide, the Ministry is also implementing a performance measurement system for local public health units. This system – together with grant request documents and related reporting requirements – are intended to strengthen the Ministry's ability to monitor program funding and service delivery. In describing transfer payment accountability, the guide stated:

> Transfer payments involve an agreement between the Province and the applicable health unit. The Ministry must ensure that prior to advancing any provincial funds to health units, signed agreements are in place that:
>
> - Bind the health unit to achieve specific, measurable results per the Mandatory Health Programs and Services Guidelines;
>
> - Require health units, as a condition of funding to have in place governance and administrative structures and processes necessary to ensure prudent and effective management of public funds;
>
> - Require health units to provide periodic reports on financial status and relevant financial and program results achieved;
>
> - Clearly establish the province's right to require independent verification of reported information by independent professionals;
>
> - Limit the obligations of the province according to the terms of programs approved by Cabinet; and
>
> - Permit the recovery of provincial funds and/or the discontinuance of ongoing funds in the event of health unit non-performance.

Monitoring and Reporting

The Ministry is required to obtain and review information on the status of health unit eligibility and performance and identify non-compliance with agreements and the failure of health units to demonstrate continued eligibility.

Complementing these initiatives is an increased role of the Auditor General (formerly called the Provincial Auditor.) The aforementioned guide advised boards of health and health unit staff that Bill 18, *An Act Respecting the Provincial Auditor,* received Royal Assent in November 2004. It expands the mandate of the Auditor General to conduct discretionary value-for-money[497] audits of local boards of health. Section 9.1 of the Act states:

> 9.1(1) On or after April 1, 2005, the Auditor General may conduct a special audit of a grant recipient with respect to a reviewable grant received by the grant recipient directly or indirectly on or after the date on which the *Audit Statute Law Amendment Act, 2004* receives Royal Assent.
>
> Exception
>
> (2) Subsection (1) does not apply with respect to a grant recipient that is a municipality.

497. According to the web site of the Auditor General: "An extremely important part of the Auditor General's mandate is the value-for-money component. Value-for-money audits are assessments of whether or not money was spent with due regard for economy and efficiency and whether appropriate procedures were in place to measure and report on the effectiveness of government programs. Under the *Auditor General Act*, the Office is required to report to the Legislature significant instances where it is observed that the government is not fulfilling its responsibilities in these areas. To fulfill its value-for-money mandate, the Office annually conducts audits of selected ministry or agency programs and activities. Major programs and activities are generally audited every five years or so. Every year, senior management of the Office consider a number of risk factors when selecting which programs to audit in the coming audit period. These factors include: the results of previous audits, the total revenues or expenditures at risk, the impact of the program or activity on the public, the inherent risk due to the complexity and diversity of operations, the significance of possible issues that may be identified by an audit, and the costs of performing the audit in relation to the perceived benefits. The results of value-for-money audits are reported on in the Auditor General's Annual Report and constitute a large portion of that document. As well, of all the observations that the Auditor General reports on, value-for-money findings tend to attract the largest proportion of media coverage and interest from the public and from the Standing Committee on Public Accounts." (See http://www.auditor.on.ca/english/aboutus/whatwedo_frame.html).

However, while the Auditor General does not have the mandate to audit municipalities, s. 9.2 of the Act does provide the following authority with regards to municipal grants:

> 9.2(1) The Auditor General may examine accounting records relating to a reviewable grant received directly or indirectly by a municipality.
>
> (2) The Auditor General may require a municipality to prepare and submit a financial statement setting the details of its disposition of the reviewable grant.

The Ministry indicated that it has also established the Public Health e-Health Council, cochaired by Dr. Basrur and Dr. George Pasut, the Medical Officer of Health for Simcoe County. The council has 14 members, including physician, hospital, continuing care and laboratory representatives. The council's mandate is to provide a forum for the discussion of e-health issues in the public health sector and to provide leadership and advice in resolving them.

Appendix C: Commission Process and Ongoing Work

The Commission was appointed by Order in Council dated June 10, 2003. Some preliminary interviews were conducted in June and July[498] and the work got fully under way in August after premises were secured and a small core of staff had been retained.

On April 15, 2004, the Commission provided to the Minister of Health an interim report titled *"SARS and Public Health in Ontario."* That interim report was based upon the public health aspects of the SARS crisis that had emerged from the evidence obtained during the course of investigation to that date.

Following the release of the first interim report, the Commission continued to interview witnesses and review documents. That work will continue beyond this second interim report in order to tell the public the story of SARS, what happened, what went right, what went wrong, and what lessons emerge from the entire experience. The specific terms of reference, to be addressed in the final report, are set out in Appendix F. These issues include, among others, infection control in hospitals, health worker protection and occupational health and safety in hospitals. Many who contracted SARS and who lost family members to SARS have spoken to the Commission with particular concerns, which will be addressed in the final report.

For this interim report, in addition to the interviews, the Commission in July, sent letters to 55 institutions and individuals, including hospitals, public health units, professional organizations and government. Many responded with thoughtful insights and recommendations. The responses provide invaluable information and great assistance to the Commission. Not all have been incorporated in this interim report. Some recommendations were outside the scope of this interim report and will be considered for the final report.

498. During June and into July the health care system was still dealing with SARS patients and public health authorities were still dealing with SARS issues. It was required by the terms of reference, and by common sense, that the investigation be conducted in a manner that does not impede ongoing efforts to isolate and contain SARS.

Most of the Commission's investigation takes place through confidential interviews. Over 400 interviews have been held on the condition that those interviewed will not be identified by name in the report and that their disclosure to the Commission is confidential and not subject to private or public access.

The Commission is grateful to those who have come forward to provide information and in particular to the many who suffered from SARS and lost family members to SARS, who shared their stories despite the pain of reliving their suffering and loss. The Commission will speak to more SARS victims in the months ahead including those who lost loved ones to SARS.

The Commission will continue to conduct interviews in the months to come. Anyone who wishes to speak to the Commission should contact Commission Counsel, Mr. Douglas Hunt, Q.C., (416-212-6868) or Assistant Commission Counsel, Ms. Jennifer Crawford (416-212-6867).

In addition to the private interviews, the Commission held six days of public hearings. The first round of public hearings were held on September 29, 30 and October 1 at the St. Lawrence Market (North Market) in Toronto. The second round of hearings were held on November 17, 18 and 19, at the St. Lawrence Hall, in Toronto. Everyone who asked to present to the Commission was given an opportunity to be heard. Over one hundred people spoke publicly during these six days of public hearings.

Transcripts of the presentations, along with some of the power point presentations and written submissions provided to the Commission by presenters during the public hearings, are available for public viewing at the Commission web site: www.sarscommission.ca.

There is no deadline for the completion and submission of the final report. The work will continue until the Commissioner is satisfied that all necessary evidence has been reviewed and that the terms of reference have been fulfilled. For further information or future updates on the work of the Commission, please visit our web site at www.sarscommission.ca.

Appendix D: Letter of Appointment

Ministry of Health
and Long-Term Care

Office of the Minister
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June 10, 2003

The Honourable Mr. Justice Archie G. Campbell
130 Queen Street West
Toronto, ON M5H 2N5

Dear Mr. Justice Campbell:

This letter will confirm your appointment as an independent Investigator, pursuant to section 78 of the *Health Protection and Promotion Act*, to investigate the recent introduction and spread of Severe Acute Respiratory Syndrome (SARS). I would like to express my thanks for your valuable input into the development of the Terms of Reference for this inquiry, a copy of which is appended hereto.

As you are aware, persons who disclose information to you in the course of your investigation will be protected from any adverse employment action, pursuant to Section 9.1(1) of the *Public Inquiries Act.*

As indicated in the Terms of Reference, you will deliver your reports to me and I will release them to the public. You will receive resources and support staff through the Ministry of the Attorney General, pursuant to paragraph 7 of the Terms of Reference.

In accordance with the attached Order in Council, all Government ministries, agencies, boards and commissions and their employees have been directed to co-operate with your investigation and to respect its independence.

On behalf of the Government and the people of Ontario, I thank you for agreeing to accept this most important mandate.

Yours very truly,

Tony Clement
Minister

Appendix E: Order in Council

Ontario
Executive Council
Conseil exécutif

On the recommendation of the undersigned, the Lieutenant Governor, by and with the advice and concurrence of the Executive Council, orders that:

Sur la recommandation de la personne soussignée, le lieutenant-gouverneur, sur l'avis et avec le consentement du Conseil exécutif, décrète ce qui suit:

WHEREAS the Minister of Health and Long-Term Care has appointed the Honourable Mr. Justice Archie G. Campbell to investigate the recent introduction and spread of Severe Acute Respiratory Syndrome ("SARS") pursuant to section 78 of the Health Protection and Promotion Act;

WHEREAS the Minister of Health and Long-Term Care has provided Mr. Justice Campbell terms of reference for the investigation in a letter dated June 10, 2003;

WHEREAS persons who disclose information to Justice Campbell in the course of his investigation will be protected from any adverse employment action;

AND WHEREAS it is desirable to support Mr. Justice Campbell's investigation and to mandate full co-operation with him by all Government ministries, boards, agencies and commissions:

ALL Government Ministries, Boards, Agencies and Commissions, and their employees, shall assist Mr. Justice Campbell to the fullest extent in order that he may carry out his investigation;

ALL Government Ministries, Boards, Agencies and Commissions shall respect the independence of the investigation;

THE Attorney General shall furnish Mr. Justice Campbell with the resources and support referred to in paragraph 7 of the terms of reference for the investigation.

Recommended: _____
Minister of Health and
Long-Term Care

Concurred: _____
Chair of Cabinet

Approved and Ordered: June 10, 2003
Date

_____
Lieutenant-Governor

O.C./Décret 1230/2003

Appendix F: Terms of Reference

Independent SARS Commission
Terms of Reference

1. The subject matter of the investigation shall be:

   (a) how the SARS virus was introduced here and what measures, if any, could have been taken at points of entry to prevent its introduction;

   (b) how the SARS virus spread;

   (c) the extent to which information related to SARS was communicated among health care workers and institutions involved in dealing with the disease;

   (d) whether health care workers and patients in health care treatment facilities and long-term care facilities were adequately protected from exposure to SARS, having regard for the knowledge and information available at the time;

   (e) the extent of efforts taken to isolate and contain the virus and whether they were satisfactory or whether they could have been improved;

   (f) existing legislative and regulatory provisions related to or that have implications for the isolation and containment of infectious diseases, including the quarantine of suspected carriers;

   (g) any suggested improvements to provincial legislation or regulations, and any submissions that the Province of Ontario should make concerning desirable amendments to federal legislation or regulations; and,

   (h) all other relevant matters that Mr. Justice Campbell considers necessary to ensure that the health of Ontarians is protected and promoted and that the risks posed by SARS and other communicable diseases are effectively managed in the future.

2. The investigation shall be conducted in a manner that does not impede ongoing efforts to isolate and contain SARS.

3. Mr. Justice Campbell may request any person to provide relevant information or records to him where he believes that the person has such information or records in his, hers or its possession or control.

4. Mr. Justice Campbell shall hold such public or private meetings as he deems advisable in the course of his investigation.

5. Mr. Justice Campbell shall conduct the investigation and make his report without expressing any conclusion or recommendation regarding the civil or criminal responsibility of any person or organization, without interfering in any ongoing criminal, civil or other legal proceedings, and without making any findings of fact with respect to civil or criminal responsibility of any person or organization.

6. Mr. Justice Campbell shall produce an interim report at his discretion and deliver it to the Minister of Health and Long-Term Care who shall make the report available to the public. Upon completion of his investigation, Mr. Justice Campbell shall deliver his final report containing his findings, conclusions and recommendations to Minister of Health and Long-Term Care who shall make such report available to the public.

7. To conduct his investigation Mr. Justice Campbell shall be provided with such resources as are required, and be authorized by the Attorney General and shall have the authority to engage lawyers, experts, research and other staff as he deems appropriate, at reasonable remuneration approved by the Ministry of the Attorney General.

8. The reports shall be prepared in a form appropriate for release to the public, pursuant to the *Freedom of Information and Protection of Privacy Act*.

9. These terms of reference shall be interpreted in a manner consistent with the limits of the constitutional jurisdiction of the Province of Ontario.

In the event that Mr. Justice Campbell is unable to carry out any individual term of his mandate, the remainder of these terms of reference shall continue to operate, it being the intention of the Minister of Health and Long-Term Care that the provisions of these terms of reference operate independently.

Appendix G: Correspondence

Letter to The Honourable Dalton McGuinty, Premier, from Dr. James Young, Commissioner of Emergency Management, dated June 21, 2004

Letter to Mr. Phil Hassen, Deputy Minister, Ministry of Health and Long-Term Care, from Mr. Douglas C. Hunt, Q.C., SARS Commission Counsel, dated June 30, 2004

Letter to Mr. Douglas C. Hunt, Q.C., SARS Commission Counsel, from Mr. Phil Hassen, Deputy Minister, Ministry of Health and Long-Term Care, dated August 4, 2004

Letter to The Honourable Mr. George Smitherman, Minister of Health and Long-Term Care, from The Honourable Mr. Justice Archie Campbell, Commissioner, SARS Commission, dated January 17, 2005

Letter to The Honourable Mr. Justice Archie Campbell, Commissioner, SARS Commission, from The Honourable Mr. George Smitherman, Minister of Health and Long-Term Care, and Mr. Monte Kwinter, Minister of Community Safety and Correctional Services, dated March 14, 2005

Letter to Ms. Pat Vanini, Executive Director, Association of Municipalities of Ontario, from Mr. Douglas C. Hunt, Q.C., SARS Commission Counsel, dated June 30, 2004

Letter to Mr. Douglas C. Hunt, Q.C., SARS Commission Counsel, from Ms. Ann Mulvale, President, Association of Municipalities of Ontario, dated July 19, 2004

Letter to Ms. Petra Wolfbeiss, Association of Municipalities of Ontario, from Ms. Jennifer Crawford, Assistant Commission Counsel, SARS Commission, dated January 12, 2005