

The SARS Commission

SECOND INTERIM REPORT

SARS and Public Health Legislation

1. Medical Independence and Leadership

Public confidence requires that the fight against infectious disease be driven by medical expertise, free from bureaucratic or political pressure. The Commission, in its first interim report, recommended more independence for the Chief Medical Officer of Health. The government has made significant progress in that direction, by amending the *Health Protection and Promotion Act* to give the Chief Medical Officer of Health a greater measure of independence.

The Commission, in this second interim report, recommends¹⁸ that this work be completed by transferring operational authority over public health labs, assessors, inspectors¹⁹ and enforcement provisions of the Act,²⁰ from the Minister to the Chief Medical Officer of Health. This work must be completed so that the Chief Medical Officer of Health is fully independent of political considerations in respect of medical decisions and direct public health management.

18. The Commission's recommendations, if accepted, will have to be put into statutory language by Legislative Counsel, an officer of the Legislative Assembly, with the assistance of departmental lawyers. Although the recommendations sometimes use statutory language they are not offered as statutory amendments but only as a basis for the drafting language chosen by Legislative Counsel to achieve their intent and purpose.

19. The Commission notes that the *Health Protection and Promotion Act* is confusing in its use of inspectors, under s. 80 and public health inspectors, under s. 41. While the former inspects health units and the latter exercises powers under Part III of the Act, to someone not intimately familiar with the Act, it is somewhat confusing that there are inspectors who are not public health inspectors and public health inspectors who are not inspectors.

20. Those contained in s. 102(2) of the *Health Protection and Promotion Act* give power to the Minister of Health to apply to a judge of the Superior Court of Justice for an order prohibiting continuation or repetition of the contravention of an order made under the Act.

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The Commission also recommends a parallel measure of independence for local medical officers of health, who are the backbone of our protection against disease. Protecting the local medical officer of health from political and bureaucratic influence is as equally important as protecting the Chief Medical Officer of Health. As recommended in the Commission's first interim report, such independence should be coupled with a measure of central medical leadership and direction from the Chief Medical Officer of Health, to ensure protection consistency throughout Ontario's 36²¹ semi-autonomous health units.

Similar consolidation is required to ensure that the Chief Medical Officer of Health and local medical officers of health lead public health emergency planning, and are responsible for public health risk communication. A later chapter will deal with the requirement that the Chief Medical Officer of Health assume leadership of the public health aspects of any provincial emergency.

The Commission therefore recommends that the province:

- Complete the work of making the Chief Medical Officer of Health independent of political considerations in respect of medical decisions and direct public health management. This requires the transfer of operational authority from the Minister to the Chief Medical Officer of Health in respect of public health labs, assessors, inspectors and enforcement.
- Amend the *Health Protection and Promotion Act* so that the powers now assigned by law to the local medical officers of health are assigned concurrently to the Chief Medical Officer of Health. These powers shall be exercised by the medical officer of health in the local region, subject to the direction of the Chief Medical Officer of Health.
- Give local medical officers of health independence in medical matters parallel to that of the Chief Medical Officer of Health.

21. Now 36, with the absorption on April 1 of the Muskoka-Parry Sound Health Unit into neighbouring health units. Ministry of Health and Long-Term Care News Release, "Chief Medical Officer of Health Releases Plan to Strengthen Public Health in Muskoka-Parry Sound," March 9, 2005. This measure, described below, provides a good example of how well the public health system can work under its new leadership and how much there is yet to be done.

- Provide a greater measure of central provincial medical leadership and control in respect of infectious disease protection and management, over the 36 semi-autonomous health units throughout the province.
- Put provincial public health emergency planning under the authority of the Chief Medical Officer of Health and local public health emergency planning under the authority of local medical officers of health.
- Amend the *Health Protection and Promotion Act* to extend the protection from personal liability contained in s. 95(1) to everyone employed by or providing services to a public health board or the provincial Public Health Division, everyone from the Chief Medical Officer of Health to its expert advisors, to public health employees in the field.

The Commission's Earlier Findings and Recommendations

The management of infectious disease must be driven by medical expertise, not by political expediency. This requires the independence of the Chief Medical Officer of Health in vital areas of medical decision making and direct public health management. Decisions to impose and to relax precautions must be free from political motivation, and must be seen to be free from political motivation.

The Commission so far has not found any evidence of political interference during SARS. But any perception of political interference will sap public confidence and diminish public cooperation. As the Commission noted in its first interim report:

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. This perception is shared by many who worked throughout the system during the crisis. 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

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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.²²

The Commission recommended that the Chief Medical Officer of Health be given independence in respect of medical matters, with the right and the duty to report directly to the public on the risk from infectious diseases, and on the measures necessary to protect the community from communicable disease.

The Commission concluded that the office of the Chief Medical Officer of Health needs a greater degree of actual and perceived independence from government. This independence is vital to ensuring public confidence in the Chief Medical Officer of Health's ability to act in their best interest and for the sole purpose of protecting the public health. As Dr. Richard Schabas, a former Chief Medical Officer of Health for Ontario, so aptly described the issue to the Commission at its public hearings:

I think it [the public health system] has to be arms-length from the political process. I've avoided discussing the impact of politics on this outbreak but I think that to ensure that there's public credibility, that the public understands that the public health officials are acting only in the interests of public health and are not influenced by political considerations, that this has – or that we have to put greater political distance between our senior public health officials and the politicians.

Although the Commission recommended increased independence of the Chief Medical Officer of Health, it also found that there must be an appropriate balance of independence to ensure that there is not so much arms length distance between the Chief Medical Officer of Health and the government so as to impede the accountability of the Chief Medical Officer of Health and her close links with other parts of the provincial health system. As one thoughtful observer noted, it makes more sense for the Chief Medical Officer of Health, if some machinery of independence is added to the office, to be at the table within government rather than a watchdog off in a corner:

It's not just a question of balancing independence and accountability. It's also a question of ensuring that the Chief Medical Officer of Health can

22. The Commission's first interim report, p. 56.

get the job done, can fulfill the delivery of the mandatory public health programmes by the local units and carry out the responsibilities of the Chief Medical Officer of Health under the *Health Protection and Promotion Act*. If the Chief Medical Officer is in the Ministry they are at the table and has a degree of influence from being at the table but also has to be part of a team to some extent. In my opinion a lot can be accomplished by working within the system provided you have a pathway and protection to speak out when needed, both procedural and legal protection.

The Ministry needs to maintain and control policy, funding, and accountability including the transfer payment function to the local boards of health; the Chief Medical Officer of Health should oversee that. The Chief Medical Officer should retain programmatic responsibilities. Being an assistant deputy minister gives you rights of access you don't have if you're a watchdog off in the corner someplace.²³

The Commission recommended that the Chief Medical Officer of Health:

- Subject to the guarantees of independence set out below, should retain a position as an Assistant Deputy Minister in the Ministry of Health and Long-Term Care.
- 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.
- 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.²⁴

The Commission also recommended that the Chief Medical Officer of Health and the Public Health Division assume greater central control over health protection, in particular in relation to infectious diseases. As the Commission noted:

23. *Ibid*, pp. 167-168.

24. *Ibid*, p. 168.

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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.

The present distribution of legal powers under the *Health Protection and Promotion Act* gives the local medical officer of health an enormous ambit of uncontrolled personal discretion, which is not ordinarily subject to the review or influence of the Chief Medical Officer of Health. The Chief Medical Officer of Health does have some override powers, and cumbersome machinery does exist under which the province might ultimately bring to heel a rogue board of health. But public health authority in Ontario over infectious disease control, including outbreak management, is primarily that of local officials with no direct accountability to any central authority.

There is no clear accountability to any central provincial authority for local public health decisions to quarantine thousands of people locally. There is no clear accountability to any central authority for local decisions not to quarantine, decisions that could lead to epidemic community outbreak of a deadly disease. This lack of clear central authority could require the Chief Medical Officer of Health, during a virulent outbreak like SARS, to negotiate with separate local medical officers of health whether particular cases should be reported as SARS to the international community, and whether or not the quarantine power should be invoked. This lack of central authority could lead to gross and irrational inequality in the application of the quarantine powers throughout the province if different local medical officers of health exercised their individual authority without regard to any consistent central guidance.

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.

Although some local medical officers of health treasure their local autonomy from the province and from the Chief Medical Officer of Health, even in relation to outbreak control, there is a degree of recognition that clear and consistent central provincial authority is required for effective protection against infectious disease.²⁵

Dr. Richard Schabas, a former Chief Medical Officer of Health, noted at the public hearings:

I think we need clearer lines of authority within our public health system. At the moment, local public health authorities are not directly answerable or reportable to the provincial authority and I think, particularly in a crisis like SARS, that's something that's important.²⁶

The Commission found a striking lack of clarity around the respective accountability of the Chief Medical Officer of Health and the local medical officer of health. As one former medical officer of health said, in response to a question from the Commissioner:

Q:I am unclear as to what effective powers the Chief Medical Officer of Health has in general terms over the system of protection against infectious disease.

A:Well it is hugely unclear, is it not? ... Certainly clarifying the accountability would be a benefit whether the people like the outcome or not because right now it is very vague.²⁷

25. *Ibid*, pp. 201-202.

26. SARS Commission Public Hearings, September 30, 2003, p. 28.

27. The Commission's first interim report, p. 202.

In respect of central control, the Commission made the following recommendation:

Under the present Act, the legal and practical backbone of local disease control is the local medical officer of health. It makes sense that the initial responsibility should be local. But that initial arrangement makes no sense unless it can be influenced by provincial leadership and can shift, instantly, to the provincial level when a threatened or actual outbreak imperils the provincial public interest.

There are two basic ways to ensure the appropriate measure of central accountability and authority for infectious disease protection.

The first way is to leave essential public health legal powers in the initial hands of the local medical officer of health, subject to some machinery to displace those powers to the Chief Medical Officer of Health during a designated provincial public health outbreak. Although this system maximizes the ordinary local autonomy of local medical officers of health, municipal autonomy is hardly a value of superordinate importance when dealing with viruses that cross municipal, provincial, federal, national, and international boundaries. And the complicated legal machinery necessary to trigger the imposition of central powers, unless made infinitely more simple than the almost medieval system for provincial override of local public health boards, would deprive the provincial override of any practical value in a public health threat.

The second way is to place essential public health legal powers with the Chief Medical Officer of Health, those powers to be exercised on a day to day basis by the local medical officer of health, subject to the ultimate direction of the Chief Medical Officer of Health. This retains all the public health powers under the Act within the presumptive local authority of the local medical officer of health. But it leaves a clear role for provincial leadership and it provides a safeguard and an immediate change of the default position, whenever required, to central provincial authority. This kind of arrangement works well in the justice system where the local Crown Attorney is the agent of the Attorney General, and where the regional senior judge exercises in their region the powers of the Chief Justice, subject to the direction of the Chief Justice.

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 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.²⁸

Some public health officials have interpreted this recommendation as requiring the removal of all boards of health and the demotion of local medical officers of health to the status of mere agents of the Chief Medical Officer of Health in each local unit. This, as explained below, was never the intention nor the recommendation of the Commission. The recommendation, exercised with common sense and mutual respect, would leave day to day decisions in the hands of the local medical officer of health with no diminution in practical terms of his or her local autonomy.

The only adjustment the Commission would make in this recommendation is to provide that the local medical officers of health retain all their current powers, to be assigned concurrently to the Chief Medical Officer of Health and to be exercised by the local medical officer of health subject to the central direction and accountability of the office of Chief Medical Officer of Health.

The revised recommendation is this:

- The powers now assigned by law to the medical officer of health are

28. The Commission's first interim report, pp. 204-205.

assigned concurrently to the Chief Medical Officer of Health, and

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

More will be said about this later in this chapter.

Chief Medical Officer of Health: What the Government Did

On October 14, 2004, Health Minister Smitherman introduced Bill 124, “*An Act to Amend the Health Protection and Promotion Act*” to give the Chief Medical Officer of Health greater independence, saying:

I’m delighted to rise in this House today to introduce a bill entitled the Health Protection and Promotion Amendment Act. It amends the *Health Protection and Promotion Act*. The title being a little unwieldy, I prefer to think of it as the independent Chief Medical Officer of Health act ...

When there is a health crisis and politicians speak, some people listen. But when there is a health crisis and the Chief Medical Officer of Health speaks, everybody listens. It is at those times, times when diseases like SARS or West Nile are a real threat, that the Chief Medical Officer of Health must be there for his or her patients, all 12 million of them. It is at times like those that the Chief Medical Officer of Health must be able to interact with his or her patients without worrying about what the Minister of Health might think, what the effect might be on the government or what the opposition might say. We learned that lesson as a province during Walkerton, West Nile and SARS. We learned that what Ontarians wanted, what they needed, from their chief doctor was his or her undivided attention.

In the wake of the SARS crisis, both the Campbell and Walker reports recommended that the Chief Medical Officer of Health be independent, with the authority, and in fact with the duty, to communicate with the public whenever he or she sees fit. He wrote that any doubts about the source, timing or motives of public health information have a corrosive effect on confidence, and addressing this perception and reinforcing the

centrality of an independent voice for public health is a key step in promoting public health renewal in Ontario.

With the legislation I have introduced today we are taking that step . . .²⁹

Mr. Smitherman, following the tabling of the proposed amendments to the *Health Protection and Promotion Act*, said:

In the event of a health crisis, Ontarians want to know that their Chief Medical Officer is free of political concerns and interference. An independent CMOH will be able to put the health and safety of Ontarians first.³⁰

The amendments received Royal Assent on December 16, 2004, and achieved the following:

- Establishes appointment of the Chief Medical Officer of Health by the Lieutenant Governor in Council, on the address of the Legislative Assembly. Appointment is for a five-year term, which may be renewed.³¹
- Requires that the Chief Medical Officer of Health make an annual report in writing on the state of public health in Ontario, and deliver the report to the Speaker of the Legislative Assembly.³²
- Gives the Chief Medical Officer of Health the power to communicate with the public, stating that the Chief Medical Officer of Health may

29. Ontario, Legislative Assembly, *Official Report of Debates (Hansard)* (October 14, 2004), pp. 3387-3388.

30. The London Free Press, "Chief Medical Officer of Health Getting More Independence," October 15, 2004.

31. Subsections 81(1)-81(3) deals with the appointment, term of office and renewal of the Chief Medical Officer of Health. It sets out that the Lieutenant Governor in Council shall appoint the Chief Medical Officer of Health on the address of the legislative assembly; that the term of appointment is for five years and may be reappointed for a further term or terms by the Lieutenant Governor in Council on the address of the Legislative Assembly; that he/she may be removed for cause by the Lieutenant Governor in Council on the address of the Legislative Assembly.

32. Subsections 81(4)-81(6) deal with the annual reports of the Chief Medical Officer of Health. Subsection 81(4) requires the Chief Medical Officer of Health every year to make a report in writing on the state of public health in Ontario, and deliver the report to the Speaker of the Legislative Assembly. The Speaker shall lay the report before the Assembly at the earliest reasonable opportunity. Subsection 81(6) provides that the Chief Medical Officer of Health shall deliver a copy of the report to the Minister at least 30 days before delivering it to the Speaker.

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make any other reports respecting public health as he or she considers appropriate and may present such a report to the public or any other person he or she considers appropriate.³³

- Transfers the powers in s. 86 of the *Health Protection and Promotion Act*, previously assigned to the Minister, to the Chief Medical Officer of Health. These powers give the Chief Medical Officer of Health the power to investigate and take action where there is health risk.³⁴ It allows the Chief Medical Officer of Health to exercise the powers of boards of health and local medical officers of health or to direct a person whose services are engaged by a board of health.³⁵

33. Subsection 81(7) gives the Chief Medical Officer of Health the power to communicate with the public. It states that the Chief Medical Officer of Health may make any other reports respecting the public health as he or she considers appropriate and may present such a report to the public or any other person he or she considers appropriate.

34. Subsection 86(1) provides:

Chief Medical Officer of Health may act where risk to health

86(1) If the Minister is of the opinion that a situation exists anywhere in Ontario that constitutes or may constitute a risk to the health of any persons, he or she may investigate the situation and take such action as he or she considers appropriate to prevent, eliminate or decrease the risk.

35. The amendments to ss. 86(2) and 86(3) extend the powers of local boards of health and local medical officers of health in Ontario to the Chief Medical Officer of Health. Those sections provide:
Same

(2) For the purpose of subsection (1), the Chief Medical Officer of Health,

(a) may exercise anywhere in Ontario any of the powers of a board of health and any of the powers of a medical officer of health; and

(b) may direct a person whose services are engaged by a board of health to do, anywhere in Ontario (whether within or outside the health unit served by the board of health), any act,

(i) that the person has power to do under this Act, or

(ii) that the medical officer of health for the health unit served by the board of health has authority to direct the person to do within the health unit.

Authority and duty of persons directed to act

(3) If the Chief Medical Officer of Health gives a direction under subsection (2) to a person whose services are engaged by a board of health,

- Transfers to the Chief Medical Officer of Health the power in s. 86.1 to apply to a judge of the Superior Court of Justice for an Order requiring a local board of health to take such action as the judge considers appropriate to prevent, eliminate or decrease the risk caused by the situation.³⁶
- Transfers to the Chief Medical Officer of Health the power in s. 86.2 to request a board of health to provide such information, in relation to the board of health and the health unit served by the board of health, as the Minister specifies.³⁷

(a) the person has authority to act, anywhere in Ontario (whether within or outside the health unit served by the board of health), to the same extent as if the direction had been given by the medical officer of health of the board of health and the Act had been done in the health unit; and

(b) the person shall carry out the direction as soon as practicable.

Section 22 Powers

(4) For the purpose of the exercise by the Chief Medical Officer of Health under subsection (2) of the powers of a medical officer of health, a reference in section 22 to a communicable disease shall be deemed to be a reference to an infectious disease.

36. Section 86.1 provides:

(1) If the Minister is of the opinion that a situation exists anywhere in Ontario that constitutes or may constitute a risk to the health of any persons, he or she may apply to a judge of the Superior Court of Justice for an order under subsection (2).

Order of judge of Superior Court of Justice

(2) If an application is made under subsection (1), the judge,

(a) may order the board of health of a health unit in which the situation causing the risk exists to take such action as the judge considers appropriate to prevent, eliminate or decrease the risk caused by the situation; and

(b) may order the board of health of a health unit in which the health of any persons is at risk as a result of a situation existing outside the health unit to take such action as the judge considers appropriate to prevent, eliminate or decrease the risk to the health of the persons in the health unit.

37. Section 86.2 gives the Chief Medical Officer of Health the power to request a board of health to provide such information, in relation to the board of health and the health unit served by the board of health, as the Chief Medical Officer of Health specifies. Subsection 86.2(2) provides that the Chief Medical Officer of Health may specify the time and the form in which the information must be provided. Subsection 86.2(3) states that the board of health shall comply with such a request. These powers were previously held by the Minister of Health and Long-Term Care.

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Along with these amendments, Dr. Sheela Basrur, Chief Medical Officer of Health, also retained the position of Assistant Deputy Minister, within the Ministry of Health and Long-Term Care, in addition to her role as Chief Medical Officer of Health.³⁸

On October 5, 2004, at the Standing Committee on Estimates, Dr. Basrur made the following comments in response to a question as to the nature of her proposed independence, despite the fact that she remained in government as an Assistant Deputy Minister:

... What I can tell you is that under Operation Health Protection, which is our blueprint for the future for public health, there is a commitment to codifying and strengthening the independence of the Chief Medical Officer of Health through amendments to the *Health Protection and Promotion Act*, the legislation the minister was just referring to.

If I go back to the plan that was announced publicly in June 2004, 60 days after we had received the interim report from Justice Campbell and when we received the final report from Dr. David Walker, who chaired the expert panel on infectious diseases, it was clear that one of the components that needed to be strengthened was the independence of the statutory role that I hold. There were a number of elements that were laid out in that plan relating to the ability and the duty to make reports on matters affecting the health of Ontarians and, secondly, to having a removal of even the perception of political advice or, even worse, interference in public health decision-making. Those elements were set out in that plan of June 2004.

Mr. Baird: Do you feel you have that independence today?

Dr. Basrur: De facto, yes. It is nice to have it codified for clarity and, as I say, to remove any perception that anything untoward might be the case.³⁹

Dr. Basrur's comments were the harbinger of the legislation to come.

38. Ministry of Health and Long-Term Care Press Release: "McGuinty government provides greater independence to Chief Medical Officer Of Health," New Legislation Will Give Ontario's Top Doctor More Power To Protect, Toronto, Dec. 16.

39. Ontario, Legislative Assembly, Standing Committee on Estimates, *Official Reports of Debates (Hansard)*, (October 5, 2004), p. E-117.

Independence of the Chief Medical Officer of Health: Finishing the Task

There seems to be unanimous agreement that the legislative amendments contained in Bill 124 are a step in the right direction. However, there remain a number of powers in the *Health Protection and Promotion Act*, which continue to be exercised by the Minister that should also be transferred to the Chief Medical Officer of Health to ensure the Chief Medical Officer of Health's complete independence.

The *Health Protection and Promotion Act* provides six bundles of powers that are now assigned by law to the Minister. These include the power to investigate by way of inquiry, the power to establish and direct laboratories, the power to appoint inspectors, enforcement powers under s. 102(2), the power to possess a premises as a temporary isolation facility, and the power to appoint assessors and make directions arising from assessor's report. Should these powers remain with the Minister or be transferred in whole or part to the Chief Medical Officer of Health?

Some of these powers are operational in nature and have to do with public health management as opposed to political oversight. These operational powers are an essential part of the managerial stewardship of the public health system, which should reside in a public servant rather than a Minister to the Crown. There are four categories of operational or managerial powers that remain within the domain of the Minister of Health and Long-Term Care, which the Commission recommends be transferred to the Chief Medical Officer of Health:

- Power over assessors;
- Public health laboratories;
- Enforcement powers under s. 102(2); and
- Power to appoint inspectors.

Power Over Assessors

Although the Chief Medical Officer of Health will now hold the power under s. 86(2) to exercise the powers of a board of health where there is a health risk to any person, she lacks the complementary power to order an assessment of a local board of

health. This power would enable her to determine whether the board of health is fulfilling its obligations under the Act and, where it is not, to order specific steps be taken to remedy the failure.

The power to order an assessment of a board of health is contained in s. 82 of the *Health Protection and Promotion Act*. It simply provides “The Minister shall appoint assessors for the purposes of this Act.” Subsection 82(3) provides the purposes for which an assessor may carry out an assessment. It provides:

- (3) An assessor may carry out an assessment of a board of health for the purpose of,
 - (a) ascertaining whether the board of health is providing or ensuring the provision of health programmes and services in accordance with sections 5, 6 and 7, of the regulations and the guidelines;
 - (b) ascertaining whether the board of health is complying in all other respects with this Act and the regulations; or
 - (c) assessing the quality of the management or administration of the affairs of the board of health.

Once an assessment has been completed, s. 83 allows the Minister to give a written direction to the board of health to remedy the problem identified in the assessment.⁴⁰

40. Section 83 provides:

Direction to board of health

83(1) The Minister may give a board of health a written direction described in subsection (2) if he or she is of the opinion, based on an assessment under section 82, that the board of health has,

- (a) failed to provide or ensure the provision of a health programme or service in accordance with section 5, 6 or 7, the regulations or the guidelines;
- (b) failed to comply in any other respect with this Act or the regulations; or
- (b) failed to ensure the adequacy of the quality of the administration or management of its affairs.

Same

Section 84 allows the Minister to take steps to ensure the direction is carried out.⁴¹

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- (2) In a direction under this section, the Minister may require a board of health,
- (a) to do anything that the Minister considers necessary or advisable to correct the failure identified in the direction; or
 - (b) to cease to do anything that the Minister believes may have caused or contributed to the failure identified in the direction.

Compliance with Direction

- (3) A board of health that is given a direction under this section shall comply with the direction,
- (a) within the period of time specified in the direction; or
- if no period of time is specified in the direction, within 30 days from the day the direction is given.

41. Section 84(1) sets out the actions that the Minister may take. It provides:

Power to take steps to ensure direction is carried out

84(1) If, in the opinion of the Minister, a board of health has failed to comply with a direction under section 83 within the period of time required under subsection 83 (3), the Minister may do whatever is necessary to ensure that the direction is carried out, including but not limited to,

- (a) providing or ensuring the provision of any health programme or service in accordance with sections 5, 6 and 7, the regulations and the guidelines;
- (b) exercising any of the powers of the board of health or the medical officer of health of the board of health;
- (c) appointing a person to act as the medical officer of health of the board of health in the place of the medical officer of health appointed by the board;
- (d) providing advice and guidance to the board of health, the medical officer of health of the board of health, and any person whose services are engaged by the board of health;
- (e) approving, revoking or amending any decision of the board of health, the medical officer of health of the board of health, or any person whose services are engaged by the board of health; and
- (f) accessing any record or document that is in the custody or under the control of the board of health, the medical officer of health of the board of health, or any person whose services are engaged by the board of health.

When Dr. Basrur recently appointed an assessor, Mr. Graham Scott, to examine the state of affairs in the Muskoka-Parry Sound Health Unit, she did so pursuant to authority delegated to her by the Minister of Health and Long-Term Care. This salutary example of leadership is discussed below.

It makes little sense to continue to vest in the Minister this corrective power. The Chief Medical Officer of Health must be able to investigate boards of health where there is a concern that duties under the *Health Protection and Promotion Act* are not being met, and to order that they take action to remedy such a failure.

The shift of these assessment and correction powers from the Minister to the Chief Medical Officer of Health is necessary to ensure that such decisions are made, and seen to be made, exclusively on public health considerations. To leave the power with the Minister is to invite the perception and fuel speculation that the decision to bring a local board to account or to leave it alone is influenced by political considerations. This danger is particularly great with the active political role of so many members of local boards of health.

Recommendation

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to transfer the powers in ss. 82 through 85 to the Chief Medical Officer of Health.**

Public Health Laboratories

Another important area of responsibility under the Act, provincial public health labs, remains under the direction of the Minister. Subsection 79(1) provides that the Minister may “establish and maintain public health laboratory centres at such places and with such buildings, appliances and equipment as the Minister considers proper.” Subsection 79(2) provides that the Minister “may give direction from time to time to a public health laboratory centre as to its operation and the nature and extent of its work, and the public health laboratory centre shall comply with the direction.” Currently, the labs fall under the domain of the Laboratories Branch of the Health Services Division of the Ministry of Health and Long-Term Care. The Central Public Health Lab has a non-medical director who reports to an Assistant Deputy Minister, also a non-medical person. If the Chief Medical Officer of Health is to hold

both the responsibility to ensure the protection of the public health of Ontario and the power to act independently to ensure that she fulfills that responsibility, the public health labs must be part of the transfer of power.

The provincial lab has a critical role to play in public health. Part of the Ministry of Health, the Ontario Public Health Laboratory is a network consisting of one provincial laboratory in Toronto, known as the Central Public Health Laboratory, and 11 regional labs. Approximately half of the 500 technical and support staff are employed in the Toronto facility.⁴² Their role is described as follows:

The public health labs provide diagnostic microbiology testing in support of public health programmes, outbreak management and control, and microbiology reference services for the province in areas where front line microbiology diagnostic testing is not available.⁴³

One observer described their importance to the smooth functioning of the Ontario public health system as follows:

But with a public health laboratory, while they do deal with individual patients, it doesn't have that patient as their number one priority despite the fact that, you know, the patient is very important. Their number one priority is understanding how this one patient with that particular disease, whatever it may be, may impact on the greater public. And so a public health laboratory has as its main focus not the one patient but how that one patient may impact on the greater public.

The Walker report,⁴⁴ the Naylor Report and the Commission's first interim report noted serious inadequacies in Ontario's public health laboratory capacity during SARS. As noted in the Commission's first interim report, SARS highlighted both the need for a well-resourced, smooth functioning lab, and the abysmal state of the Ontario's Central Public Health Laboratory. The provincial laboratory in

42. Dr. Margaret Fearon, Medical Microbiologist, Central Public Health Laboratory, Ontario Ministry of Health and Long-Term Care, *SARS: The Ontario Public Health Lab's Experience*, presented at the National Forum on Laboratory Reform, (Toronto: March 23-4, 2004), p. 3. (Subsequently referred to as the Fearon Presentation.)

43. The Fearon Presentation, p. 3.

44. Ontario Expert Panel on SARS and Infectious Disease Control, *For the Public's Health*, (Ministry of Health and Long-Term Care: December 2003) (subsequently referred to as the Walker Interim Report).

Toronto quickly became swamped with specimens but it was ill-equipped and unprepared to deal with the expanded demands of an outbreak like SARS. Consequently, as Dr. Naylor noted in his report, many of the private hospitals either by-passed the provincial lab altogether, sending specimens directly to the National Microbiology Laboratory in Winnipeg, or they handled the testing themselves, becoming as Dr. Naylor described “the *de facto* and unfunded referral centres for Toronto SARS testing.”⁴⁵

Laboratories are at the heart of our protection against infectious disease. The Chief Medical Officer of Health, with her independence and professional qualifications, should have the responsibility to establish and maintain the provincial public health labs. This includes ensuring that they are properly resourced. Furthermore, there is a need to ensure that the Central Public Health Lab is connected to and works effectively with the Public Health Division of the Ministry of Health and Long-Term Care. Many of those interviewed by the Commission remarked that the Central Public Health Lab tended to operate as a separate silo, rather than an integrated part of the Public Health Division. One expert noted that during SARS the Public Health Branch had trouble getting information from the public health laboratory, even though they were part of the same Ministry. This disconnect caused great concern for many experts who came forward to help with the Ontario response. As one of them noted:

The lab was a huge issue . . . What we were really worried about, too, was the number of cases that were positive on the lab test that were negative clinically. Were they missing cases and were these going to be the ones that were transmitting the cases even further, because they were our real worry, because that’s how we would lose containment, by the asymptomatic cases . . . We had trouble getting access to any of the lab information at the Ministry, even though it was the same Ministry.

It is only logical that the Chief Medical Officer of Health should have within her basket of powers the ability to direct the provincial public health labs as a vital aspect of public health protection. This direction should not come from an elected official without medical training or public health expertise.

SARS showed us also that it is essential that one person be in overall charge of our public health defence against infectious outbreaks. While cooperation and teamwork

45. Naylor Report, p. 33.

are required in any large endeavor, an effective defence requires that all public health aspects be under the leadership of one person. Why hive off from the Chief Medical Officer of Health the responsibility for public health laboratories? Why put that function under a separate division of the Ministry under different leadership? Essential links in our public health defence against infectious disease, like the public health laboratories, should be under the leadership of the Chief Medical Officer of Health, not an independent bureaucratic entity. SARS showed that this kind of bureaucratic barrier leads only to problems.

The Walker panel recommended that, in the short term, the Ministry of Health and Long-Term Care would retain control of the public health labs:

“Short-term: continued management of public health laboratory system, increasing role of Public Health Division.”⁴⁶

In the long-term, however, Walker recommended transferring the public health labs to the proposed Ontario Health Protection and Promotion Agency:

“Long-term: transfer of responsibility for management of the public health laboratories through coordination with Agency.”⁴⁷

In respect of the Ontario Health Protection and Promotion Agency, Walker recommended the following role for the Chief Medical Officer of Health, to ensure clear linkages between the Chief Medical Officer of Health and the Agency:

It is proposed that strategic direction for the Agency be set by the Chief Medical Officer of Health (CMOH) and day to day operational and scientific leadership be provided by a Chief Executive Officer. The final Walker report also recommended: “. . . that the Chief Medical Officer of Health be an ex-officio member of the board to ensure a link to the broader direction and functioning of the Agency.”⁴⁸

On June 22, 2004, Minister Smitherman released the three-year public health action

46. Ontario Expert Panel on SARS and Infectious Disease Control, *For the Public's Health: A Plan of Action*, (Ministry of Health and Long-Term Care: April 2004), p. 127. (Subsequently referred to as the Walker Final Report).

47. The Walker Final Report, p. 127.

48. The Walker Final Report, p. 92.

plan called “Operation Health Protection.”⁴⁹ Its purpose is to institute the recommendations in the Commission’s first interim report, and the Walker Report. This plan indicated that the Ontario Centre for Disease Control (called the Ontario Health Protection and Promotion Agency) and its new laboratory would begin operations in the 2006/7 fiscal year. It also called for the Ministry of Health to “undertake a formal review of the public health laboratory system in [fiscal] 2004/5 to determine the functional and procedural enhancements required for the system to provide appropriate tests and perform optimally during outbreaks and non-outbreak situations.”⁵⁰

The recommendation that the Chief Medical Officer of Health assume responsibility for Ontario’s Public Health Laboratories is intended as a short-term transfer of powers pending the development of the Ontario Health Protection and Promotion Agency and the transfer of powers in accordance with the recommendations in the Walker Report, with which this Commission concurs. Once developed the Agency will be responsible for the public health laboratory system. The Agency in turn will come under the direction of the Chief Medical Officer of Health. It only makes sense for the Chief Medical Officer of Health to have authority over public health laboratories at this time, pending the development of the Health Protection and Promotion Agency. Conversely it makes no sense to leave with the Minister the medical power to direct the public health laboratory as to its operation and the nature and extent of its work.

Recommendation

The Commission therefore recommends that:

- **The Minister’s power under s. 79 of the *Health Protection and Promotion Act*, to establish and direct public health laboratory centres be transferred from the Minister to the Chief Medical Officer of Health, until such time as the establishment of the Ontario Health Protection and Promotion Agency and the transfer of power over the laboratories in accordance with the recommendations of the Walker Report.**

49. Ministry of Health and Long-Term Care, “Operation Health Protection: An Action Plan to Prevent Threats to our Health and to Promote a Healthy Ontario” (June 22, 2004). (Subsequently referred to as Operation Health Protection).

50. Operation Health Protection, Appendix B, p. 5.

Enforcement Powers

Three separate provisions of the *Health Protection and Promotion Act* address the issue of enforcement. These three sections, s. 35, s. 86.1 and s. 102, authorize court action in the face of noncompliance.

If the powers of the local medical officer of health are assigned concurrently to the Chief Medical Officer of Health as recommended, the Chief Medical Officer of Health would have enforcement powers under s. 35 in addition to the enforcement powers acquired under s. 86.1 following the recent amendment to the Act.

Subsection 102(1) allows the person who made an order or the Chief Medical Officer of Health, or the Minister, to apply to the Superior Court of Justice for an order restraining a contravention of the Act. That subsection provides:

102(1) Despite any other remedy or any penalty, the contravention by any person of an order made under this Act may be restrained by order of a judge of the Superior Court of Justice upon application without notice by the person who made the order or by the Chief Medical Officer of Health or the Minister.

Subsection 102(2) authorizes an application to the Superior Court of Justice for an order prohibiting the continuation or repetition of the contravention or the carrying on of any activity specified in the order. That subsection provides:

102(2) Where any provision of this Act or the regulations is contravened, despite any other remedy or any penalty imposed, the Minister may apply to a judge of the Superior Court of Justice for an order prohibiting the continuation or repetition of the contravention or the carrying on of any activity specified in the order that, in the opinion of the judge, will or will likely result in the continuation or repetition of the contravention by the person committing the contravention, and the judge may make the order and it may be enforced in the same manner as any other order or judgment of the Superior Court of Justice.

More will be said below about the confusing nature of these two parts of this provision. It makes little sense that the Chief Medical Officer of Health should have the power to request an order restraining in s. 102(1) but lacks the power to request an order prohibiting continuation or repetition in s. 102(2). These are operational

powers, not political oversight powers, and they should be in the hands of the Chief Medical Officer of Health rather than the Minister.

*Recommendations*⁵¹

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to transfer the power in s. 102(2) to the Chief Medical Officer of Health.**
- **The *Health Protection and Promotion Act* be amended to remove from s. 102(1) the Minister as a listed person who may exercise that power.**

Powers over Inspectors

Another important enforcement power that currently remains with the Minister is the responsibility for inspectors under the *Health Protection and Promotion Act*. Section 80(1) sets out the power of the Minister to appoint inspectors.⁵² Subsection 80(2) sets out the duty of an inspector and s. 80(3) allows the Minister to set limits on the duty or authority of inspectors:

(2) An inspector shall make inspections of health units to ascertain the extent of compliance with this Act and the regulations and the carrying out of the purpose of this Act.

(3) The Minister in an appointment may limit the duties or the authority or both of an inspector in such manner as the Minister considers necessary or advisable.

Subsection 80(4) provides that the Minister may require an inspector to act under the

51. These recommendations are directed towards this section if it remains as it is. As discussed in Chapter 10, Legal Access, the sections need to be clarified and amended in their entirety, and set out in a clear, comprehensive enforcement section of the Act.

52. Subsection 80(1) provides:

The Minister may appoint in writing one or more employees of the Ministry or other persons as inspectors.

direction of, or report to, the Minister, the Deputy Minister of Health, the Chief Medical Officer of Health or other officer in the Ministry.

It seems logical that if the Chief Medical Officer of Health has the responsibility to ensure compliance with the *Health Protection and Promotion Act* across the province, she must also have the complimentary power to appoint and direct the inspectors who conduct inspections to determine the extent of a health unit's compliance with the Act. These are powers of management and enforcement, not powers of political oversight, and therefore should reside with the Chief Medical Officer of Health, not the Minister.

Recommendation

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to transfer the powers in s. 80 to the Chief Medical Officer of Health.**

Powers to Remain with the Minister of Health and Long-Term Care

Once these four statutory bundles of power (assessors, public health labs, enforcement and inspectors) are transferred to the Chief Medical Officer of Health, two important powers remain with the Minister: the power to investigate by way of inquiry and the power to take possession of premises for the purposes of temporary isolation.

The power to investigate by way of inquiry is contained in s. 78 of the *Health Protection and Promotion Act*. Section 78 provides that the Minister may make investigations respecting the causes of disease and mortality, and may direct anyone to conduct such an investigation, exercising the powers of a commission under Part II of the *Public Inquiries Act*.⁵³ It is this

53. Part II of the *Public Inquiries Act*, R.S.O. 1990, c. P. 41, sets out the power of a Commissioner. In particular, s. 7 allows the Commissioner to compel evidence:

A commission may require any person by summons,

(a) to give evidence on oath or affirmation at an inquiry; or

(b) to produce in evidence at an inquiry such documents and things as the commission may specify, relevant to the subject-matter of the inquiry and not inadmissible in evidence at the inquiry under section 11.

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power, reflected in the Commission's terms of reference and Order in Council, that enables the work of this Commission. There is no good reason to transfer this power to the Chief Medical Officer of Health. It is not a power that requires any medical expertise or knowledge about infectious disease. Medical expertise is not required to determine that the public interest requires an investigation into some matter of public concern involving the health system. This power belongs with the Minister of Health, an elected official, answerable in the Legislative Assembly and to the public. For this reason the Commission recommends no change to the power of the Minister under s. 78 to launch an investigation into the causes of disease and mortality.

Section 87 of the *Health Protection and Promotion Act* allows the Minister to commandeer any building for use as a temporary isolation facility or as part of a temporary isolation facility.⁵⁴ While some have submitted to the Commission that this power be

54. Possession of premises for temporary isolation facility

87(1) The Minister, in the circumstances mentioned in subsection (2), by order may require the occupier of any premises to deliver possession of all or any specified part of the premises to the Minister to be used as a temporary isolation facility or as part of a temporary isolation facility.

Extension

(1.1) An order under subsection (1) shall set out an expiry date for the order that is not more than 12 months after the day of its making and the Minister may extend the order for a further period of not more than 12 months.

Grounds for order

(2) The Minister may make an order in writing under subsection (1) where the Chief Medical Officer of Health certifies to the Minister that,

(a) there exists or there is an immediate risk of an outbreak of a communicable disease anywhere in Ontario; and

(b) the premises are needed for use as a temporary isolation facility or as part of a temporary isolation facility in respect of the communicable disease.

Delivery of possession

(3) An order under subsection (1) may require delivery of possession on the date specified in the order.

Hearing and submissions

(4) The Minister need not hold or afford to any person an opportunity for a hearing or afford to any person an opportunity to make submissions before making an order under subsection (1).

transferred to the Chief Medical Officer of Health, the Commission recommends that it remain within the authority of the Minister of Health and Long-Term Care.

Order for possession

- (5) Where a judge of the Superior Court of Justice is satisfied on evidence upon oath,
- (a) that there has been or is an immediate risk of an outbreak of a communicable disease anywhere in Ontario;
 - (b) that the premises are needed for use as a temporary isolation facility or as part of a temporary isolation facility in respect of the communicable disease; and
 - (c) that the occupier of the premises,
 - (i) has refused to deliver possession of the premises to the Minister in accordance with the Minister's order under subsection (1),
 - (ii) is not likely to comply with the Minister's order under subsection (1), or
 - (iii) cannot be readily identified or located and as a result the Minister's order under subsection (1) cannot be carried out promptly,

the judge may issue an order directing the sheriff for the area in which the premises are located, or any other person whom the judge considers suitable, to put and maintain the Minister and any persons designated by the Minister in possession of the premises, by force if necessary.

Execution of order

- (6) An order made under this section shall be executed at reasonable times as specified in the order.

Application without notice

- (7) A judge may receive and consider an application for an order under this section without notice to and in the absence of the owner or the occupier of the premises.

Compensation

- (9) The occupier of the premises is entitled to compensation from the Crown in right of Ontario for the use and occupation of the premises and in the absence of agreement as to the compensation the Ontario Municipal Board, upon application in accordance with the rules governing the practice and procedure of that board, shall determine the compensation in accordance with the *Expropriations Act*.

Procedure

- (10) Except in respect of proceedings before the Ontario Municipal Board in accordance with subsection (9), the *Expropriations Act* does not apply to proceedings under this section.

The power in s. 87 is considerable. It empowers the Minister to commandeer any building. It differs in nature from purely operational public health powers and reaches beyond the health care system and those directly affected by disease. It thus requires a different level of nonmedical accountability than that required for purely medical or operational powers. Under the current system the Minister is directly accountable for any exercise of this extraordinary power. On the other hand, the Minister may only make such an order on the advice of the Chief Medical Officer of Health. The latter must certify that there exists or there is an immediate risk of an outbreak of a communicable disease anywhere in Ontario and that the premises are needed for use as a temporary isolation facility or as part of a temporary isolation facility in respect of the communicable disease. The current system thus ensures a double level of accountability, political and medical, for the exercise of this power.

Recommendation

The Commission therefore recommends that:

- **The powers in s. 78 (appointment of inquiry) and in s. 87 (commandeering buildings for use as temporary isolation facilities) remain as they are, to be exercised by the Minister of Health and Long-Term Care.**

Parallel Independence of Local Medical Officers of Health

The local medical officers of health throughout the province are the backbone of our protection against infectious disease. They, like the Chief Medical Officer of Health, require independence from political and bureaucratic pressures in relation to the prevention and management of infectious disease.

The medical officer of health, as noted earlier, requires a degree of independence parallel to that enjoyed by the Chief Medical Officer of Health, which was recently the subject of amendments to the *Health Protection and Promotion Act*.⁵⁵ Local

55. Subsection 81(1.3) was recently added to require the Chief Medical Officer of Health to report annually to the public on the state of public health in Ontario and to authorize them to make any other reports respecting public health as she considers appropriate. The relevant sections are:

medical officers of health must have both the duty and the power to speak out publicly about local public health concerns. These must include the power to bring to the attention of the public a local board's failure or refusal to comply with its obligations under the Act. The local medical officer of health must be able to do so without fear of reprisal, dismissal, or other adverse employment consequences.

As will be discussed in greater detail in the following chapter, in many municipalities the local medical officer of health is buried within the municipal governance structure. Their desire to freely communicate on behalf of those citizens living in their unit, in relation to health risks, is tempered by their desire to preserve their jobs. Ironically, one medical officer of health, while supporting greater independence, noted their inability to voice that opinion publicly:

Interestingly enough, with the announcement related to the independence of the Chief Medical Officer of Health, a reporter asked wouldn't it make sense if that was parallel at the community level as well? And of course in the interests of preserving my job, I actually said I could not comment. So I think that that sort of instinctively appeals and is understood because I think the reasons were very well understood why the Chief Medical Officer of Health needed that independence.

There is a strong concern in the medical officer of health community that their ability to communicate with the public is hampered by their lack of independence and their

(4) The Chief Medical Officer of Health shall, in every year, make a report in writing on the state of public health in Ontario, and shall deliver the report to the Speaker of the Legislative Assembly.

Laying before Assembly

(5) The Speaker shall lay the report before the Assembly at the earliest reasonable opportunity.

Minister's Copy

(6) The Chief Medical Officer of Health shall deliver a copy of the report to the Minister at least 30 days before delivering it to the Speaker.

Other Reports

(7) The Chief Medical Officer of Health may make any other reports respecting the public health as he or she considers appropriate, and may present such a report to the public or any other person he or she considers appropriate.

struggles within the municipal governance structure. One local medical officer of health described how hard it is to get the public health message out to the public:

. . . for many years I insisted on preparing my own annual report and we printed it and we distributed it through libraries and all the usual venues. The regional corporation actually at that time never had an annual report of their own and they heard about this, so they decided to do their own annual report, I mean apart from their financial statement, which of course they've always had to do, but they decided they needed a glossy annual report so for awhile I was allowed to have the two middle pages that related specifically to the health of the residents and over the last two, three years that has disappeared as well, I gave up fighting for that.

As another medical officer of health described the problem:

... communication and public health risk communication is different from corporate communication and that is a very difficult concept for regional corporations to understand, they just feel they own all of the communication because what it means to them is ensuring that pathways are in place for re-election.

Yet another medical officer of health described the struggle to communicate with the public:

I recall one incident where the regional municipality wanted to speak out on a communicable disease investigation. They [the region] make unhealthy public health policy decisions all the time and because I'm embedded in the regional municipality, I can't speak out, and I think what you're seeing as well is a disturbing trend of integrating public health risk communications into the municipal communications. The problem with that is the latter often serves as a press secretary function to the regional politicians. And I think you need to give a great deal of consideration to this one, more generally, with respect to emergencies. You need to protect the independent voice of the medical officer of health with respect to public health risk communications, particularly in the municipal setting, because there are conflicts all the time. This may be the opportunity to clean it up so that we can speak authoritatively, locally, on public health risk standards. My hope would be that we would get the same sort of protection that the Chief Medical Officer of Health presumably is going to get, maybe even more as a part of the independ-

ence package that we're expecting in the Fall.

The problem is particularly acute when it may be necessary to speak out against a health risk created by the municipality itself:

If you subsume the public risk communications machinery in the corporate communications machinery, then your strong public health messages may be sanitized or killed because your message may look bad. [What about] a region who is charged with violations under the Ontario Water Resources Act, failure to report abnormal test results. As you know, we're required to issue boiled water advisories and as such we are also in the loop with respect to reporting, as is the Ministry of the Environment. Clearly there would be a conflict of interest in us speaking out, if in fact there was a problem with reporting to public health, if in fact it undermined the defence of the Region with respect to charges under the Ministry of the Environment. I mean this is just one of many, many examples, but I think public health risk communication is very, very important.

It is unacceptable that medical officers of health are restricted in their ability to tell the public what it has a right to know about health risk. Public health leadership and risk communication must be the clear domain of the local medical officer of health. The *Health Protection and Promotion Act* must authorize them to speak out on behalf of public health, without fear of adverse employment consequences. They have the duty, and require the power, to tell the public directly about any health risk. Local politics and bureaucratic turf wars have no place in the protection of the public's health. It is vital to ensure the ability of the medical officer of health to speak out. It is equally vital, as noted in the following chapter, to protect the local medical officer of health from the municipal bureaucracy and ensure his or her direct authority for the administration of staff and public health resources. Both changes are necessary to ensure the ability of the local medical officer of health to protect the public.

The independence recently given to the Chief Medical Officer of Health by statutory amendment should now be extended to those responsible locally for our day to day health protection. As one local medical officer of health said:

I think those of us who are in public health as physicians, really believe in the ability to improve people's health, and that's why we got in the job in the first place, and that's why I'm here, because I want to help shape the system.

They must have the legal authority and independence.

Recommendation

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to provide for every local medical officer of health a degree of independence parallel to that of the Chief Medical Officer of Health. This would include:**
 - **Giving the local medical officers of health the same reporting duties and authority as the Chief Medical Officer of Health:**
 - **To report every year publicly on the state of public health in the unit. This report must be provided to the local board of health and the Chief Medical Officer of Health 30 days prior to it being made public; and**
 - **To make any other reports respecting the public's health as he or she considers appropriate, and to present such a report to the public or any other person, at any time he or she considers appropriate.**
 - **Protecting the independence of the local medical officer of health by providing that no adverse employment action may be taken against any medical officer of health in respect of the good faith exercise of those reporting powers and duties.**

A Continued Need for Greater Central Control over Health Protection

The present system of central accountability and control is impractical and cannot continue. When a board of health fails in its obligations, the cumbersome enforcement provisions of ss. 82 through 86 are the only recourse for the Chief Medical Officer of Health. As the Commission observed in the first interim report:

The difficulty is that the assessment and compliance machinery is infinitely complicated, replete with notices, directions, orders, procedures before the Health Services Appeal and Review Board and the Superior Court of Justice and appeals therefrom. It more resembles an interna-

tional peacekeeping operation than it resembles effective machinery to enforce basic health protection standards across the province.

These powers had to be invoked in the Muskoka-Parry Sound Health Unit debacle, described below. The process in that case was time consuming and resource intensive. The Chief Medical Officer of Health, as Ontario's health protection leader, requires a simpler process of intervention than the complex process set out in the *Health Protection and Promotion Act*. The assurance of a uniform level of health protection across the province, particularly in relation to infectious diseases, demands that the Chief Medical Officer of Health have the power to intervene quickly and effectively whenever necessary to protect the public. Health protection across the province relies not only on effective boards of health, but also on knowledgeable, effective local medical officers of health. It is the local medical officers of health who have the authority to make orders under the *Health Protection and Promotion Act*, in the interests of protecting the public's health. Curiously, although the Chief Medical Officer of Health is the leader for health protection in the province, she does not have the same powers as the local medical officers of health. Moreover, she has no ability to direct persons whose services are engaged by a board of health, short of taking over the board of health.

The Chief Medical Officer of Health can only exercise direct powers under s. 86 of the Act, which requires that she determine that "a situation exists anywhere in Ontario that constitutes or may constitute a risk to the health of any persons." In such a case, the Chief Medical Officer of Health may investigate the situation and take any action, as she considers appropriate, to prevent, eliminate or decrease the risk. Subsection (2) states that where these criteria are met, she can exercise the powers of the local medical officer of health or the board of health, or direct the services of a person whose services are engaged by the board of health. Although this standard of intervention is not high, it is nonetheless a legal hurdle to intervention. As a legal hurdle it attracts all the legal issues associated with the intervention of a superior authority into the affairs of an autonomous local entity.

That is the wrong way to view the collegial relationship between the Chief Medical Officer of Health and the 36 local medical officers of health scattered throughout the province. The relationship, although collegial, cannot be entirely equal in an era in which the rapid communication of deadly disease requires a strong measure of central accountability and control. The ability of the Chief Medical Officer of Health to intervene where necessary in a local health unit should be part of a seamless continuum where daily authority is exercised by the local medical officer of health subject to the direction, whenever necessary, of the authority of the Chief Medical Officer of

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Health. The exercise of central leadership and authority cannot be impeded by this formal legal hurdle more appropriate to an era when local autonomy necessarily trumped central control. The public interest in unified accountability and control requires that there be no formal legal impediment to the local involvement and leadership of the Chief Medical Officer of Health whenever it is required in the wider provincial interest.

Ontario is fortunate in its many skilled, experienced and dedicated local medical officers of health who do a remarkable job delivering services and protecting the public. But this does not detract from the need for the Chief Medical Officer of Health to be able to intervene where the local authorities need leadership, assistance, or intervention.

Threats to public health may arise suddenly and without warning, overwhelming the capacity of a local health unit and local medical officer of health. It is essential in such cases that central resources and leadership be deployed immediately not only to assist the local unit but also to guard against the spread of disease to the rest of the province.

If a West Nile problem or a future SARS or some other hazard cannot be easily contained because the situation overwhelms the resources of the local health unit, they should be able to count on the Chief Medical Officer of Health to do what is necessary, whether that be deploying resources from other health units or the province.

For this reason alone, the Chief Medical Officer of Health requires the ability to step in immediately without the hurdle of s. 86, described above.

The problem with the present lines of authority between the Chief Medical Officer of Health and the local health units is that they harken from a pre-SARS era when it seemed fine for municipalities to run the show as independent legal entities. SARS showed that public health is a provincial concern, not just a local concern. Infectious diseases do not respect the geographic boundaries of Ontario's local health units. As noted so often, an infectious disease outbreak in one health unit could bring the whole province to its knees within days. Local autonomy has many advantages, but not when it comes to infectious disease problems that threaten the larger Ontario public interest.

The recommendation, for concurrent Chief Medical Officer of Health and medical officer of health powers, exercised locally by the medical officer of health subject to the ultimate central direction of the Chief Medical Officer of Health, does not mean

that the local medical officers of health lose their duties and obligations under the Act or their local leadership and authority. They are still in charge at the local level, better protected against local bureaucratic and political interference, and subject only to the central leadership and direction of the politically independent Chief Medical Officer of Health.

Nor does the recommendation mean that local medical officers of health would lose their ability to address their community needs. It does not mean a cookie cutter approach to public health across the province. The public health challenges faced in a major urban center such as Toronto are not identical to those faced in a small northern community such as Dryden, and neither of those are identical to those faced by a border community such as Niagara Falls. In critical aspects such as infection control, surveillance, and management, as well as emergency preparedness, one would expect that the Chief Medical Officer of Health would lead strongly in setting clear standards that must be met in each health unit. This is vital to ensuring a seamless level of protection against infectious disease across the province. In other activities, however, like those unique to a particular community, the expectation is that the local medical officer of health would have wide discretion in programme planning and delivery of services. Requiring that mandatory standards be met and giving the Chief Medical Officer of Health a strong central role, do not mean that all health units' programmes must be carbon copies of each other. Nor does it mean that the local medical officer of health would lose the ability to tailor the programmes to the particular region. The recommendation is not to remove their current powers or independence, but simply to give the Chief Medical Officer of Health concurrent power to reinforce central leadership and control when needed.

One local medical officer of health expressed this concern:

I think the principle that you want to set up a framework whereby the Chief Medical Officer of Health can exercise authority at the local level when needed is a good principle. I think that you are right that that exercise is more likely to happen on issues of communicable disease control than it is in other areas. I am just wondering what the best way to do that is. I guess the local MOH is almost always going to be closer to the situation and in a better position by virtue of having information and having worked with it probably for a little while before the issue comes up of whether the Chief Medical Officer of Health should step in.

I would almost rather see the presumption being that there is local autonomy with a mechanism for override rather than delegation with the

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option of taking the authority back and there may be some legal differences in those two ways of structuring it. I think the default should be that the person on the scene in the first instance has the responsibility for making decisions.

This thoughtful concern is met by the practical reality that no Chief Medical Officer of Health fulfilling his or her overall provincial responsibilities will have the time, the inclination or the resources to tinker inappropriately with local decisions. Under the present system, whatever its future, local autonomy is required on a day to day basis because you simply cannot run the whole province from Toronto. Day to day management of health protection will devolve necessarily on the local medical officer of health subject to central leadership and direction by the Chief Medical Officer of Health, without legal hurdles, when it seems reasonable.

Under this recommendation it would be business as usual. The local medical officer of health under the present practice runs public health locally but consults with the Chief Medical Officer of Health when particularly sensitive issues arise on which the local medical officer of health wants advice and support from the Chief Medical Officer of Health. This recommendation retains the initial presumption of local control. There is no proposed increase in actual power for the Chief Medical Officer of Health who already has the power of intervention in s. 86, described above. This recommendation simply removes the legalistic baggage potentially attracted by s. 86 and makes the central leadership of the Chief Medical Officer of Health more direct.

Others have raised the concern that transferring the powers to the Chief Medical Officer of Health creates the potential for abuse of these powers by the Chief Medical Officer of Health. While they do not raise this concern about the current Chief Medical Officer of Health, they worry about the use of this power in the hands of an unknown successor.

As noted above and discussed in greater detail below, the independence of the Chief Medical Officer of Health, as well as the greater independence of the local medical officer of health, combined with the ability and security to speak out publicly, would act as a deterrent against any inappropriate use of the powers of the Chief Medical Officer of Health.

One local medical officer of health expressed the concern that problems will arise not necessarily when the Chief Medical Officer of Health decides she needs to intervene, but when members of the public or others in the community seek to use her authority

to undermine or challenge the independence and authority of the local medical officer of health:

I guess a good situation would be one in which the Chief Medical Officer of Health found it relatively easy to step in where needed at their discretion, but the people whom the local medical officer of health is dealing on a day to day basis would not find it easy to appeal as it were over the head of the local MOH. You do not want to give the people that we have to work with on a regular basis the idea that if they do not like the MOH's decision, they can just bump it up a level.

. . . is it possible if you do not want to have criteria that would set boundaries, is it possible to indicate a level of concern so that it makes it clear that it is not a day to day avenue that is open to people, some language around extraordinary circumstances or posing a risk to the health of the population. I do not know what would work but a little bit of guidance to people trying to interpret the legislation.

The Chief Medical Officer of Health must ensure that it is clear to everyone, through policy and practice, that her authority and intervention is not available to those who seek to use it simply to second guess an unpopular decision of the local medical officer of health. As recommended above, the strengthened independence of the local medical officer of health recommended below by the Commission will provide an effective safeguard against any inappropriate use of the powers of the Chief Medical Officer of Health.

The Commission proposes a system of dispersed central authority whereby the local medical officer of health exercises in ordinary times local authority concurrent with that of the Chief Medical Officer of Health. Local autonomy of the local medical officer of health is the ordinary position. Local autonomy is secured by the newly recommended independence of the local medical officer of health from bureaucratic interference or political pressure. Local autonomy is fortified by the newly recommended duty and power of the local medical officer of health to speak out publicly in respect of health risks. The local autonomy of the medical officer of health is subject only to the central leadership and ultimate direction by the Chief Medical Officer of Health that is required to ensure a uniformly strong level of protection across the 36 separate local health units, particularly in relation to infectious disease.

Recommendations

The Commission therefore recommends that:

- **The powers now assigned by law to the medical officer of health are assigned concurrently to the Chief Medical Officer of Health.**
- **These concurrent powers shall be exercised by the medical officer of health in the local region, subject to the direction of the Chief Medical Officer of Health.**

Public Health Emergency Preparedness and Response

SARS showed us also that it is essential that one person be in overall charge of our public health defence against infectious outbreaks. While cooperation and teamwork are required in any large endeavor, effective defence against infectious disease requires that all public health aspects of that defence be under the leadership of one person.

Since SARS, emergency committees have proliferated and multiplied within the government and particularly within the Ministry of Health and Long-Term Care. Within the Ministry of Health and Long-Term Care, the Health Emergency Management Committee plans for emergencies, the Ontario Health Pandemic Influenza Plan Steering Committee plans for pandemic influenza emergencies, the Emergency Management Unit manages emergencies, and the Executive Emergency Management Committee makes executive decisions. There are also additional layers of committees at the centre of government.

Strangely, the Chief Medical Officer of Health is in charge of none of these committees which are central to Ontario's defence against public health emergencies.

A case in point is the Emergency Management Unit, established in December 2003, to oversee all the Ministry's emergency management activities. Under the leadership of a dedicated long-time official in the Ministry of Health and Long-Term Care, the Unit plays a central role in many crucial public health emergency planning activities:

- It is the lead for pandemic influenza planning, including overseeing the steering committee it established to oversee the development of the health pandemic flu plan.

- It is developing a smallpox emergency response plan.
- It is developing a radiation health response plan.
- It is working on the health component of the Foreign Animal Disease Plan.

The Unit's extensive activities have necessitated the development of draft Terms of Reference for a Scientific Advisory Team to:

Provide advice to EMU based on evidence and best practices on medical/scientific aspects of health emergency planning and response, including but not limited to:

- Personal protection for health care workers;
- Medical response to and treatment of chemical, radiological and nuclear agents;
- Patient triage treatment and transport priorities;
- Needs analysis for pharmaceutical and other antidotes;
- Interaction and integration among health care providers; and
- Educational and research initiatives.

Review and provide input into relevant policies, standards and guidelines as directed by EMU.

Upon request, act as a Scientific Response Team to be convened to support the Ministry's health emergency response (specific membership to reflect the needs of the emergency).

Provide scientific advice specific to health emergency threats upon request of the Director.⁵⁶

56. Ministry of Health and Long-Term Care, Emergency Management Unit, "Update on EMU Reference Groups," February 21, 2005.

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For expertise on infectious disease, the Unit is also developing a relationship with the Provincial Infectious Diseases Advisory Committee (PIDAC) that may require a memorandum of understanding. A recent summary of the EMU's activities related to PIDAC said:

- Expertise on new and emerging infectious diseases is provided by PIDAC.
- [EMU] Scientific Advisor and Director, EMU members of PIDAC.
- Work under way to develop a memorandum of understanding regarding mutual expectations in an emergency.
- Requests for specific advice on infectious diseases provided on an ad hoc basis, e.g., consolidation of SARS directives, confirmation of basic personal protective equipment in response to an infectious disease.⁵⁷

The Unit's web site is also the primary vehicle for public risk communication on significant public health issues. The portion of the web site aimed at the general public contains information on avian flu, influenza pandemic and health advisories. The portion of the web site intended for health care professionals contains technical information on pandemic influenza, avian flu, including screening tools, infection control standards, and important health notices.

The March 1, 2005, organizational chart of the Ministry of Health and Long-Term Care shows the Emergency Management Unit as a separate entity, with an apparent reporting relationship to the Associate Deputy Minister. There is no reporting link from the Emergency Management Unit to the Chief Medical Officer of Health.⁵⁸

This is clearly a unit that should be under the direct authority of the Chief Medical Officer of Health. Nothing could be more central to the mandate of that office in protecting Ontarians from deadly infection. It makes no sense to hive off from the Chief Medical Officer of Health the responsibility for public health planning for smallpox and pandemic influenza. It makes no sense to put the responsibility for smallpox and pandemic influenza planning under a separate division of the Ministry. Public health emergency planning requires the leadership of the Chief Medical

57. *Ibid.*

58. See Appendix G to this Report.

Officer of Health, not an independent bureaucratic entity. SARS showed that this kind of bureaucratic barrier leads only to problems.

A recent “Important Health Notice” from the Ministry of Health in respect of avian flu was distributed on the Unit’s web site and was co-signed by the Associate Chief Medical Officer of Health and the head of the Emergency Management Unit, an official with no medical qualifications and no reporting relationship to the Chief Medical Officer of Health. To those familiar with the confusion during SARS arising from the split responsibility between the Commissioner of Emergency Management and the Chief Medical Officer of Health, this arrangement produces a shock of recognition.

Dr. Basrur explained to the Justice Policy Committee the problem during SARS of this very kind of arrangement:

... there were a multitude of directives issued under the authority of the two commissioners – the Commissioner of Emergency Management and the Commissioner of Public Health – and many comments back that people were unsure who was in charge because there were two signatories; there were always two people who had to be consulted.⁵⁹

In the event of a provincial pandemic influenza emergency, can we expect three signatures, the Commissioner of Public Safety and Security, the head of the Ministry of Health and Long-Term Care’s Emergency Management Unit, and the Chief Medical Officer of Health, two of whom are not medically trained? To ask the question is to demonstrate that the Ministry’s present organization of emergency responsibility needs amendment to put the Chief Medical Officer of Health clearly in charge.

Another big problem during SARS that resulted from too many people managing the same problem was the multiplicity of information requests. The Commission repeatedly heard from SARS front line workers that much of their time was spent responding to multiple requests from various parts of the government, particularly within the Ministry of Health and Long-Term Care. As one Ministry employee who worked at the epi-unit told the Commission:

59. Ontario, Legislative Assembly, Standing Committee on Justice Policy (subsequently referred to as the Justice Policy Committee), *Official Report of Debates (Hansard)*, Public Hearings, August 18, 2004, p. 142.

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Compounding that as we went on, the demand for data and data analysis just became enormous. You know, the mailing list got to be this humungous monster. Everybody wanted the data. Everybody wanted certain charts developed.

As the demands for information grew, people started duplicating work. The insatiable requests for information cascaded down to the front line workers and local medical officers of health and their staff, significantly contributing to their frustration and fatigue. It is important to guard against the creation of multiple responding agencies and committees, which can, by their very multiple existence, create barriers to effective emergency response. Should another infectious disease emergency hit the province, we are at risk, under the current emergency system within the Ministry of Health and Long-Term Care, of repeating the very problems that arose during SARS, with multiple separate groups demanding case information and feeling entitled to it by nature of their emergency response mandate.

This is not to say that the Chief Medical Officer of Health or the local medical officers of health would work in isolation or be responsible for each and every detail of public health emergencies. That is an impossible responsibility. Much of the planning for future emergencies involves the creation of partnerships and working groups. While it is essential to have partnerships and working groups in place prior to an outbreak there still needs to be a single leader, identifiable both internally and externally. As one expert from outside Ontario who worked at the provincial level during SARS described the problem;

Outbreak management 101 would never set up the situation for something like this where you do not have a single person defined as being overall responsible. That does not mean that the person works alone in isolation and would report to someone with legislative powers to do certain things but you do not do something as confusing as this with two leaders ...

SARS caught Ontario's public health system unprepared. Unified preparedness and planning is a vital piece of armour in our protection against infectious disease. It must be a priority not only for the Public Health Division but also for every local health unit.

More will be said about this and the important issue of who is in charge, in the chapter on Emergency Legislation. Public health emergency planning is addressed here, in the context of Chief Medical Officer of Health leadership, as an area of the Ministry

of Health and Long-Term Care that must be put under the direction and control of the Chief Medical Officer of Health.

Key members of the SARS Scientific Advisory Committee suggest that it is important for the EMU, the Ministry's operational response to a public health emergency and its lead in preparedness planning and implementation and management, to report directly to the Chief Medical Officer of Health. They recommend:

If the Chief Medical Officer of Health is the incident commander during a health emergency, it follows therefore that all other health sectors are accountable to the Chief Medical Officer of Health. This was the premise during the SARS outbreak and worked to the extent that proper command and control structures were exercised, and now the Emergency Management Unit of the Ministry of Health and Long-Term Care is the coordinating structure by which provincial health care providers and organizations would report to the Chief Medical Officer of Health during an emergency and this should be recognized in legislation. During the SARS outbreak there was duplication of information and efforts from within the MOHLTC. One central Emergency Management Unit reporting to the Chief Medical Officer of Health will avoid duplication and confusion.

The Commission endorses their recommendation.

Public health emergency preparedness and planning implementation must be the responsibility of the medical officer of health not only at the provincial level but also at the local level. It is not enough to ensure that the central provincial machinery is prepared. The local machinery in each part of the province must be equally prepared. Local preparation is essential not only to ensure a consistent province-wide response in each locality, but also because some public health emergencies will be local in nature without any immediate province-wide implications.

As one local medical officer of health noted, there must also be clarity around the leadership role of the local medical officer of health in respect of local health emergencies, and when responding to a provincial health emergency, in partnership with the Chief Medical Officer of Health:

We have not talked at all about health emergencies and who is in charge and what is a health emergency and in fact what is the role of the MOH at the local level with respect to health emergencies if at all and does

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there need to be a corresponding bulking up of the mandatory health programmes and services and guidelines under that with respect to health emergencies ... But I guess why I am asking this question is I meet with and chair a health emergency preparedness kind of committee that involves the hospitals, long-term care and so forth ... I pulled this together because nothing is happening locally and I was shocked to learn that despite there being a health emergency management unit created in the Ministry of Health, it has given hospitals, long-term care, and so forth no direction whatsoever to have emergency plans. So, to the extent there are other actors that need to be involved in responding to a local health emergency that does not require a provincial response for example, how does that happen, and what powers and duties can be brought to bear to deal with that situation.

In addition to preparedness and planning, the Chief Medical Officer of Health and the local medical officers of health must have the lead role in public health emergency mitigation, management, recovery, coordination and risk communication. Above all, there must be clarity around roles and responsibilities.

As Dr. Bonnie Henry, former associate Medical Officer of Health for Toronto, noted in her testimony before the Justice Policy Committee, there is currently little clarity around roles and responsibilities:

A few other little things that came out: we have conflicting legislation right now about who has to do what in an emergency. I think that needs to be either umbrella legislation through EMA or we need to look at the Emergency Management Act, the Public Hospitals Act and the HPPA separately to rectify some of the conflicting legislative pieces.⁶⁰

Dr. Henry stressed the importance of local public health leadership in a public health emergency:

One of the things we need to remember is that all the actual physical, hands-on management of emergencies happens at the local level. So while we absolutely need to have the authority and decision-making

60. Justice Policy Committee, Public Hearings, August 18, 2004, p. 148.

and a command-and-control structure at the provincial level-and I absolutely agree with that-the authority then needs to go to the local people to do what they need to do within their own local jurisdictions, because we know the quirks of our own jurisdictions. Some of the problems we've run into, for example, are that under the Public Hospitals Act, hospitals are not necessarily required to be involved with their local emergency response organizations. That needs to be changed. There's nothing that requires them to be involved at the local level; they report to the province. That, I think, is an issue we have been trying to deal with.⁶¹

There is currently nothing in the *Health Protection and Promotion Act* that requires the local medical officer of health to be responsible for public health emergency preparedness, management and recovery or for public health risk communication. While there are scattered references to outbreak planning, emergency planning and risk communication in the Mandatory Guidelines, they are general in nature and do not make it clear what must be done and by whom.⁶² None of these references put the local medical officer of health in charge at the local level during a public health emergency or in charge of public health risk communication.

One local medical officer of health described the need for reform as follows:

If you had a mandatory programme or standard so that every health unit shall work out a health emergency plan, a public health emergency plan, and that part of your function is, in the event of a public health emergency, public communication or risk assessment. I think that you have to do it in two places. I think that you have to deal with s. 5(1) and s. 7 ... because if you do that then it gives you the authority, it helps you get money from the municipalities. I would also go a step further with respect to public health risk communications, I would also strengthen s.

61. *Ibid*, p. 148.

62. For example, s. 2.0 of the Mandatory Guidelines says that services provided by the board of health are expected to be planned and delivered by staff with the required technical/professional skills including skills in risk communication (one of many skills identified). Section 5.0 requires the board of health to have an outbreak response plan, and s. 6.0 requires the board to ensure input to hospital infection control programmes in health units and nursing homes and homes for the aged on their outbreak contingency plan. However, nothing in the mandatory guidelines puts the local medical officer of health squarely in charge of health emergency planning, preparedness, mitigation, management, coordination, recovery or risk communication.

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67 so that there are explicit powers for the MOH to speak out with respect to health emergencies. You and I would agree that that may be covered under s. 67(1) but the people that you need to get to are the municipalities. You need to have some tools at hand to force them to pay for programmes and the way you do that is by declaring something mandatory. And when you do that, not only does the board of health and an obligated municipality have to provide and pay for it, but also it legitimizes the province providing the funding. So that is one of the advantages of naming those two areas in s. 5 and perhaps providing standards under s. 7. But I would also beef up in general the communications page under s. 67 and I think that there are enough other tools in the Act to allow us to get the job done, notably s. 13, s. 14 and infectious disease s. 22.

Another medical officer of health added:

I think the standards would have to be very prescriptive as to the elements of the emergency response plan, and they should be tested on an annual basis. I think there should be support in the Public Health Division to ensure that the quality of the plan across the province is acceptable and that we have people to liaise with.

The *Health Protection and Promotion Act* must be amended to include local public health emergency planning, preparedness, mitigation, management, recovery, coordination and risk communication as a responsibility of the local medical officer of health. A number of submissions to the Commission have recommended:

Amend section 5 of the *Health Protection and Promotion Act* to include “public health emergency preparedness, management and recovery and public health risk communication.”

Similarly, the *Health Protection and Promotion Act* must clearly state that at the provincial level, the Chief Medical Officer of Health is in charge of public health emergency planning, preparedness, mitigation, management, recovery, coordination and risk communication.

Subsection 6.2(1) of the *Emergency Management Act* requires that each municipality, minister of the Crown and designated agency, board, commission and other branch of government submit a copy of their plan to the Chief, Emergency Management

Ontario, and must ensure that they have the most current plan.⁶³ The *Health Protection and Promotion Act* should be amended in a parallel manner so as to require that local medical officers of health and local boards of health submit a copy of their emergency plan to the Chief Medical Officer of Health and ensure that she has the most recent copy.

Dr. Bonnie Henry, described to the Justice Policy Committee the need for better integration at the local level and between the various health units:

I think one of the really key things we need to work on is integration of emergency management programmes at the local level. Right now, everybody is required to have an emergency management program. Health is involved to varying extents in different places but it is not a major player at the local level. As well, we need to integrate with our neighbours. Our emergency management organization has a very different structure than does Peel, for example, but we share a lot of common borders and a lot of common issues, and how we do things is quite different.⁶⁴

As Dr. Henry also said:

I think the whole issue of hospitals and other parts of the health care organization being part of our critical infrastructure is something that's not well understood by people in the emergency side of the world – the people who look after critical infrastructure even at the city level. Hospitals are a provincial entity. Do they fit into us, or is the province looking after them? Who's going to make sure they get the power back on soon? Who's going to make sure they get the trucks to fill their generators so the patients don't suffer?⁶⁵

The local medical officer of health must ensure that hospitals, long-term care facilities, nursing homes, outreach programmes, shelters, correctional institutions, and

63. Subsection 6.2(1) provides:

Every municipality, minister of the Crown and designated agency, board, commission and other branch of government shall submit a copy of their emergency plans and of any revisions to their emergency plans to the Chief, Emergency Management Ontario, and shall ensure that the Chief, Emergency Management Ontario has, at any time, the most current version of their emergency plans. 2002, c. 14, s. 10.

64. Justice Policy Committee, Public Hearings, August 18, 2004, p. 149.

65. *Ibid.*

other organizations and institutions that would be involved in, or affected by a public health emergency, have their own emergency plans fully integrated with the public health emergency plan, all under the overall policy direction of the Chief Medical Officer of Health.

With this additional responsibility must come additional resources to ensure that the local medical officer of health and the Chief Medical Officer of Health can actually fulfill these expanded duties. To do otherwise would be to create an unacceptable risk.

Recommendations

The Commission therefore recommends that:

- **Public health emergency planning, preparedness, mitigation, management, recovery, coordination and public health risk communication at the provincial level be put under the direct authority of the Chief Medical Officer of Health under the *Health Protection and Promotion Act*.**
- **Public health emergency planning, preparedness, mitigation, management, recovery, coordination and public health risk communication under the direction of the local medical officer of health be added to the list of mandatory public health programmes and services required by s. 5 of the *Health Protection and Promotion Act*.⁶⁶**

66. Section 5 provides:

Mandatory health programs and services

5. Every board of health shall superintend, provide or ensure the provision of health programs and services in the following areas:

1. Community sanitation, to ensure the maintenance of sanitary conditions and the prevention or elimination of health hazards.
2. Control of infectious diseases and reportable diseases, including provision of immunization services to children and adults.
3. Health promotion, health protection and disease and injury prevention, including the prevention and control of cardiovascular disease, cancer, AIDS and other diseases.
4. Family health, including,

- **The Emergency Management Unit of the Ministry of Health and Long-Term Care be moved to the Public Health Division with its Director reporting directly to the Chief Medical Officer of Health.**
- **The *Health Protection and Promotion Act* be amended to require that each local board of health and each medical officer of health provide to the Chief Medical Officer of Health a copy of their general public health emergency plan and any incident specific plans and ensure that the Chief Medical Officer of Health has, at any time, the most current version of those plans.**

Protection from Personal Liability

The *Health Protection and Promotion Act*⁶⁷ now protects from personal liability for damages a limited class of people who act in good faith in the intended execution of their duties under the statute. These people include board of health members, medical officers of health and associate medical officers of health, and public health inspectors. Section 95 provides:

No action or other proceeding for damages or otherwise shall be insti-

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- i. counselling services,
 - ii. family planning services,
 - iii. health services to infants, pregnant women in high risk health categories and the elderly,
 - iv. preschool and school health services, including dental services,
 - v. screening programs to reduce the morbidity and mortality of disease,
 - vi. tobacco use prevention programs, and
 - vii. nutrition services.

4.1 Collection and analysis of epidemiological data.

4.2 Such additional health programs and services as are prescribed by the regulations.

5. Home care services that are insured services under the *Health Insurance Act*, including services to the acutely ill and the chronically ill.

67. Section 95(1).

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tuted against a member of a board of health, a medical officer of health, an associate medical officer of health of a board of health, an acting medical officer of health of a board of health or a public health inspector for any act done in good faith in the execution or the intended execution of any duty or power under this Act or for any alleged neglect or default in the execution in good faith of any such duty or power.

Although these individuals are personally protected from being sued, anyone damaged by their negligence still has the right to sue the board of health itself.⁶⁸ The provision thus protects a limited number of public health workers personally while it preserves the rights of anyone allegedly damaged by their actions.

The provision is cast too narrowly. By protecting public health officials like the medical officers of health and withholding protection from others like public health nurses, it withholds protection from those who may need it most. It also excludes the Chief Medical Officer of Health.

Section 95 of the *Health Protection and Promotion Act* should be amended to extend its protection to everyone employed by or providing services to a public health board or the provincial Public Health Division, everyone from the Chief Medical Officer of Health, to its expert advisors, to public health employees in the field.

This amendment will ensure that public health workers are adequately protected against personal liability for damages while preserving the right of anyone allegedly damaged to sue the worker's employer.

Recommendation

The Commission therefore recommends that:

- **Section 95 of the *Health Protection and Promotion Act* should be amended to extend its protection to everyone employed by or providing services to a public health board or the provincial Public Health Division, everyone from the Chief Medical Officer of Health, to its expert advisors, to public health employees in the field.**

68. Section 95(3).

Conclusion

To avoid the problems that arose during SARS and to increase our protection against infectious disease, it is necessary to increase the independence of the Chief Medical Officer of Health and the local medical officers of health and consolidate public health leadership in the hands of the Chief Medical Officer of Health.

Recommendations

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to transfer the powers in ss. 82 through 85 (power over assessors) to the Chief Medical Officer of Health.**
- **The Minister's power under s. 79 of the *Health Protection and Promotion Act*, to establish and direct public health laboratory centres be transferred from the Minister to the Chief Medical Officer of Health, until such time as the establishment of the Ontario Health Protection and Promotion Agency and the transfer of power over the laboratories in accordance with the recommendations of the Walker Report.**
- **The *Health Protection and Promotion Act* be amended to transfer the power in s. 102(2) (enforcement powers) to the Chief Medical Officer of Health.**
- **The *Health Protection and Promotion Act* be amended to remove from s. 102(1) the Minister as a listed person who may exercise that power.**
- **The *Health Protection and Promotion Act* be amended to transfer the powers in s. 80 (power over inspectors) to the Chief Medical Officer of Health.**
- **The powers in s. 78 (appointment of inquiry) and in s. 87 (commandeering buildings for use as temporary isolation facilities) remain as they are, to be exercised by the Minister of Health and Long-Term Care.**
- **The *Health Protection and Promotion Act* be amended to provide for every local medical officer of health a degree of independence parallel to that of the Chief Medical Officer of Health. This would include:**

- **Giving the local medical officers of health the same reporting duties and authority as the Chief Medical Officer of Health:**
 - **To report every year publicly on the state of public health in the unit. This report must be provided to the local board of health and the Chief Medical Officer of Health 30 days prior to it being made public; and**
 - **To make any other reports respecting the public's health as he or she considers appropriate, and to present such a report to the public or any other person, at any time he or she considers appropriate.**
- **Protecting the independence of the local medical officer of health by providing that no adverse employment action may be taken against any medical officer of health in respect of the good faith exercise of those reporting powers and duties.**
- **The powers now assigned by law to the medical officer of health are assigned concurrently to the Chief Medical Officer of Health.**
- **These concurrent powers shall be exercised by the medical officer of health in the local region, subject to the direction of the Chief Medical Officer of Health.**
- **Public health emergency planning, preparedness, mitigation, management, recovery, coordination and public health risk communication at the provincial level be put under the direct authority of the Chief Medical Officer of Health under the *Health Protection and Promotion Act*.**
- **Public health emergency planning, preparedness, mitigation, management, recovery, coordination and public health risk communication under the direction of the local medical officer of health be added to the list of mandatory public health programmes and services required by s. 5 of the *Health Protection and Promotion Act*.**
- **The Emergency Management Unit of the Ministry of Health and Long-Term Care be moved to the Public Health Division with its Director reporting directly to the Chief Medical Officer of Health.**
- **The *Health Protection and Promotion Act* be amended to require that each**

local board of health and each medical officer of health provide to the Chief Medical Officer of Health a copy of their general public health emergency plan and any incident specific plans and ensure that the Chief Medical Officer of Health has, at any time, the most current version of those plans.

- **Section 95 (protection from personal liability) of the *Health Protection and Promotion Act* should be amended to extend its protection to everyone employed by or providing services to a public health board or the provincial Public Health Division, everyone from the Chief Medical Officer of Health, to its expert advisors, to public health employees in the field.**

