14. An Ontario Centre for Disease Control

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

One thoughtful observer described the need for clear lines between the work of the agency and the work of the Public Health Branch:

> I would like to see an agency created as an intelligence service to public health, provincially and locally. There should be a clear lead for the Ministry on governance functions, and a clear lead for the agency on things like training, technology, knowledge transfer, advice on mandatory programme standards, and health human resource planning, the whole gamut of things that frankly those in the Ministry can't attend to. The agency would have a degree of administrative flexibility that you don't have in the civil service.

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

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

Second, it should be an adjunct to the work of the Chief Medical Officer of Health and the local Medical Officers of Health, not a competing body. SARS showed that there are already enough autonomous players on the block who can get in each other's way if not properly coordinated. There is always a danger in introducing a semi-

autonomous body into a system like public health that is accountable to the public through the government. The risk is that such a body can take on a life of its own and an ivory tower agenda of its own that does not necessarily serve the public interest it was designed to support.

Third, it must be made clear from the beginning that the agency is not an end in itself but exists only to support public health. A useful summary of the appropriate role for such an agency is set out in the external review report of the B.C. Centre for Disease Control:

> The B.C. CDC exists to carry out provincial surveillance, both epidemiologic and laboratory based, to provide expert assistance to local public health professionals and to provide some specific disease control services i.e., for tuberculosis and sexually transmitted diseases. The UBC CDC was created to ensure that research and the development of knowledge was promoted to complement the service mandate of B.C. CDC. The only other similar organization in Canada is the Institut national de santé publique of the Province of Québec. That organization is also responsible for provincial public health laboratory services, research, and expert support for public health practice in the province.[159]

To ensure that the new Ontario agency complements the service mandate of the public health system, the relationship must be clear between the new Ontario agency and the Chief Medical Officer of Health. Unless he or she has a clear say in the ongoing work and overall direction of the agency, and the ability to mobilize the resources of the agency to meet a public health problem when required, the agency will not fulfill its role as a source of support to public health operations. The Chief Medical Officer of Health must have more than a token role in the direction of any such agency. If the new agency is to have a Board of Directors, the Chief Medical Officer of Health, if not its Chair, should be at least its Associate Chair. To the extent the agency is operational as opposed to purely advisory, the Chief Medical Officer of Health must, in the face of a public health problem, be able to direct the operational resources of the agency so as best to meet the problem at hand, whether the resources are epidemiological, laboratory, or other.

If the Chief Medical Officer of Health lacks the ability to mobilize the resources of the new centre, resources created to support the work of the Chief Medical Officer of

159. Report by Dr. Paul Gully and Dr. Thomas Marrie, October 30, 2003.

Health and the local Medical Officers of Health, the danger exists that arose during SARS when the Science Committee and the Epi Unit were disconnected from the field operations. Whatever independence may be needed from government, whatever buffer required to ensure the academic and scientific integrity of the new agency, that independence and those buffers should not prevent the mobilization of its resources under the direction of the Chief Medical Officer of Health when required to meet a public health emergency.

For any public health agency to work, it must have authority with other sectors of the health care system and with the community as a whole. While some legislative authority will be necessary, the most important authority is what one local Medical Officer of Health described as "moral authority." Speaking of the role he considered the local Medical Officer of Health to play in a community he stated:

> Now you talk about the authority of public health . . . I have never felt that I have great authority. On paper, legislatively I have great authority. I can order people to do all kinds of stuff and they can choose not to do it and I can go in front of a judge, as I have on a number of occasions, to have something done. But most of our public health authority comes from our credibility and willingness and ability to work with other people to get things done. It does not come from the Medical Officer of Health issuing orders . . . Our authority comes in terms of dealing with individuals so most of public health success does not come through authority, not legal authority but through moral authority if there is such a thing.

This will no doubt hold true for a Centre for Disease Control in Ontario. The success of centres such as the CDC in Atlanta and the CDC in British Columbia flows largely from a widespread recognition that these institutions house the very best of the best. The authority comes from their recognition as centres of excellence that can be counted on to work collaboratively with local agencies. To achieve this authority and success an Ontario Centre for Disease Control will require considerable resources and a strong commitment from government to maintain those resources. It will only work if it has the resources to attract recognized experts and to provide them with the best technology and equipment and optimal support to perform their work. It will take years to build a reputation for excellence and anything less than a 100-per-cent commitment to this long-term goal will surely result in failure.