17. Central Control over Health Protection

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

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 traveling 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.

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.[171]

The lack of clarity around the respective accountability of the Chief Medical Officer of Health and the local Medical Officer of Health is striking. To quote a former Medical Officer of Health:

> 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.
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> 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.

Another Medical Officer of Health commented on the inconsistent relationship between the Chief Medical Officer of Health and the local Medical Officer of Health:

171. *SARS Commission Public Hearings,* September 30, 2003, p. 28.

> . . . the relationship between the local Medical Officer of Health and Chief Medical Officer of Health is not formalized. At times, the Chief Medical Officer of Health can be a mentor and adviser, at other time he or she serves an appellate court function (e.g., HPPA s. 22.1). In dealing with perspectives related to one person in one position, it is also important to acknowledge that personality traits will also influence these informal relationships. At times, incumbent Chief Medical Officers of Health have acted as if a master-servant relationship existed, where none is defined by law or policy. At most other times, the perspective of the province is that public health is delivered through independent boards, with all accountability for decisions a local matter, and an unwillingness to advocate for or support the local Medical Officers of Health. Recommendations in this area would be largely determined by the directions the province chooses to follow with respect to governance, funding and structure.

Another experienced Medical Officer of Health, while favouring a continuing element of local control, agreed that clearer lines of authority were necessary:

> I think the first issue is whether Ontario wants to continue to have a decentralized system for public health and decentralized governance under local Boards of Health. If yes, when exceptions would apply in a health emergency, whether infectious or non-infectious. I do think that is a mutual benefit in maintaining some devolution of control to the local level for day-to-day responsibilities including day-to-day management of infection control and local outbreaks. It would be totally overwhelming for the province to be responsible for and give direction on the huge weight of disease issues that come up every day. But the roles and responsibilities and terms of engagement that need to take effect in a multi-jurisdictional situation, an outbreak in a number of local units, needs to be much clearer. One of the outcomes from our collective experiences during SARS is that those roles and relationships need to be more clearly defined . . .
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> The province will have to revisit both the current framework and the existing mandatory programmes to make the surveillance process stronger and less ambiguous. It is no good at the end of the day to point fingers at each other and say "I thought you were supposed to be doing it" The public has no tolerance for it, and neither do those who work in the system.

Another experienced Medical Officer of Health, no friend of central authority for its own sake, recognized its need in respect of communicable disease control:

> I think it has been more recognized because of the widespread nature of the impact of SARS that there is a provincial interest in having an effective public health system . . . [We] do not have in real terms a health care system because of the variety of components that work or do not work together effectively. But the public health system is loosely connected because it is decentralized and is probably appropriate for many different kinds of public health programs that you need to customize to the local needs. But communicable disease control is increasingly being recognized as something necessary across the province and the system needs to work together where communicable disease crosses [local boundaries].

Another Medical Officer of Health, while advocating local public health autonomy in a general sense, recognized in thoughtful terms that infectious disease control requires a stronger element of central provincial control:

> I think that communicable disease is one of the areas where local control is a bit less important in my estimation, where consistency is more important. But I would hate to have the entire template for public health set based on that example because local control is more important with many of the other things that we deal with, where you are trying to change community values such as around tobacco, changing the way that the community thinks about health issues, thinks about behaviours which have an impact on health. It is much more important to work locally and they do that very differently in Kenora than in Toronto. But communicable disease control in a hospital in Kenora and Toronto is not as different as it is with these other programmes. I make a plea that local control is very important particularly for other programmes . . .
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> Clearly infectious disease really requires some kind of consistent application. I would rather have the central organization send out whatever [directives] are necessary even if the are wrong, in one sense, because they could then correct it as they learn more. Whereas if each of the Medical Officer of Health were developing our own procedures and protocols, some of us may be right and others may be wrong and the confusion that would come from that would be far worse than having the central group be wrong and then correct it all around the province the next day or the day after. So I think related to communicable disease control, consistency

> is important. So clearly the provincial organization that can collect data on a larger number of cases should be in a much better position to come up with important ways of dealing with that particular kind of infection and should be able to distribute that out to the field in some linked and logical and coordinated kind of way to ensure at the local level that those things are being carried out.

In theory, mechanisms do exist for the province to assert control over a local health unit that is not delivering adequate public health protection. One Medical Officer of Health was asked about this issue:

> Q: What if the local board does not allocate enough money to maintain the necessary level of public health protection?
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> A: Then you move to the assessment and compliance machinery in the HPPA.

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 international peacekeeping operation than it resembles effective machinery to enforce basic health protection standards across the province. And there is a further question of political will. One Medical Officer of Health asked the question:

> As long as public health is entangled in two different levels of government it becomes more difficult to find the political will to improve public health. If the provincial government wants to make a deal with a municipality on transport funding, and needs the goodwill of the municipality, will the government encourage the Minister of Health to crack down on the municipality if it isn't up to standard on public health protection?

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 super ordinate 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 in the hands of 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.

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

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

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