# 9. Independence and Accountability

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

A number of local Medical Officers of Health noted the need for a greater degree of independence for the Chief Medical Officer of Health. To quote two of them:

> The Chief Medical Officer of Health should not report to any specific Minister but perhaps to a neutral non-political third party to take information to Cabinet. It would be preferable if there was continuity rather than intermittent political people in the reporting structure . . .
>
> Public health must be independent of political interference both at the provincial and local level. Not only is the Chief Medical Officer of Health a position that must be out of the political spectrum, but local Medical Officers of Health must also continue to enjoy that position.

It is one thing to say that the Chief Medical Officer of Health needs to be more independent. It is another thing to understand what independence means; independent from whom? Independent to do what? It is yet another thing to prove that any public servant should be independent from the ordinary systems of government accountability. In a democratically accountable system any claim for independence from government, in the exercise of direct power over citizens and in the expenditure of public funds, must be subjected to intense scrutiny.

Whatever independence may be required by the Chief Medical Officer of Health for public health decisions during an outbreak and for the right to speak out publicly whenever necessary, he or she should remain accountable to the government for overall public health policy and direction and for the expenditure of public funds. Public health is a function of government. It is the legitimate business of government to set overall policy and spending priorities. If the government wants to increase or decrease the proportion of public funds being used to promote bicycle safety or infection control, that is perfectly legitimate. At the heart of democratic decision making is the

principle that the elected government, accountable to the public through the Legislative Assembly, sets the priorities for government activities and decides how public funds are spent, and takes responsibility for its performance. One public health official noted that members of the public, if things go wrong in the public health system, will say:

> I want to know, who do I vote out?

There must be a clear line of political accountability for public health performance. It is one thing to give the Chief Medical Officer of Health a direct pipeline to the Legislative Assembly and the public, to point out areas where more funds should be spent and to warn of dangers if programmes are not instituted. Also to give the Chief Medical Officer of Health a clearly defined independence in respect of operational decision-making, in deciding whether to say a disease outbreak is over or in deciding whether to quarantine large numbers of people. It is quite another thing to set the Chief Medical Officer of Health above the democratic process in relation to overall policy direction and priorities.

Necessary independent powers to warn the government and the public about dangers to public health, and autonomy in respect of operational decisions in the management of outbreaks, should not be confused with the independent power to make public health policy and decide how public funds are spent.

On the evidence examined thus far, the Commission, as noted above, has found no evidence of political interference with public health decisions during SARS. The investigation continues and more will be said about this issue in the final report on the basis of all the evidence examined.

The problem is that many people suspected political interference and many were convinced that politics was somehow at work behind public health decisions. However, no one interviewed thus far is able to recall any statement or any action by anyone that provides evidence to support that impression. Whatever the Commission's eventual finding on this issue may be, the problem must be addressed of public perception of the necessary degree of independence of the Chief Medical Officer of Health and the public health system generally.

As noted above, a consensus has developed that machinery is necessary to give the Chief Medical Officer of Health a measure of political independence. Dr. Richard Schabas, a former Chief Medical Officer of Health for Ontario, told 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 understand 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.[144]

There is a consensus that the office of Chief Medical Officer of Health needs a greater degree of actual and perceived independence from government. The key question is what precise kind of independence is needed and how that independence is best balanced with the necessary degree of accountability.

Senator Kirby pointed out that too much of an arm's length distance between the Chief Medical Officer of Health and the government would affect not only accountability but also the ability of the Chief Medical Officer of Health to have the close links with other parts of the provincial health care system that this Commission found to be inadequate during SARS.

The Naylor Report in advocating a new Chief Public Health Officer for Canada noted the need for a measure of independence in that office. The report pointed out that British Columbia and Manitoba both have independence safeguards of the kinds recommended for the new Canadian Chief Public Health Officer.

In British Columbia, the *Health Act* provides that the Provincial Public Health Officer shall report to the public, in the way he or she considers most appropriate, if in his or her view the public interest requires a public report on health issues in B.C. or the need for legislation or changes in policy or practice. In addition to the power to report to the public whenever the Provincial Public Health Officer thinks fit, he or she must give an annual report to the minister who is obliged to lay the report before the Legislative Assembly as soon as practicable.

In Manitoba the Chief Medical Officer of Health, while accountable to the department and the Minister, has an arrangement that permits him or her to function independently when necessary with a specific power to issue public health advisories and bulletins:

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

> While accountable to the Department, the Chief Medical Officer of Health may function autonomously when necessary in the interests of the health of the public. Under these circumstances, the Chief Medical Officer of Health has the authority to issue public health advisories and bulletins, or take other actions. The Chief Medical Officer of Health will inform the Deputy Minister and/or the Minister prior to such actions or as soon as practically possible, in accordance with established protocols.

In Québec, the statute that establishes the Québec National Public Health Institute provides that the public health mission of the Institute is not only to inform the Minister but also to inform the public. The Institute's mission includes:

> informing the Minister of the impact of public policies on the health and well-being of the population of Québec;
>
> informing the population of the state of public health and well-being, and of emerging problems, their causes, and the most effective means of preventing or resolving them

The Walker interim report recommended that the Ontario Chief Medical Officer of Health should be able to report directly to the Legislative Assembly and to make public comment on significant public health issues independently.

One Medical Officer of Health, who saw no need for the structural independence of the Chief Medical Officer of Health, thought however, that the freedom to speak out on public health matters should be guaranteed:

> . . . [The] Chief Medical Officer of Health must be free to speak out on issues and produce reports that contain recommendations that are not yet government policy and may be controversial.

One knowledgeable observer concluded that a position within the Ministry, coupled with the right to report independently to the public, would provide the right balance between accountability and independence:

> It would be my preference for the Chief Medical Officer of Health to retain administrative control and internal influence that comes with being an Assistant Deputy in the Ministry of Health and to have the agency as support to the Chief Medical Officer of Health with the obligation to make annual reports to the legislature with advance notice to

> the Minister, perhaps using the *B.C. Health Act* as a template, with the additional safeguard that the Chief Medical Officer of Health in his or her judgment can make additional reports public through any appropriate means. That way the Minister gets a heads up in the ordinary course of an annual report but the Minister is not the gatekeeper if the Chief Medical Officer of Health thinks something should be made public.

The proposed power to report directly to the public, combined with independence in relation to the management of infectious outbreaks, provides a significant measure of independence to the Chief Medical Officer of Health. It ensures that on important public health issues the Chief Medical Officer of Health cannot be muzzled and that the public can get a direct sense of emerging public health problems without passing through any political filters. It ensures both the reality and the public perception that the management of infectious disease outbreaks will be based on public health principles and not on politics.

Should the Chief Medical Officer of Health remain within the Ministry of Health and Long-Term care? Or should the position be hived off from the Ministry into an independent agency with a line of accountability to the Legislative Assembly similar to independent watchdog officers like the Ombudsman, the Integrity Commissioner, the Environmental Commissioner, the Provincial Auditor and the Privacy Commissioner?

Unlike these officers, the Chief Medical Officer of Health provides leadership to a large and widely dispersed operational system responsible on the ground for infectious disease surveillance and health protection programmes. 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 being 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 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.

The logic of this position is persuasive.

The Commission therefore recommends:

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

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

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

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