# 3. HPPA Tuneup

The *Health Protection and Promotion Act* is the legal engine that makes public health go. The work of protecting us from infectious disease, during SARS and in normal times, is conducted under its authority. Actions to protect us against disease – prevention, investigation, and intervention – are all taken under this statute. It is a fundamental tool public health authorities use to protect us against infectious outbreaks.

The *Health Protection and Promotion Act* was proclaimed in force in 1983, replacing the former *Public Health Act*. There have been minor amendments since then, directed mainly at funding arrangements and the machinery of service delivery by local boards of health. These amendments have not altered the confusing structure of the statute.

SARS prompted a few urgent spot amendments.[119] As noted below, the speed with which these amendments were enacted is a tribute to the skill and professionalism of the lawyers in the Attorney General's department, including those seconded to legal branches in other Ministries. These amendments aside, there has been no major overhaul of the statute since 1983. That in itself is no reason to amend it. But the more the

119. *The SARS Assistance and Recovery Strategy Act*, 2003, S.O. 2003, c. 1. received royal assent (and thereby came into force) on May 5, 2003. Part I contemplates (s.6) various SARS-related leave scenarios, and then provides for various protections including (ss.8ff) reinstatement, protection of wage rates, and protections against reprisals. In essence this portion of the Act establishes a "SARS leave" which is in addition to the entitlement to the emergency leave provided under recent amendments to the *Employment Standards Act, 2000* (*ESA*). The Act also provides protection to employers where a termination was carried out "solely for reasons unrelated to the leave." Part II of the Act provides for a suspension of the retail sales tax on hotel charges during a 5-month period following the SARS crisis. Part III of the Act amends s. 7.1 of the *Emergency Management Act*, which gives the Lieutenant Governor in Council power to make temporary orders to facilitate assistance to victims of an emergency. The new s 7.1(1) specifies that the purpose of the section is to authorize the Lieutenant Governor in Council to make appropriate orders when, in his or her opinion, the victims of an emergency need greater services, benefits or compensation than the law of Ontario provides. Part IV amends Ontario's *Health Protection and Promotion Act* (HPPA) to allow a medical officer of health to issue a s. 22 order to "a class of persons." Section 35 was amended to permit the court to name not only a hospital but some "other appropriate facility" in the order. The amended s.87 provides that the Minister may make an order requiring the occupier of any premises to give up possession for use as a temporary isolation facility for a period of 12 months.

Commission worked with the Act in the course of interviewing public health workers, and those in the wider health system who are obliged to comply with it on a daily basis, the more it became apparent that this complex piece of legal machinery needs to be made clearer.

The *Health Protection and Promotion Act* is a convoluted statute, understood by a handful of lawyers and public health officials intimately familiar with it on a daily basis. To those who do not work with it every day the meaning of the *Health Protection and Promotion Act* is not always clear. Even those who do work with it regularly are struck by some of its ambiguities.

In the aftermath of SARS, the powers and authority of public health officials must be carefully reviewed and revised to ensure that during the next infectious disease outbreak, there is no lack of clarity about the precise powers of public health officials to intervene early and manage the outbreak effectively. Nor should there be any ambiguity about the precise obligation of members of the community to abide by orders made by public health officials. The legal authority to intervene and act must be unequivocal. Lack of legal clarity produces confusion, wrangling, and delay when time is of the essence.

The Act needs a major overhaul to remove ambiguity and ensure clarity. The Commission, without embarking on such a major review in this interim report, has identified four examples of what needs to be done:

- Simplify disease categories;

- Clarify the three streams of power to intervene, removing the dangerous ambiguity as to the extent of the powers in s. 13 and simplify the process by which the Chief Medical Officer of Health can exercise the powers provided in Part III and Part IV;

- Clarify and simplify the standards of intervention throughout the Act; and

- Strengthen and clarify the powers contained in s. 22 of the Act.

The *Health Protection and Promotion Act* requires amending not only because existing powers are inadequate, as noted above, but because they are unclear, as noted later in this chapter. Some of the Act's problems, such as reporting obligations, quarantine powers, the independence of the Chief Medical Officer of Health and the local medical officers of health, the municipal role, and recommendations for additional

powers, are dealt with in other sections of this report. Fixing these will go a long way towards strengthening the Act. For example, amending the reporting provisions as recommended will enhance the ability of the local medical officer of health to learn about infectious cases before they turn into outbreaks. But it is not enough to amend and reword the existing structure. SARS showed us that new infectious diseases can emerge suddenly with enormous consequences for the legal machinery of public health. The lessons learned from SARS and the threat of even deadlier risks, such as avian flu and influenza pandemics, suggest that the *Health Protection and Promotion Act* should be thoroughly reviewed to provide the clearest possible statement of public health authority and its precise limits.

A statute like the *Health Protection and Promotion Act,* which drives the entire public health system and empowers the state to encroach on individual liberty by personal detention and isolation, must above all be entirely clear. This is not the case with the *Health Protection and Promotion Act*. It displays the same problems as those identified in the former Food and Drug Regulations by the Honourable Horace Krever:

> It is recommended that the Food and Drug Regulations be rewritten to make them intelligible … The Food and Drug Regulations, as they are structured at present, are complex, hard to read, and difficult to interpret … It is essential that any regulation be intelligible to the regulated, and it is desirable that it also be intelligible to the public. The current regulations fail on both counts ... [120]

Everything said by Justice Krever about the old Food and Drug Regulations applies to the *Health Protection and Promotion Act*. Its complexities and difficulties of interpretation must be removed.

The Commission in this chapter identifies some parts of the *Health Protection and Promotion Act* that require clarification, particularly those parts that deal with infectious disease. This is by no means an exhaustive analysis or proposal for statutory amendment; it merely sets out examples of major revision the Ministry needs to do in consultation with the public health community, and the wider health community. This

120. "The Food and Drug Regulations, as they are structured at present, are complex, hard to read, and difficult to interpret, largely because of the many amendments that have been made over the years. It is essential that any regulation be intelligible to the regulated, and it is desirable that it also be intelligible to the public. The current regulations fail on both counts." (Source: Volume 3, page 1067, of the Final Report of the Commission of Inquiry on the Blood System in Canada, headed by The Honourable Mr. Justice Horace Krever and released in November 1997.)

is a convenient place to observe that a tremendous body of expertise is available in the fairly small group of lawyers who advise local boards of health. They work with the statute on a regular basis and have a firm understanding of what is needed to make the statute clear. Their advice in the process of amendment would be most valuable.

## Overview of the Act

The *Health Protection and Promotion Act* presents an assortment of public health powers scattered throughout different parts of the Act. A snapshot of the powers, their triggers and standards of application, show an overall lack of consistency, clarity, and unified organization. To exemplify the need for general reorganization and revision, a handful of specific provisions will be set out below, with brief illustrative comments.

The powers of a local medical officer of health and the Chief Medical Officer of Health are contained primarily[121] in three main parts of the Act: community health protection, communicable disease, and administration. The powers contained in those sections that were relevant during SARS can be summarized in the following chart:

| | **Part III Community Health Protection** | **Part IV Communicable Diseases** | **Part VII Administration** |
|---|---|---|---|
| APPLICATION | s. 1 – definition of health hazard; condition of premises, substance, thing, plant or animal other than man, or a solid, liquid, gas or combination of any of them, that has or is likely to have an adverse effect on the health of any person (Part I) | Communicable disease as defined in Ont. Reg. 558/91<br>Reportable disease as defined in Ont. Reg. 559/91<br>Virulent disease as defined in Ont. Reg. 95/03 and s. 1 in the *HPPA* | s. 86(1) – situation that constitutes or may constitute a risk to the health of any persons |
| DUTY | s. 10(1) – every MOH shall inspect or cause the inspection of the health unit served by him or her for the purpose of preventing, eliminating and decreasing the effects of health hazards in the health unit | Set out in mandatory guidelines (representation on hospital IC, consultation with hospital on infection control and outbreak contingency plan, providing advice when needed or requested for communicable disease management) | s. 86(1) – is discretionary on part of Chief Medical Officer of Health (formerly was power of Minister of Health) |

121. While these appear to be the main sections which contain powers, other, specific powers can be found in other parts of the Act. For example, the right of entry is included in Part V.

| | **Part III Community Health Protection** | **Part IV Communicable Diseases** | **Part VII Administration** |
|---|---|---|---|
| POWER | s. 13(1) – MOH or public health inspector may, by written order, require a person to take or to refrain from taking any action that is specified in the order in respect of a health hazard | s. 22(1) – MOH by written order may require a person to take or to refrain from taking any action that is specified in the order in respect of a communicable disease | s. 86 – CMOH may investigate the situation and take such action as he/she considers appropriate to prevent, eliminate or decrease the risk |
| CRITERIA FOR USING POWER | s. 13(2)(a) – a health hazard exists in the health unit and s. 13(2)(b) – requirements specified in the order are necessary in order to decrease the effect of or eliminate the health hazard | s. 22(2)(a) – communicable disease exists or may exist or there is an immediate risk of an outbreak of a communicable disease in the health unit; and s. 22(2)(b) – the communicable disease presents a risk to the health of persons in the health unit; ands. 22(2)(c) – the requirements specified in the order are necessary in order to decrease or eliminate the risk to health presented by the communicable disease | s. 86 (1) – situation exists anywhere in Ontario that constitutes or may constitute a risk to the health of any persons |
| STANDARD FOR USING POWER | s. 13(2) – opinion, upon reasonable and probable grounds | s. 22(2) – opinion, upon reasonable and probable grounds | s. 86(1) – opinion (no reasonable and probable grounds standard) |
| JUDICIAL REVIEW | s. 102(1) – application by CMOH or MOH to Superior Court for an order restraining a contravention of an orders. 102(2) – application by Minister to Superior Court of Justice for an order prohibiting the continuation or repetition of the contravention of an order | s. 35 – application to Ontario Court of Justice for order of detention, examination or treatment in respect of virulent disease s. 102(1) – application by CMOH or MOH to Superior Court for an order restraining a contravention of an order s. 102(2) – application by Minister to Superior Court of Justice for an order prohibiting the continuation or repetition of the contravention of an order | s. 86.1 (1) – application by Chief Medical Officer of Health to Superior Court of Justice to order a board of health to take such action as considered appropriate to prevent, eliminate or decrease the risk |

During SARS, legal issues were for the most part put aside. Patients, health care workers, and institutions complied generally with government direction in the hopes that compliance would stop SARS from spreading.

## Simplify Disease Categories

The *Health Protection and Promotion Act* requires amendment to clarify its four overlapping and confusing categories of disease.

The four different categories of disease: infectious, communicable, reportable, and virulent, attract different overlapping sets of legal powers and duties, different reporting duties on the part of doctors and hospitals, and different control powers on the part of medical officers of health and the Minister.

Two categories, communicable, and reportable, are defined in s. 1(1) by way of their inclusion in regulations:

- "communicable disease" means a disease specified as a communicable disease by regulation made by the Minister.

- "reportable disease" means a disease specified as a reportable disease by regulation made by the Minister.

Once the Minister puts a disease into the communicable disease regulation it attracts certain legal consequences, and once the Minister puts a disease into the reportable disease regulation it attracts other legal consequences. The communicable disease regulation specifies 58 diseases and 16 subcategories as communicable.[122] The

122. Ontario Regulation 558/91, Amended to O. Reg. 97/03, Specification of Communicable Diseases made under s. 1 of the *Health Protection and Promotion Act* lists. Acquired Immunodeficiency Syndrome (AIDS); Amebiasis; Anthrax; Botulism; Brucellosis; Campylobacter enteritis; Chancroid; Chickenpox (Varicella); Chlamydia trachomatis infections; Cholera; Cytomegalovirus infection, congenital; Diphtheria; Encephalitis, primary viral; Food poisoning, all causes; Gastroenteritis, institutional outbreaks; Giardiasis; Gonorrhoea; Group A Streptococcal disease, invasive; Haemophilus influenzae b disease, invasive; Hemorrhagic fevers, including: i. Ebola virus disease, ii. Marburg virus disease, iii. Other viral causes; Hepatitis, viral: i. Hepatitis A, ii. Hepatitis B, iii. Hepatitis D (Delta hepatitis), iv. Hepatitis C; Influenza; Lassa Fever; Legionellosis; Leprosy; Listeriosis; Lyme Disease; Malaria; Measles; Meningitis, acute: i. Bacterial, ii. Viral, iii. Other; Meningococcal disease, invasive; Mumps; Ophthalmia neonatorum; Paratyphoid Fever; Pertussis (Whooping Cough); Plague; Pneumococcal disease, invasive; Poliomyelitis, acute; Psittacosis/ Ornithosis; Q Fever; Rabies; Respiratory infection outbreaks in institutions; Rubella; Rubella,

reportable disease regulation[123] specifies all the communicable diseases as reportable and adds to the list of reportable diseases six other diseases, which are not communicable.[124] Thus all 58 communicable diseases are reportable but six of the reportable diseases are not communicable. The third category, virulent diseases, is defined partly by statute and partly by regulation.

Subsection 1(1) of the *Health Protection and Promotion Act* defines 12 diseases as virulent.[125] SARS is the only disease specified by regulation as virulent.[126] Most of the virulent diseases are also communicable and reportable except for Ebola and Marburg virus which are neither communicable nor reportable.

A further category of "infectious diseases" is not defined in the statute or regulations. Control of infectious diseases is a mandatory programme that every board of health is required to deliver:

> Every board of health shall superintend, provide or ensure the provision of health programs and services in the following areas . . .
>
> 2. Control of infectious diseases and reportable diseases, including provision of immunization services to children and adults.

A further level of complexity is added by s. 86 (4) which provides that when the Minister of Health exercises the authority of a local medical officer of health under s. 22 in respect of a communicable disease, the reference in s. 22 to a communicable disease shall be deemed to be a reference to an infectious disease:

---

congenital syndrome; Salmonellosis; Severe Acute Respiratory Syndrome (SARS); Shigellosis; Smallpox; Syphilis; Transmissible Spongiform Encephalopathy, including: i. Creutzfeldt-Jakob Disease, all types, ii. Gerstmann-Sträussler-Scheinker Syndrome, iii. Fatal Familial Insomnia, iv. Kuru; Trichinosis; Tuberculosis; Tularemia; Typhoid Fever; Verotoxin-producing E. coli infections; West Nile Virus Illness: i. West Nile Virus Fever, ii. West Nile Virus Neurological Manifestations; Yellow Fever; Yersiniosis.

123. Ontario Regulation 559/91 *Amended to O. Reg. 96/03,* Specification of Reportable Diseases.

124. Cryptosporidiosis, cyclosporiasis, Group B Streptococcal disease, neonatal, Hantavirus pulmonary syndrome, Herpes, neonatal, tetanus. The reportable disease list also includes 4 subcategories of encephalitis that are not listed in the communicable disease regulation.

125. Cholera, Diphtheria, Ebola virus disease, Gonorrhoea, Hemorrhagic fever, Lassa fever, Leprosy, Marburg virus disease, Plague, Syphilis, Smallpox, Tuberculosis.

126. Regulation 95/03 made by the Minister on March 25 2003 specifies SARS as a virulent disease. In total there are 13 diseases defined as virulent, in either the Act or Regulation.

> For the purpose of the exercise by the Minister 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.

It is difficult to understand why the statute adds this extra layer of undefined "infectious disease" on top of the three defined categories of communicable, reportable, and virulent.

Merely to describe these four categories of disease: infectious, communicable, reportable and virulent, is to illustrate an overlapping and confusing statutory and regulatory framework. Those who work with the *Health Protection and Promotion Act* on a daily basis are so familiar with its nooks and crannies that they do not complain about the dense confusion of disease categories. To members of the public, and even lawyers who are not steeped in its peculiarities, the *Health Protection and Promotion Act* categories of disease look like an impenetrable maze.

There was undoubtedly some original logic in the different categories. It makes sense to have two categories of disease to distinguish between virulent diseases like SARS, which require strong and immediate action, and less dangerous diseases like Herpes, which require less dramatic and immediate intervention. It also makes sense to have some very serious diseases specified by statute so that the Legislative Assembly can control the gate for exercising the extreme powers needed to deal with these dangerous bugs. It also makes sense to give the Minister the urgent power to specify immediately by regulation an emerging disease like SARS when there is no time to await the passage of legislation.

But the present structure of four categories of disease, utilizing different methods of designation, and different legal powers and duties, is unnecessarily complex and confusing.

## *Recommendation*

**The Commission therefore recommends that:**

- **The four present categories of disease: infectious, communicable, reportable, and virulent, be simplified and reduced to two categories with clear boundaries and clear legal consequences.**

## Two Streams of Power

As noted above, the power of the local medical officer of health to act to protect the public is dispersed in two distinct parts of the Act. During SARS, public health authorities derived most of their authority to act from Part IV, Communicable Diseases, but at times had to hope that the Community Health Protection provisions, contained in Part III of the Act, would apply. Yet from the perspective of statutory construction, the fact that the powers in s. 13 are not contained in the communicable disease part of the Act, raises the question of whether they were intended to fill this gap or whether s. 22 was intended to be a one-stop section for powers in relation to communicable diseases.

For example, an unclear application of the Act arises where a hospital's infection control practices are unsafe and, without improvement, may cause a person to be infected with a communicable disease or create a health risk to the public. Under what section of the Act are public health officials authorized to intervene and give orders to the hospital? Some have argued that this power currently exists in the *Health Protection and Promotion Act* and in support of this they point to ss. 11, 13 and 14, which authorize a medical officer of health to inspect and make orders where there is a "health hazard." Action under these sections, however, is premised on there being a "health hazard."

Health hazard is defined in s.1 of the Act as follows:

> "health hazard" means,
> (a) a condition of a premises,
> (b) a substance, thing, plant or animal other than man, or
> (c) a solid, liquid, gas or combination of any of them,
> that has or that is likely to have an adverse effect on the health of any person.

First of all, it is worth noting that the powers set out in ss. 11 through 14 are contained in the community health section of the *Health Protection and Promotion Act*. This part of the Act focuses clearly on environmental and occupational health hazards, not on infectious disease risks which are addressed separately in Part IV, Communicable Diseases. That noted, it is doubtful that these powers were intended to address any situations that arose during SARS, let alone the specific problem of infection control and infectious outbreaks in hospitals. Moreover, the standard of proof in s. 13 makes it inappropriate for use in the context of infectious diseases in

hospitals, and even more importantly it stretches the structure, definitions, and context of Part III to apply these powers to hospital infection control and oubreak problems. It reflects a high degree of legal ambiguity in the *Health Protection and Promotion Act* when public health lawyers can hold sharply divided views on this fundamental issue.

If the powers set out in s. 13 are intended to apply to communicable diseases, the *Health Protection and Promotion Act* should be amended to clarify this point.

Recently, the issue has arisen as to whether the power in s. 13 would allow decontamination of a person. In September, 2004, the Ministry of Health and Long-Term Care, expressed the opinion to Mr. Katch Koch, the Clerk of the Standing Committee on Justice Policy, that s. 13 of the *Health Protection and Promotion Act* could authorize decontamination of a person:

> If a situation exists where a possible toxic substance may have contaminated persons in the community (for example the "white powder" scare that occurred across North America following the events of September 11, 2001) it may be appropriate to consider the exercise of certain other powers under the Health Protection and Promotion Act.
>
> Under section 13 of the Act, a medical officer of health or a public health inspector by a written order may require a person to take or refrain from taking any action that is specified in the order in respect of a health hazard. An order may be made under section 13 where the medical officer of health or the public health inspector is of the opinion, on reasonable and probable grounds:
>
> that a health hazard exists in the health unit served by him or her; and
>
> that requirements specified in the order are necessary in order to decrease the effect of or eliminate the health hazard.
>
> An order under s. 13 may include, but is not limited to:
>
> requiring the vacating of premises;
>
> requiring the placarding of premises to give notice to an order requiring the closing of the premises;

> requiring the removal of anything that the order states is a health hazard from the premises or the environs of the premises specified in the order;
>
> requiring the cleaning or disinfecting, or both, of the premises or the thing specified in the order; and
>
> prohibiting or regulating the use of any premises or thing.
>
> Because the list[127] is not exhaustive, it is arguable that a term could include ordering decontamination of a person, where the legal test under s. 13(2) is met.

It is far from clear, and arguably doubtful, that this interpretation of the Act is correct. While s. 13(1) states that the medical officer of health may require a person to take or refrain from taking any action that is specified in the order in respect of a health hazard, a review of the types of things authorized reveals that none of the contemplated actions include a power to do something to a person physically, such as deten-

---

127. This is not a complete list of the specified powers in s. 13(4). Subsection 13(4) provides:

> An order under this section may include, but is not limited to,
>
> (a) requiring the vacating of premises;
>
> (b) requiring the owner or occupier of premises to close the premises or a specific part of the premises;
>
> (c) requiring the placarding of premises to give notice of an order requiring the closing of the premises;
>
> (d) requiring the doing of work specified in the order in, on or about premises specified in the order;
>
> (e) requiring the removal of anything that the order states is a health hazard from the premises or the environs of the premises specified in the order;
>
> (f) requiring the cleaning or disinfecting, or both, of the premises or the thing specified in the order;
>
> (g) requiring the destruction of the matter or thing specified in the order;
>
> (h) prohibiting or regulating the manufacturing, processing, preparation, storage, handling, display, transportation, sale, offering for sale or distribution of any food or thing;
>
> (i) prohibiting or regulating the use of any premises or thing.

tion, examination and treatment, as is authorized in s. 22 of Part IV. On the contrary, all powers specified in s. 13 relate to directions to do something or refrain from doing something to a premises. While one might argue that the powers in s. 13(4) are not exhaustive, the fact that the statute does not specifically prohibit something does not mean that it is permitted. Part III, read as a whole, does not suggest that any of the powers are intended to authorize any physical action taken against a person.

As noted later in the chapter titled "*A Stronger Health Protection and Promotion Act,*" the decontamination of a person gives rise to a number of issues including their right to refuse, and the process by which a person may be decontaminated against their will. Unlike the powers in s. 35, contained in Part IV, there is nothing in Part III that establishes a process by which a person who refuses to abide by an order of the medical officer of health may be legally forced to do so. It would appear that s. 102(1),[128] which allows a Superior Court judge to restrain a contravention of an order made under the Act, would be the avenue of enforcement. Contrasting the powers in s. 35 with those contained in s. 102(1) suggests that it is very unlikely that s. 102(1) was intended to force someone to comply with a process or procedure ordered against them physically. There is no authority in s. 102(1) to force a person to submit to such a procedure or process; rather it speaks to restraining a contravention. Furthermore, there is no authority to detain a person in s. 13. There is a very strong argument that nothing in s. 13 authorizes the medical officer of health to make an order that involves interference with or direction over a person's bodily integrity.

There is a stream of legal opinion, exemplified by the Ministry of Health and Long-Term Care opinion set out above, that s. 13 can be used to supply any deficiency in

---

128. Subsection 102(1) provides:

> 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.
>
> Proceedings to prohibit continuation or repetition of contravention
>
> (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.

other parts of the Act, such as Part IV, Communicable Diseases. Unfortunately, where the authority to act is unclear or not explicitly authorized, this is a section to which public health lawyers must resort, in hopes that the interpretation will stand. It is unacceptable to have important powers, such as the power to issue directives to health care facilities in respect of unsafe infection control practices, or the power to decontaminate individuals, subject to uncertainty and legal wrangling and debate. When these powers are needed it will hamper public health's ability to respond if debate and legal wrangling ensue and lawyers spend days writing legal opinions trying to prove whether the power exists. The Act must be clear. If the current system of three streams of operational powers contained in Part III, Part IV and Part VII is to be maintained, it must be apparent to anyone using the *Health Protection and Promotion Act* what each Part authorizes and how one Part relates to another.

Finally, in respect of s. 13 of the Act, some individuals and organizations have submitted to the Commission that the definition of "health hazard" needs to be reconsidered and expanded.[129] The precise language needed to define a health hazard is beyond the expertise of the Commission. It is recommended, however, that the Ministry of Health, in consultation with local public health officials, review the current definition with a view to determining if there are situations amounting to health hazards that are not currently captured in the Act.

## *Recommendations*

**The Commission therefore recommends that:**

- **The *Health Protection and Promotion Act* be amended to clarify whether the powers contained in the various parts of the Act apply outside of the Part of the Act in which the power is contained. For example, does s. 13 apply in the case of a communicable disease?**

- **The Ministry of Health and Long-Term Care consider whether the definition of "health hazard" needs to be updated or expanded.**

129. For example a number of submissions recommended that "health hazard" be amended to include a person.

## Clarify Standards for Intervention

Another aspect of the Act requiring clarification is the apparently haphazard overlapping standards for intervention. The standards for intervention are the legal triggers that allow the medical officer of health to act. They are, however, scattered throughout the Act in a seemingly haphazard and illogical manner:

- for the purpose of preventing, eliminating and decreasing the effects of health hazards in the health unit (s. 10(1));
- necessary in order to decrease the effect of or to eliminate the health hazard (s. 13(2));
- immediate risk of an outbreak of communicable disease (s. 22(2)(a));
- communicable disease presents a risk to the health of persons in the health unit served by the medical officer of health (s. 22(2)(b));
- necessary in order to decrease or eliminate the risk to health presented by the communicable disease (s. 22(2)(c));
- significantly increase the risk to the health of any person (s. 22(5.0.3));
- significant risk to the health of the public (s. 35(11)(b));
- a risk to the health of any persons (s. 86(1));
- likely to have an adverse effect on the health of any person (s. 96(4)(c)(d) and (e)).

The Act has both hard triggers, such as reasonable and probable grounds, and soft triggers, such as simply having the opinion that a risk to the public's health exists. While these differential triggers may be appropriate, there does not seem to be any logic to their current placement in the Act.

For example, in s. 22 of the Act, the standard of intervention is "opinion, upon reasonable and probable grounds." This is a high hurdle to meet. In the case of communicable diseases, it is a hard trigger that demands that the medical officer of health, before making an order, meet the criminal or quasi-criminal standard of proof

required before instituting *Criminal Code* or *Provincial Offences Act* proceedings.[130] This high criminal standard of proof may not exist in the early stages of an infectious disease outbreak or infection control problem. What then is the authority to act where a health risk or hazard is present but does not meet the trigger for intervention in s. 22, either because it is in the early stages and unknown or because it is something that is not a classified communicable disease?[131]

Again, this standard of intervention may be appropriate for some actions but too high for others. For example, when deciding to close a hospital, one would expect the medical officer of health to be governed by a high standard of intervention; one would expect that this would be a "hard" trigger. On the other hand, an order under s. 22(4)(d), requiring that a place be cleaned or disinfected, need not require a high standard of invention and therefore should be a "soft" trigger.

It is time to take a hard look at this disparate collection of standards, and to develop some consistency, some scalable set of triggers so there is a clear progression from a low-end risk with low-end interventions to high-end risk with high-end interventions. What is needed is a hard look at the standards and legal triggers for intervention, and an adjustment to ensure that the soft trigger is available where the danger of inaction outweighs the need for objectively provable grounds, but that the hard trigger is maintained for other cases.

## *Recommendations*

**The Commission therefore recommends that:**

- **The Ministry of Health and Long-Term Care review the numerous standards of intervention contained in the Act, examples of which are noted above, with a view to amending the Act to simplify and rationalize the apparently haphazard and overlapping standards for intervention, and to ensure that whether there is a hard trigger or a soft trigger, it should be rationally connected to the power being wielded.**

- **Section 22 of the *Health Protection and Promotion Act* be amended to adjust the standard of intervention to provide that the medical officer of health can**

130. R.S.C. 1985, C-46, s. 504; R.S.O. 1990, c. P-33.

131. The same standard applies in s. 13 and the same issue arising through the use of this standard in Part IV, arise in its use in Part III.

**take necessary action without the criminal or quasi-criminal standard of objective proof on reasonable and probable grounds.**

## Strengthen Section 22

In respect of communicable diseases, public health officials derive most of their power from s. 22. They rely on it to give them authority to intervene and take action to protect the public. Because of its importance, Ministry officials must be vigilant in ensuring that the section works and that any weakeness or legal ambiguities are addressed clearly and swiftly.

For example, some public health officials have expressed concern about the practical dificulties of administering s. 22 of the Act particularly where the subject of the order is something other than an actual person, for instance a homeless shelter. Subsection 22(1) provides that an order may be made against a "person". Subsection 22(5) provides that an order may be directed to a person:

a) who resides or is present;

b) who owns or is the occupier of any premises;

c) who owns or is in charge of any thing;

d) who is engaged in or administers an enterprise or activity;

in the health unit served by the medical officer of health.

It may be difficult to determine legal ownership or administration in a timely fashion. If the order is directed at an institution and it requires steps that affect many people, it is critical to direct the order to a wider audience than the person who occupies the premises. Ascertaining who is "in charge" may also be difficult and time-consuming. The problem requires examination by the Ministry of Health and Long-Term Care in consultation with the public health legal community.

Another issue raised by those working in the field is the lack of clarity whether a s. 22 order written and served in one health unit applies outside of that health unit. Those with infectious diseases do not always stay in one unit. When they cross boundaries, the unit in which they are found should be entitled to rely on the existing order from the other unit. It is a waste of scarce resources if every unit must produce their own written order each time an infectious person decides to cross health unit boundaries.

## *Recommendations*

**The Commission therefore recommends that:**

- **The Ministry of Health and Long-Term Care, in consultation with the public health community, examine the issue of any practical difficulties of administering s. 22, with a view to make it more effective for those who rely on its powers.**

- **The *Health Protection and Promotion Act* be amended to provide that an order made under s. 22, in respect of a person infected with a communicable disease, is valid in any health unit in Ontario.**

# Conclusion

The above highlights just a few examples of confusion in the Act. The Act must be clear and workable for those who use it to obtain their day to day authority to protect the public's health. Otherwise, uncertainty and confusion will be the refuge for a noncompliant person or institution. Action that is necessary to protect the public may be delayed as public health officials and lawyers try to determine what they can do and when. If they are bold enough to act in the face of uncertainty, they risk legal challenges to their authority, which may in turn delay their ability to act effectively.

The *Health Protection and Promotion Act* is a complex statute that has served the people of Ontario well since its inception. That being said, in the aftermath of SARS, it is time for the Ministry of Health and Long-Term Care to review the Act, in consultation with the Attorney General and those who work daily with the Act on the front lines of public health defence.

## *Recommendations*

**The Commission therefore recommends that:**

- **The four present categories of disease: infectious, communicable, reportable, and virulent, be simplified and reduced to two categories with clear boundaries and clear legal consequences.**

- **The *Health Protection and Promotion Act* be amended to clarify whether the powers contained in the various parts of the Act apply outside of the Part of the Act in which the power is contained. For example, does s. 13 apply in the case of a communicable disease?**

- **The Ministry of Health and Long-Term Care consider whether the definition of "health hazard" needs to be updated or expanded.**

- **The Ministry of Health and Long-Term Care review the numerous standards of intervention contained in the Act, examples of which are noted above, with a view to amending the Act to simplify and rationalize the apparently haphazard and overlapping standards for intervention, and to ensure that whether there is a hard trigger or a soft trigger, it should be rationally connected to the power being wielded.**

- **Section 22 of the *Health Protection and Promotion Act* be amended to adjust the standard of intervention to provide that the medical officer of health can take necessary action without the criminal or quasi-criminal standard of objective proof on reasonable and probable grounds.**

- **The Ministry of Health and Long-Term Care, in consultation with the public health community, examine the issue of any practical difficulties of administering s. 22, with a view to make it more effective for those who rely on its powers.**

- **The *Health Protection and Promotion Act* be amended to provide that an order made under s. 22, in respect of a person infected with a communicable disease, is valid in any health unit in Ontario.**