Introduction and Executive Summary

Introduction — Fixing the System

The Commission's first interim report in April 2004[1] recommended major changes in the public health system. The government accepted those recommendations and committed itself to implement them in an ambitious three-year programme. Improvements so far have been significant. But much more work remains to fix the broken public health system revealed by SARS in 2003.

More financial and professional resources are needed, otherwise all the legislative changes and programme reforms will prove to be nothing but empty promises. The test of the government's commitment will come when the time arrives for the heavy expenditures required to bring our public health protection up to a reasonable standard.

This second interim report deals with legislation to strengthen the *Health Protection and Promotion Act*[2] and to enact emergency powers for public health disasters like SARS or flu pandemics. It is produced now to respond to current government plans for further amendments to the *Health Protection and Promotion Act* and radical changes to the *Emergency Management Act*.[3]

The recommendations in this second report are interim, not final or exhaustive. The report touches only on those issues subjected already to sufficient discussion between the government and the health community to make them ripe for action. More extensive consultation is required on issues such as the role of public health in infection control and surveillance in health care facilities, the proposals for emergency powers such as compulsory immunization, the enhancement of infection control standards through amendments to legislation such as the *Public Hospitals Act*[4] and the *Long-*

1. The Honourable Mr. Justice Archie Campbell, The SARS Commission Interim Report, *SARS and Public Health in Ontario,* April 15, 2004. (Subsequently referred to as the Commission's first interim report.)
2. R.S.O. 1990, c. H-7.
3. R.S.O. 1990, c. E-9.
4. R.S.O. 1990, c. P-40.

Term Care Act, 1994,[5] and communication between public health and health care facilities.

Suggestions have been received for legislation to strengthen occupational health and safety protection for health workers. That issue will be dealt with in the final report. Occupational health and safety is a vital aspect of the Commission's work. It cannot however be addressed adequately in the limited confines of this report and must be addressed together with the stories of the many health care workers who sacrified so much to battle SARS.

The Commission continues to investigate the story of SARS. As noted in Appendix C, Commission's Process and Ongoing Work, more than 400 interviews have been held, including victims of SARS and those who lost family members. Their stories and those of health care workers and others who fought bravely to contain SARS have informed these preliminary reports and will be told in the final report. The final report also will give a general account of what happened during SARS and what further steps are necessary, beyond those already recommended in the Commission's two interim reports, to correct the problems disclosed by SARS.

Independent Medical Leadership

Medical leadership that is free of bureaucratic and political pressure is what builds public confidence in the fight against deadly infectious diseases such as SARS.

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'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.

5. S.O. 1994, c. 26.

The Commission, noting the government's steps to give the Chief Medical Officer of Health more independence, recommends completion of the work of ensuring that office is independent of political considerations. Leadership and management of Ontario public health should be consolidated in the hands of the Chief Medical Officer of Health. This requires placing public health emergency planning, preparedness, mitigation, recovery, coordination and public risk communication under the direct authority of the Chief Medical Officer of Health. It also requires transfer of operational authority for public health labs, assessors, inspectors and enforcement from the Minister of Health to the Chief Medical Officer of Health.

The Commission also recommends that a parallel measure of independence be given to local medical officers of health, who are the backbone of our protection against disease in Ontario's communities. The Commission noted that in some municipalities the local medical officer of health is buried in the municipal bureaucracy. (More on those problems is found in Chapter 3 Local Governance.) Local medical officers of health must be able to to speak out about local public health concerns without fear of resprisal, dismissal or other adverse employment consequences.

Since SARS, there has been a proliferation of emergency committees throughout the provincial government. Strangely the Chief Medical Officer of Health is not in charge of those committees that bear directly on issues such as pandemic influenza which are central to our defence in public health emergencies. SARS showed us that while cooperation and teamwork are important, it is essential that one person be in overall charge of our public health defence against infectious outbreaks. The Chief Medical Officer of Health should be in charge of public health emergency planning and public health emergency management.

Public Health Governance

Any one of the 36 local health units can be the weak link in Ontario's chain of protection against infectious outbreaks. It takes only one dysfunctional health unit to incubate an epidemic that brings the province to its knees.

Public health problems often result from the system of two governments, provincial and municipal, being involved in the operation of local health units. The public health community is divided into those who think this split governance is satisfactory, or at least salvageable, and those who say 100 per cent of funding and control of local health units should be uploaded to the province.

The Commission has heard continuing reports of municipalities diverting public health staff and funds to other departments, boards of health with members whose sole objective was to reduce health budgets, and medical officers of health fighting municipal bureaucracies and budget constraints to attain a proper standard of public health protection.

Not all local health units are dysfunctional. Some are well governed, but certainly the current weak state of affairs is unacceptable and cannot continue.

It is too early to say the system of divided governance is hopeless.

The government needs to make a clear decision on local health governance by the end of the year 2007, which is after the pending public health capacity review and implementation of recommendations. That gives the government time to decide whether the current system can be fixed with a reasonable outlay of resources or whether control of local public health should be uploaded 100 per cent to the province.

Ontario cannot go back and forth like a squirrel on a road, vacillating between the desire for some measure of local control and the need for uniformly high standards of infectious disease protection throughout the entire province. A clear decision point is required before some deadly infectious disease rolls over the province.

Whatever the ultimate solution to these problems, the Commission recommends five immediate measures required to strengthen public health governance and ensure a uniformly high standard of protection across the province: 1) Protect the local medical officer of health from bureaucratic encroachment; 2) Require by law the regular monitoring and auditing of local health units; 3) Change the public health programme guidelines to legally enforceable standards; 4) Increase provincial representation on local boards of health and set qualifications for board membership; and 5) Introduce a package of governance standards for local boards of health.

Local boards of health must be strengthened to ensure that those who sit on them are committed to and interested in public health, that they clearly understand their primary focus is on the protection of the public's health, and that they broadly represent the communities they serve.

Tuning Up the Legal Engine of Public Health

The work of protecting Ontarians from infectious disease is driven by the legal engine called the *Health Protection and Promotion Act*. The Act is a complex statute that has served the people of Ontario well since its inception. However, in the aftermath of SARS it is time for the Ministry of Health and Long-Term Care to review the Act to ensure there is no lack of clarity about the precise powers and authority of public health officials to intervene early and manage an outbreak effectively. The review should be conducted in consultation with those who work daily with the Act on the front lines of public health defence.

The Act needs a major overhaul to remove ambiguities that are difficult even for those who work with it daily. The Commission offers four examples of what needs to be done: 1) simplify disease categories; 2) clarify the three streams of power to intervene; 3) simplify the process by which the Chief Medical Officer of Health can exercise powers in Parts III and IV; and 4) strengthen and clarify the powers in s. 22.

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, and public protection will suffer as public health officials and lawyers try to determine what they can do and when.

Strengthening Day to Day Public Health Powers

Public health officials require better access to health risk information and greater daily authority, together with more resources and expertise to investigate, intervene, and enforce.

The Commission has identified seven fields of public health activity that require additional daily authority under the *Health Protection and Promotion Act:*

- in relation to infectious diseases in hospitals;
- to acquire information necessary for them to protect the public from a health risk;
- to investigate health risks to the public;

- for the Chief Medical Officer of Health to establish an adjudication system whereby decisions of local medical officers of health regarding classification of disease may be reviewed;

- for the Chief Medical Officer of Health to issue directives to hospitals and other health care institutions;

- to detain, as a last resort, noncompliant individuals infected with a virulent disease who pose a risk to public health;[6]

- to enter, as a last resort, a private dwelling to apprehend a noncompliant person infected with a virulent disease who poses a risk to public health.[7]

The Commission sees a greater role for public health in infection control, whether it be in a hospital, long-term care facility or private clinic. A medical officer of health must have authority under the *Health Protection and Promotion Act* to monitor, investigate and intervene in cases where infectious diseases or inadequate infection control poses a risk to public health.

It recommends entrenching in the Act that each local public health unit have a presence on hospital infection control committees.

Reporting Infectious Disease

The conditions of reporting infectious diseases in Ontario are unnecessarily complex, sometimes even illogical. A fundamental weakness is that the *Health Protection and Promotion Act* does not enable public health authorities to get from hospitals and other health care institutions the information needed to protect the public against infectious disease. Without fast access to detailed information about cases of infectious disease, public health cannot investigate, or even be aware of impending danger and therefore cannot protect the public.

The legal obligation to report infectious disease is a foundation of every system of public health legislation. It is necessary not only to encourage reporting but to ensure

6. See the full text of this recommendation which contains safeguards and limits including early court hearings.
7. *Ibid.*

that the confidentiality laws, designed to protect patient privacy, do not unintentionally undermine the ability of public health authorities to fight the spread of infectious disease.

The Commission recommends a series of changes to the Act to strengthen infection disease reporting. These range from developing standard forms and means of reporting, to clarifying chains of reporting, to educating health care workers about reporting requirements.

The Commission recommends a broad power for the Chief Medical Officer of Health to obtain information, including personal health information, and lab specimens, for the purpose of investigating and preventing the spread of infectious disease.

Privacy and Disclosure

The Commission recommends statutory amendments to make clear that the duty to disclose personal health information about cases of infectious disease to public health officials prevails over privacy legislation. Privacy, an important value, cannot be allowed to stand in the way of necessary reporting that is required by law to protect the public against infectious disease. Privacy legislation was never intended to impede the flow of vital health information mandated by the *Health Protection and Promotion Act*.

The law should be so clear that lawyers do not have to argue with each other in the middle of a public health crisis about obligations to disclose information to public health. To fight infectious disease, public health authorities require timely access to personal health information.

The Commission recommends amendments to the *Health Protection and Promotion Act* to clarify the ability of medical officers of health to share, with appropriate safeguards, personal health information where necessary to protect the public against the spread of infections.

The power to obtain personal health information brings with it strong obligations to safeguard its privacy. The Chief Medical Officer of Health should review and if necessary strengthen the internal protocols and procedures that safeguard the privacy of personal health information received by public health authorities.

Protecting Whistleblowers

Health care workers who disclose a public health hazard require legal protection from workplace reprisal. Without whistleblower protection, fear of workplace consequences might discourage the timely disclosure of a public health risk.

Whistleblowing protection should apply to a broad category of people, from nurses to doctors, to porters and clerks and cleaning staff. It should apply to anyone who employs or engages the services of a health care worker, whether part-time, casual, contract or full-time staff. Each and every health care worker in the province should be assured an equal level of protection, regardless of location of employment or employment status.

The Commission recommends that whistleblowing to the local medical officer of health or the Chief Medical Officer of Health be protected by law.

Quarantine

Any fight against infectious disease depends above all on public cooperation. SARS could not have been contained in Toronto without the tremendous public cooperation and individual sacrifice of those who were quarantined. In fact, this high level of public cooperation has drawn the attention of foreign researchers.

It is essential to ensure that the spirit of cooperation shown during SARS is not taken for granted. It must be nurtured and promoted.

Therefore, the Commission recommends that all government emergency plans have a basic blueprint for the most predictable types of compensation that can be tailored following the declaration of an emergency.

The *Health Protection and Promotion Act* should be amended to allow unpaid leaves for those quarantined or isolated and those who cannot work because they are caring for a dependent relative stricken in an infectious outbreak.

The Commission also recommends that s. 22(5.0.1) of the *Health Protection and Promotion Act* be amended to provide that the power to order and enforce the isolation of a group must, wherever practicable, be preceded by such degree of consultation with the group as is feasible in the circumstances.

The remarkable story of those who suffered quarantine without complaint will be told in the Commission's final report which will also address a number of concerns expressed about the administration of the quarantine powers.

Untangling Legal Access

SARS demonstrated weakness and confusion in the legal machinery for the enforcement of health protection orders under the *Health Protection and Promotion Act*, the legal engine that drives health protection. One lawyer told the Commission that their ability during SARS to give clear legal advice was at times hampered by weaknesses in the enforcement portions of the Act:

> During SARS, I would often say when asked if we could do something, 'you can try it, but if we are challenged we may be on shaky legal grounds and the courts will be in a very difficult position.'

Confusion and uncertainty are the only common threads throughout the legal procedures now provided by the *Health Protection and Promotion Act* for public health enforcement and remedies. Confusion and uncertainty can cause delays and delays can cost lives.

The Commission recommends amendment of the *Health Protection and Promotion Act* to address the problems of: a tangle of enforcement powers, procedural gaps in enforcement machinery, overlapping jurisdiction between the Ontario Court of Justice and the Supreme Court of Justice, lack of one-stop shopping for enforcement of orders in respect of infectious diseases, legal uncertainty in initiating and continuing enforcement procedures in court and the lack of systems to ensure legal preparedness in the application of enforcement machinery.

Health professionals and the lawyers who advise them require not only the clear authority to act in the face of public health risks. They require also a simple, rational, effective and fair set of procedures to enforce compliance and to provide legal remedies for those who challenge orders made against them.

Resources For Public Health Reform

SARS showed that Ontario's public health system is broken and needs to be fixed. Evidence of its inadequacy was presented in the Naylor Report,[8] the Walker Report,[9] and the Commission's first interim report.

Since then, as set out in Appendix B, much progress has been made. But this commendable start is merely the beginning of the effort to fix the public health system. The end will not be reached until Ontario has a public health system with the necessary resources, expertise and capabilities, and this will take years to achieve.

After long periods of neglect, inadequate resources and poor leadership, it will take years of sustained funding and resources to correct the damage. Like a large ship, a public health system, especially one as big and complex as Ontario's, cannot turn on a dime.

The point has to be made again and again that resources are essential to give effect to public health reform. Without additional resources, new leadership and new powers will do no good. To give the Chief Medical Officer of Health a new mandate without new resources is to make her powerless to effect the promised changes. As one thoughtful observer told the Commission:

> The worst-case scenario is to get the obligation to do this and not get the resources to do it. Then the Chief Medical Officer of Health would have a legal duty that she can't exercise.

To arm the public health system with more powers and duties without the necessary resources is to mislead the public and to leave Ontario vulnerable to outbreaks like SARS.

SARS focused on the need for public health to do more to protect us against disease, more by way of planning against threats like pandemic influenza, more by way of increased powers for public health authorities to monitor infectious threats in the

8. National Advisory Committee on SARS and Public Health, *Learning from SARS: Renewal in Public Health in Canada* (Health Canada: October 2003). (Subsequently referred to as the Naylor Report.)
9. 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.)

community and in health care institutions. It demonstrated that more public health resources are required in many areas, including:

- Laboratory capacity, expertise and personnel;
- Scientific advisory capacity and capabilities;
- Epidemiological expertise;
- Surge capacity;
- Infectious disease expertise and personnel;
- Public health human resources excellence and capacity; and
- Infectious disease information systems.

Emergency Legislation

The first goal of public health emergency management is to stop emergencies before they start by preventing the spread of disease. If a small outbreak is prevented or contained, draconian legal powers available to fight a full-blown emergency will not be needed.

Legal powers by themselves are false hopes in times of public crisis. Preparedness and prevention backed by enhanced daily public health powers are the best protection against public health emergencies.

Voluntary compliance is the bedrock of any emergency response. It is essential to compensate those who suffer an unfair burden of personal cost for cooperating in public health measures like quarantine.

The Commission recommends that emergency legislation require that every government emergency plan provide a basic blueprint for the most predictable types of compensation packages and that they be ready for use, with appropriate tailoring, immediately following any declaration of emergency.

Emergency powers are inherently dangerous. They carry the twin dangers of overreaction and underreaction.

The first danger is overreaction. Every emergency power, once conferred, "lies about like a loaded weapon ready for the hand of any authority that can bring forward a plausible claim of an urgent need."[10] To a hammer, everything looks like a nail. To some emergency managers, every problem may look like an opportunity to invoke emergency powers.

The second danger is underreaction. In the face of a deadly new disease with an uncertain incubation period, ambiguous symptoms, no diagnostic tests, uncertainty as to its infectiveness and mechanisms of transmission, and no idea where in the province it may be simmering, decisive action may be necessary that turns out in hindsight to have been excessive.

The central task of emergency legislation is to guard against overreaction by providing safeguards and to guard against underreaction by avoiding legal restrictions that prevent the application of the precautionary principle.[11]

There are no pure public health emergencies. Although pandemic influenza might start as a public health emergency, it would rapidly snowball into a general emergency. And big general emergencies that arise outside the field of public health usually have a public health component.

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10. Mr. Justice Jackson, dissenting, in *Korematsu vs. United States*, 323 U.S. 214 (1944) in respect of the race-based internment of Japanese Americans during WW II.
11. The precautionary principle addresses the problem of underreaction by pointing out that in face of a grave risk it is better to be safe than sorry:

    > … the absence of full scientific certainty shall not be used as a reason for postponing decisions where there is a risk of serious or irreversible harm.
    >
    > Privy Council of Canada, *A Framework for the Application of Precaution in Science-based Decision Making About Risk,* (Ottawa: 2003), p. 2.

    Mr. Justice Krever emphasized this principle in the Commission of Inquiry on the Blood System in Canada:

    > Where there is reasonable evidence of an impending threat to public health, it is inappropriate to require proof of causation beyond a reasonable doubt before taking steps to avert the threat.
    >
    > *Commission of Inquiry on the Blood System in Canada.* Final Report at page 295, see also pages 989 to 994.

Public health emergencies are unique from typical disasters like floods, fires, power blackouts, or ice storms. In floods and power losses people can take certain protective actions on their own, but they have few personal defences against an invisible virus that can kill them. They must turn to trusted medical leadership.

The most important thing in a public health emergency is public confidence that medical decisions are made by a trusted independent medical leader such as the Chief Medical Officer of Health free from any bureaucratic or political pressures. This is particularly true of public communication of health risk. People trust their health to doctors, not to politicians or government managers. It is essential that the public get from the Chief Medical Officer of Health the facts about infectious risks to the public health and the need for precautions and advice on how they can avoid infection. It is essential when public precautions are relaxed, like the removal of protective N95 respirators in hospitals, the re-opening of hospitals, or the declaration that it is business as usual in the health system, that these decisions are made and are seen to be made by and on the advice of the independent Chief Medical Officer of Health free from any bureaucratic or political pressures. It is essential in a public health emergency, or the public health aspects of an emergency such as flood-borne disease, that the Chief Medical Officer of Health be the public face of public communication from the government.

The Commission recommends that emergency legislation provide the Chief Medical Officer of Health with clear primary authority in respect of the medical and public health aspects of every provincial emergency.

In times of emergency it is essential to know who is in charge. As Dr. Basrur noted in her appearance before the Justice Policy Committee:

> The point is that someone has to be in charge; people have to know where the buck stops, where decisions are made and where they can be unmade, and who the go-to person is.

The details of the consultation and cooperation between the Commissioner of Emergency Management and the Chief Medical Officer of Health need not be reduced to legislative form. The inevitable boundaries issues can be solved by cooperation, advance planning and above all by common sense. All that is required is for the Commissioner of Emergency Management and the Chief Medical Officer of Health, whoever may succeed to those jobs from time to time, to park their egos outside the door of the incident room and get on together with the job of managing the emergency. Both require not only confidence in their authority but also a clear

acceptance of their mutual roles and limitations.

The Commission reviews competing models of emergency legislation including the "inherent powers" model, an essential element of Ontario's present system which provides no extra legal powers for the management of emergencies and relies instead on unwritten powers. Although this model, under which 218,000 people were evacuated from their homes in the 1979 Mississauga chlorine gas derailment was adequate in pre-Charter times, the advent of the *Charter of Rights and Freedoms*[12] other developments since 1979 suggest it may no longer be adequate today.

Although Ontario got through SARS without any special emergency powers the prospect of pandemic influenza or indeed any outbreak more serious than SARS requires the enactment of explicit public health emergency powers.

Because there is no clear line between public health emergencies and general emergencies it would be wrong to introduce separate, freestanding, parallel emergency regimes, one for public health emergencies and the other for all other big emergencies. The existence of two parallel regimes would bring nothing but legal confusion and administrative disorder, two things no one wants in any emergency.

The government has expressed its intention to proceed with general emergency legislation along the lines suggested in Bill 138, an *Act to Amend the Emergency Management Act* and the *Employment Standards Act, 2000*, which received first reading on November 1, 2004 as a private member's bill produced by the Standing Committee on Justice Policy after public hearings.

The Commission's mandate does not cover general emergency legislation for war, famine, flood, ice storms and power blackouts and the government decision to proceed with Bill 138 is not within the Commission's terms of reference. Because the government has chosen Bill 138 as the vehicle for all emergency legislation including public health emergency legislation the Commission must say something about Bill 138 as a vehicle for public health emergency powers.

The thoughtful work of the Justice Policy Committee in its hearings and its production of Bill 138 must now be completed. A sober second thought is required. That sober second thought must be informed by the regular processes that ordinarily precede the development of any important piece of legislation including in particular

12. Schedule B, *Constitution Act*, 1982.

a fundamental legal and constitutional review by the Attorney General. The Attorney General has indicated that he is fully engaged in reviewing Bill 138 to ensure that it meets necessary legal and constitutional requirements.

The strengths of the Committee process are obvious to anyone who has had an opportunity to review its proceedings. Certain legal concerns, flowing largely from the unusual process imposed on the Committee, are referred to in correspondence between the Commission and the government, set out in Appendix H, and are reviewed in this chapter. The essence of the Commission's concern is the unusual process of proceeding to a draft bill of such profound legal importance without prior policy and operational analysis by departments of government, and without prior legal and constitutional scrutiny by the Attorney General of the kind he has indicated he is now undertaking.

The power of compulsory mass immunization is a paradigm for public health emergency powers. It bristles with legal issues that typify any emergency proposal to interfere with individual liberties for the sake of the greater public good. It exemplifies the legal and policy and practical problems that must be addressed in every analysis of every public health emergency power. Yet it has attracted less policy analysis and discussion than other proposed powers such as the power to ration medical supplies. The power of mass compulsory immunization is not yet ripe for enactment and requires the type of legal, practical, and policy analysis needed for every proposed emergency power.

Ontario's emergency legislation will probably be challenged in court at some time. It will be a major blow to the integrity of the legislation should a court strike down as unconstitutional any part of the statute or any emergency order made under the statute. It is essential to ensure in advance, so much as possible, that the legislation conforms with the Canadian *Charter of Rights and Freedoms*.

The Commission recommends that the government and the Attorney General in their review of Bill 138 consider whether it adequately addresses the public health emergency powers referred to in this chapter.

The Commission reviews a number of legal issues around the powers in Bill 138, for instance the power to compel anyone to disclose any information demanded by the government. The Commission recommends that it be made clear whether a journalist or lawyer who refuses to disclose confidential information or the identity of its source is liable to the penalty provided by Bill 138, a fine of up to $100,000 and a term of imprisonment for up to a year for every day on which the refusal continues.

The Commission points to a number of areas that exemplify the need for fundamental review of Bill 138 including the proposed power to override laws such as the *Habeas Corpus Act,*[13] the *Legislative Assembly Act,*[14] the *Human Rights Code,*[15] the *Elections Act,*[16] and the *Courts of Justice Act.*[17]

Appendices

The appendices review the action recommended in the Commission's First Interim Report, the work done by the government since then to improve the public health system, and the ongoing work of the Commission.

13. R.S.O. 1990, c. H-1.
14. R.S.O. 1990 c. L-10.
15. R.S.O. 1990 c. H-19.
16. R.S.O. 1990, c. E-6.
17. R.S.O. 1990, c. C-43.