Office of the Auditor General of Ontario

COVID-19 Preparedness and Management

Special Report on Outbreak Planning and Decision-Making

November 2020

Special Report

Chapter 2:

Outbreak Planning and Decision-Making

1.0 Summary

This report is one in a series of reports undertaken by our Office on the provinces' response to Coronavirus Disease 2019 (COVID-19) (see **Figure 1**). It focuses on the Ontario's health sector COVID-19 response between January 2020 (when the first COVID-19 case in Canada was confirmed in Ontario) and August 2020.

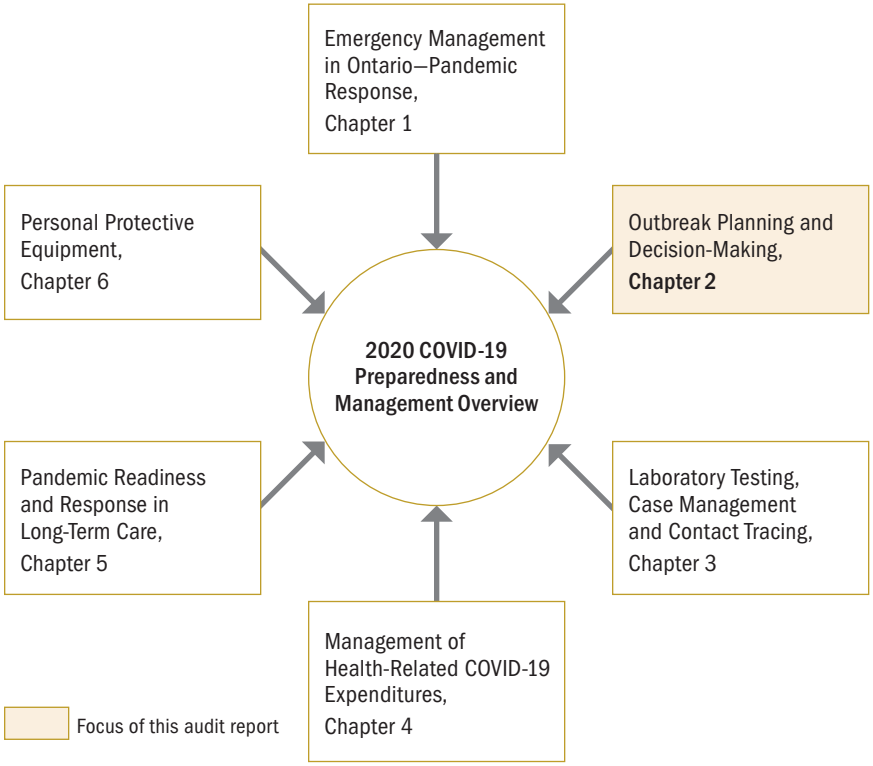
We understand that the COVID-19 pandemic presented a challenge to health experts and government decision-makers around the world that in many ways was unprecedented in its impact and complexity. Ontario health experts and Ontario government decision-makers worked together intensively to respond to the challenges of the pandemic, which were many, as Ontario struggled with Quebec as the two provinces hardest hit by the first wave. We can be grateful that the worst-case scenarios some anticipated in the spring of 2020 did not materialize. For example, Ontario's health system was not overrun during the first wave. That being said, the work we conducted resulting in this series of COVID-19 reports has shown that there are lessons to be learned and possible new approaches and actions to be taken to help the province better continue to respond to and recover from this pandemic, as well as to better prepare ourselves for future events of this kind.

COVID-19 moved quickly across the world after the first outbreak emerged in Wuhan, China in December 2019. Information on COVID-19 was shared federally with provincial and territorial governments through the Pan-Canadian Public Health Network, which started sharing information on COVID-19 in early January 2020. The first case of COVID-19 in Canada was confirmed on January 27, 2020 in Toronto, Ontario. To respond to growing concerns over the spread of COVID-19, Ontario's Ministry of Health (Ministry) established a Health Command Table on February 28, 2020 as a source of advice to the Minister of Health, Cabinet and the Premier. The Health Command Table was chaired by the Deputy Minister of Health. Other key participants in Ontario's COVID-19 response included the Chief Medical Officer of Health (who reported to the Deputy Minister of Health), Public Health Ontario (an agency responsible for providing scientific evidence and expert guidance on matters related to public health), Ontario Health (an agency responsible for managing health-care service needs across Ontario), and 34 public health units. The Health Command Table grew and took on an increasingly complex structure during the pandemic. Ontario's Health Command Table was not led by those with public health expertise. In British Columbia, the Provincial Health Officer (a role similar in structure to the Chief Medical Officer of Health) informed us that she and the Deputy Minister of Health consistently led the province's COVID-19 health response.

On March 25, 2020, the Secretary of Cabinet contracted with a consulting firm to provide advice on the design the organizational structure that

Figure 1: Six Key Areas of the COVID-19 Audit by the Office of the Auditor General of Ontario

Prepared by the Office of the Auditor General of Ontario



would be used for Ontario's COVID-19 decision-making, building upon what was in place (such as the Health Command Table) and developing the Central Co-ordination Table, which began meeting April 11, 2020. The table, chaired by the Secretary of Cabinet and the Premier's Chief of Staff, supports an integrated approach to the Government's health and non-health-related COVID-19 response. The ultimate decision-making power for responding to COVID-19 (such as the approval of new expenditure for specific COVID-19 initiatives) lay with the Premier and the Cabinet, including the Minister of Health. Key public health officials often provided advice through the Health Command Table to the Minister of Health, who was the most direct link to the rest of Cabinet and the Premier.

Overall, we found that Ontario's response to COVID-19 in the winter and spring of 2020 was slower and more reactive relative to other jurisdictions. This was partly due to an overall command structure that evolved to become cumbersome, with numerous participants at multiple tables and sub-tables. The command structure also was not dominated by appropriate expertise (key public health officials did not have the top leadership roles and did not fully exercise their powers).

As a result, Ontario's response included decisions that ran contrary to expert advice. One example was the decision in May 2020 to expand testing to individuals without COVID-19 symptoms despite limited benefit; another example was the decision to require all visitors to long-term-care homes to confirm they had received a negative COVID-19 test result.

We also found that key lessons identified in the aftermath of Severe Acute Respiratory Syndrome (SARS) were not implemented prior to or followed during Ontario's COVID-19 response. For example, the SARS Commission's final report identified the precautionary principle as the most important lesson of SARS. This principle identifies that where there is reasonable evidence of an impending threat

to public harm, reasonable efforts to reduce risk need not await scientific proof. Delays in establishing a COVID-19 emergency response structure, alerting Ontarians to avoid unnecessary travel, acknowledging community transmission, and requiring long-term-care homes to take necessary precautions all suggest this principle was not followed in a timely way.

The Public Health Measures table, which is a sub-table of the Health Command Table, provides advice to the Chief Medical Officer of Health (reporting to the Deputy Minister of Health) who then provides recommendations to the Minister of Health, the Premier and Cabinet on public health measures. However, this advice is not made public. Prior to the publishing of the provincial new COVID-19 response framework, *Keeping Ontario Safe and Open Framework*, on November 3, 2020, the Ontario government did not inform the public in a detailed way of the basis for decisions made related to this framework.

The following are some of our significant observations:

Ontario's COVID-19 Response Structure

- **The Health Command Table took on an increasingly complex structure during the pandemic with numerous participants involved.** On February 28, 2020, the Ministry set up the Health Command Table, which grew from 21 members to 90 participants (including 33 members and 57 attendees) in June 2020 and 83 participants (32 members and 51 attendees) as of August 31, and added on 25 sub-tables to feed into it, providing specific subject matter expertise. In total, more than 500 people are now involved in the Health Command Table. To further supplement the structure, Ontario Health also set up five Regional Steering Committees to discuss the local issues related to COVID-19. This structure is vastly larger than that used by British Columbia.
- **The Health Command Table and other aspects of the provincial response have not been led by public health experts.** Despite COVID-19 being a public health pandemic, we noted that those with public health expertise did not play a leading role in the Ministry's response:
- **The Chief Medical Officer of Health did not lead Ontario's response to COVID-19.** While the Ministry informed us that the Chief Medical Officer of Health and the CEO of Ontario Health were made "functional co-chairs" of the Health Command Table on March 6, 2020, some Health Command Table members we spoke with were unaware that the Chief Medical Officer of Health had this role. We learned that the Chief Medical Officer of Health did not chair any of the meetings, and the terms of reference for the table were never updated to reflect the Chief Medical Officer of Health as a co-chair. The Chief Medical Officer of Health was also not identified as a member of the Central Co-ordination Table, although he attended meetings when agenda items required it. The role of the Chief Medical Officer of Health was further reduced in August 2020, when the Ministry's Health Services Emergency Branch, which includes the Ministry Emergency Operations Centre (responsible for the COVID-19 response and emergency co-ordination), was transferred from the Chief Medical Officer of Health's portfolio to another Assistant Deputy Minister.
- **Public Health Ontario played a diminished role.** While Public Health Ontario was created after SARS specifically to provide scientific and technical expertise during health emergencies, some tasks that had been identified as Public Health Ontario's responsibility were done by Ontario Health. These tasks included consolidating and reporting provincial surveillance to the Health Command Table and co-ordinating provincial

laboratory testing for COVID-19. While Public Health Ontario representatives were on the Health Command Table, some Health Command Table members informed us that Public Health Ontario's expertise was not always sought, including on testing of all visitors to long-term-care homes for COVID-19.

- **The regional response structure was not led by public health experts.** Local Medical Officers of Health participated in Regional Steering Committees established by Ontario Health to implement provincial policy, but they were not the leaders of these tables. These tables were generally co-chaired by hospital CEOs and regional leaders who are Ontario Health staff. This hospital-sector leadership in place of public-health-sector leadership may not have been the most appropriate, given that almost 90% of people with COVID-19 as of August 31, 2020 were never hospitalized (although hospitals were involved in other aspects of the COVID-19 response, including operating assessment centres to collect specimens from people to be tested for COVID-19 and using hospital laboratories to perform COVID-19 testing).

Role and Power of the Chief Medical Officer of Health

- **Recommendations post-SARS to make the Chief Medical Officer of Health more independent were not fully implemented.** The 2004 *First Interim Report* of the SARS Commission made several recommendations to increase the powers and independence of the Chief Medical Officer of Health. Some of these were implemented, including giving the Chief Medical Officer of Health the power to issue directives to health-care providers and health-care entities. However, the Chief Medical Officer of Health is not making his advice to the Ministry publicly available, which was recommended by the SARS Commission.
- **The Chief Medical Officer of Health did not fully exercise his powers under the *Health Protection and Promotion Act* to respond to COVID-19.** The Chief Medical Officer of Health has the power to issue directives to health-care providers as well as to the province's 34 Boards of Health and local Medical Officers of Health. Directives require adopting or implementing policies or measures in relation to a public health event, emergency or pandemic. He may also exercise the powers of Boards of Health or a Medical Officer of Health when there is a risk to health. This includes the power to issue orders to any person to act to prevent, eliminate or decrease the risk. While the Chief Medical Officer of Health has the power to independently issue directives, he informed us he would not do so without consulting with others, including the Deputy Minister of Health and the Health Command Table. The Chief Medical Officer of Health did issue five directives to health-care providers and health-care entities, such as requiring the use of personal protective equipment and precautions to be taken by hospitals. But he did not issue directives to local Medical Officers of Health to ensure public health units responded consistently to the COVID-19 pandemic, nor did he issue directives on their behalf. We noted that the following consequences of this:
  - **A consistent provincial message and requirement on masking for the general public did not come until October and did not come from the Chief Medical Officer of Health.** Local Medical Officers of Health informed us that a provincial directive on rules and exceptions for wearing masks in public would have been welcome and was needed earlier to ensure better consistency across Ontario. For example, as of August 2020, there were differences in the ages at which municipalities exempted people from

mandatory masking, with some making masking mandatory for those older than age two and others making it mandatory only for those older than age 12. It was not until an October 3 Emergency Order (as opposed to a directive from the Chief Medical Officer of Health) that the province issued an emergency order mandating the use of face coverings in all public indoor settings across the province (with limited exceptions).

- **There was no provincial order to protect foreign farm workers.** The Chief Medical Officer of Health issued only a memo, not a directive, to local Medical Officers of Health, "strongly recommending" that they issue their own directives to decrease the risk of transmission of COVID-19 on farms. The memo was issued on June 21, 2020, eight weeks after the first farm outbreak on April 27, 2020. Of the 34 public health units, 13 had issued their own orders at the time of our audit. As of August 31, 2020, outbreaks had occurred in seven public health units, with about 1,335 total cases; two of these seven never issued an order.

Application of Lessons Learned from SARS

- **The key lesson from SARS was not followed.** The SARS Commission's final report identified the precautionary principle—the need to act where there is reasonable evidence of impending threat to public harm—as the most important lesson of SARS. However, the Ministry did not fully apply this as a guiding principle to take timely action to limit the impact of COVID-19 on Ontarians; other provinces did. We noted examples in these areas:
  - **The Ministry assessed the risk of COVID-19 to Ontario as low, despite evidence of spread in multiple countries, and developed its health response strategy more slowly than other provinces developed their multi-faceted response efforts.** In early January 2020, the Ministry Emergency Operations Centre became aware of COVID-19 and started monitoring its spread using information from the federal government. The Ministry Emergency Operations Centre reports to the Chief Medical Officer of Health and is responsible for monitoring the development of situations that may threaten the health system or health of Ontarians. On January 22, the Ministry Emergency Operations Centre emailed the Provincial Emergency Operations Centre, which is operated by the Ministry of the Solicitor General to monitor major emergency situations inside and outside of Ontario, about COVID-19. The email stated that "the risk to Ontarians is considered low," even though it also noted that "Cases have also been reported in neighbouring countries (e.g., Japan, South Korea, Thailand and Taiwan) and the United States." One day later, the World Health Organization's (WHO) Director-General identified in a speech that "WHO's risk assessment is that the outbreak is a very high risk in China, and a high risk regionally and globally." On January 25, the first presumed case was identified in Toronto, Ontario, which was confirmed to be COVID-19 on January 27. Ontario established its Health Command Table on February 28, 2020. Meanwhile, despite not having its first case until March 5, Alberta had already developed its overall response structure to COVID-19 by the end of January.
  - **The Ministry discouraged COVID-19 testing for most travellers, despite COVID-19 being found in many countries.** The first case definition for COVID-19, released on January 24, 2020,

targeted for testing only individuals who had recently returned from travel to Wuhan, China. This was updated to include travellers from all of China on February 7, 2020. At that time, COVID-19 had spread to about 20 countries (in addition to China and Canada). Out of concern that hospitalized patients who had travel history to countries other than China could have COVID-19, some hospitals started testing individuals who had returned from travel to other countries. However, on February 16, 2020, the Ministry of Health Emergency Operations Centre sent an e-mail to health stakeholders identifying that such practice by some hospitals was against the current Ministry COVID-19 case definition and advised health-care providers to test only those individuals within the case definition. Unlike Ontario, British Columbia did not restrict testing in this manner.

- **Travel advice provided by Ontario prior to the March break conflicted with the travel advice from other provinces and the federal government.** On March 9, the Chief Public Health Officer of Canada recommended that Canadians avoid all cruise ship travel due to COVID-19, and on March 11, the World Health Organization declared COVID-19 to be a global pandemic. On March 11, Alberta's Chief Medical Officer of Health recommended that anyone over the age of 65 with chronic health conditions not travel outside of Canada and that anyone else should think carefully about their travel plans. On March 12, the Provincial Health Officer in British Columbia also discouraged all non-essential travel outside of Canada due to the growing COVID-19 outbreak. Nevertheless, on March 12, Ontarians were still advised to go away during March break. This was contrary to the advice given by other provinces and the federal government. It was only the following day (March 13) that Ontario's Chief Medical Officer of Health sent health stakeholders a letter (dated March 12) advising that Ontarians avoid all non-essential travel. On March 13, the Prime Minister of Canada asked Canadians to avoid unnecessary travel and return to Canada immediately if they were abroad.
- **There was a delay in acknowledging the community transmission of COVID-19.** On March 15, 2020, Public Health Ontario noted that at least five of 15 COVID-19 cases under investigation were not linked to travel or known close contact with another case and therefore resulted from community transmission. Between March 15 and March 19, a number of local Medical Officers of Health, including those of Ottawa, Toronto, Simcoe Muskoka and Halton, also publicly identified local COVID-19 cases likely resulting from community transmission. On March 17, the Chief Medical Officer of Health for Ontario told media only that the province was "still waiting to see actual examples of community spread." Despite strong evidence of community transmission, the Ministry did not acknowledge it until March 26. In contrast, community spread was first announced on March 5 in British Columbia.
- **There was a delay in requiring long-term-care home staff to wear personal protective equipment.** On March 18, 2020, an Associate Medical Officer of Health at one of the public health units in Ontario emailed the Chief Medical Officer of Health that requiring long-term-care home workers to wear masks at all times while in the facility was an urgent priority. However, no immediate province-wide action was taken. On

March 18, the first COVID-19 outbreak at an Ontario long-term-care home occurred. It was not until well over two weeks later, on March 30, that the Chief Medical Officer of Health revised the directive for long-term-care homes, requiring them to follow the same directive as hospitals regarding the use of personal protective equipment for care of residents suspected or confirmed to have COVID-19. A directive requiring all long-term-care home workers to wear masks throughout their entire work shifts was not issued until April 8. At that time, the number of long-term-care home outbreaks had increased to 69 facilities, involving 857 cases and 88 deaths. This represented almost 15% of all cases reported in Ontario and 44% of all COVID-19 deaths at that time.

- **There was a delay in restricting long-term-care home staff from working at multiple facilities.** Four days after the first long-term-care home outbreak happened on March 18, 2020, the Chief Medical Officer of Health issued a directive to long-term-care homes (on March 22, 2020). The directive's wording was weak, suggesting only, "[w]herever possible, employers should work with employees to limit the number of different work locations that employees are working at." An emergency order limiting staff to one location was not issued until April 14. The order eventually came into effect on April 22, over a month after the first outbreak. In contrast, British Columbia enacted an order on March 27 (about three weeks earlier than Ontario) to restrict long-term-care home staff from working in more than one facility. On April 30, Ontario had about 3,647 cases and about 542 deaths associated with long-term-care homes, compared with about 410 such cases and about 70 such deaths in British Columbia. As of October 1, 2020, there were 8,721 cases and 1,917 deaths associated with Ontario long-term-care homes, compared with 860 cases and 169 deaths in British Columbia long-term-care homes.

Consideration of Expert Advice in Decision-Making

- **Expert advice was not always obtained or followed.** The purpose of setting up the Health Command Table was to serve as a single point of oversight to provide executive leadership and strategic direction to guide Ontario's health system's response to COVID-19. However, there were instances where decisions were not made based on expert advice. These included:
  - **Testing was expanded to individuals with no symptoms and no known COVID-19 exposure despite its limited value and no direction from the Health Command Table to do so.** On May 19, 2020, the Health Command Table was presented with an analysis of the results of testing individuals in congregate-care settings with no COVID-19 symptoms. The presentation showed that 99.8% of asymptomatic staff and residents at 20 long-term-care and retirement homes not in outbreak (that is, with no known COVID-19 cases) tested negative. Similar testing conducted at certain retirement homes in five public health units had the same result. Despite such evidence showing the limited value of asymptomatic testing where no known COVID-19 exposure exists, the province announced on May 24 that anyone could be tested for COVID-19 and it encouraged them to do so to help reduce transmission of COVID-19. At the time, the Health Command Table had not advised

in favour of this. On July 5, a Testing Strategy Expert Panel recommended against testing asymptomatic individuals, particularly those with no known exposure to COVID-19. Members of the Panel told us that since the inaugural meetings on April 5, 2020, asymptomatic persons who are not contacts of persons with COVID-19, or part of outbreak investigations, have never been recommended for testing. Despite this using laboratory resources and slowing how quickly symptomatic individuals could be tested, this policy was not changed by the Ministry until September 25, 2020.

- **All visitors to long-term-care homes were required to confirm they had tested negative for COVID-19.** On July 5, 2020, the Testing Strategy Expert Panel sub-table recommended to the Chief Medical Officer of Health that asymptomatic testing cease, and that visitors to long-term-care not be required to take a COVID-19 test. Despite these recommendations, the testing criteria for the general public were not revised until September 25, 2020, and the testing criteria for visitors to long-term-care homes remained unchanged. In contrast, British Columbia neither tests asymptomatic individuals with no known COVID-19 exposure nor requires long-term-care home visitors to be tested for COVID-19 prior to visiting.
- **COVID-19 Response Framework was much more lax than Public Health Ontario advised it should be.** On November 3, 2020, the province released the *COVID-19 Response Framework: Keeping Ontario Safe and Open* (COVID-19 Response Framework), which is a new colour-coded system for ranking public health units based on local situations, and determining measures and restrictions on businesses in each region. While Public Health Ontario was asked to provide advice on possible epidemiological indicators for the province's draft COVID-19 Response Framework, the actual framework did not contain all the recommended indicators and was generally more lax than what Public Health Ontario had advised. For example, while the COVID-19 Response Framework identifies that the Control (or Red) phase, which is the final stage before considering implementing a lockdown, will be triggered at an incidence of over 100 COVID-19 cases per 100,000 residents over seven days, Public Health Ontario advised triggering its equivalent of the final stage at 25 COVID-19 cases per 100,000 residents over seven days. Since the COVID-19 Response Framework in November was loosening restrictions in regions where the number of COVID-19 cases was still trending upward (such as Peel and Toronto), the Peel and Toronto public health units decided to impose restrictions on their own. On November 13, the province announced that after consultation with the Chief Medical Officer of Health and the Public Health Measures Table, it had lowered the threshold for each level in the framework. However, even the revised thresholds are still higher than those recommended by Public Health Ontario. For example, the revised threshold for the "Control (Red)" stage of 40 or more COVID-19 cases per 100,000 residents is still at least 1.5 times higher than the 25 cases recommended by Public Health Ontario. Public Health Ontario informed us it was supportive of the new measures, particularly given the change in COVID-19 prevalence since its first recommendations were provided.

Communication within Health Command Table and with the Public

- **Health Command Table meetings were held via teleconference and there is no detailed documentation of the discussions that took place.** All meetings were conducted via teleconference from late February 2020 to July 2020. It was only on July 14, 2020 that videoconferencing began. The number of Health Command Table participants eventually grew to 90 (33 members and 57 additional attendees) in June 2020 and 83 (32 members and 51 other attendees) as of August 31—and advice to the Minister of Health, Premier and Cabinet was provided based on only verbal consensus rather than a formal vote. Also, documentation to support any dissenting opinions was not provided. While key actions were recorded and distributed at each meeting of the Health Command Table, and meeting summaries were posted online, such summaries identified only the topics and themes of each meeting with no note of who attended and what the actual discussions were and what opinions were put forth. Key participants at the Health Command Table also shared with us their concern that it was not always clear who was speaking or whether the speaker had expertise in the subject matter being discussed and that some knowledgeable participants may have felt intimidated to speak due to the personalities and seniority of the other participants on the call.
- **Stakeholders were not always told about decisions that impacted them before the decisions were publicly announced.** Public health units and other impacted stakeholders were not always made aware of provincial decisions that impacted their operations prior to these decisions being announced publicly. This left these parties unprepared to act in a timely manner. For example:
  - On May 24, the Ontario government publicly announced the change to begin asymptomatic testing for anyone who wanted a test. The following week, assessment centre visits more than doubled. Assessment centres were not notified in advance exactly when a change to the testing criteria would occur so they were not able to plan quickly to increase their staffing and specimen collection capacity in time for the increase in demand. In some cases, people were turned away from testing or asked to come back to the assessment centre on a different day.
  - On June 9, the province publicly announced that certain daycare centres could reopen on June 12 with appropriate preventative measures in place. The province also informed daycare centres that they could speak with their local public health units if they had any questions. Public health units were not aware that this specific announcement would be made. Over 40%, or 12, of the 28 local Medical Officers of Health who responded to our survey said that they did not have time to prepare for this given no advance notice from the province.
- **Public communication was more confusing and less co-ordinated than in other provinces.** A study published September 30, 2020 in the *Canadian Medical Association Journal* compared the preparedness and response to COVID-19 in British Columbia and Ontario long-term-care homes. The study identified that while British Columbia's daily briefings and media interviews were delivered consistently, Ontario's were less co-ordinated and contained conflicting information. Local Medical Officers of Health informed us that they were confused by provincial politicians delivering public health advice in place of the Chief Medical Officer of Health. They had expected that the primary communicator

would be the Chief Medical Officer of Health. While there is a Ministry of Health Emergency Response Plan, the section on Crisis Emergency and Risk Communications Response Guide was identified as "under development," even though this plan has been in place since 2013.

- Specific indicators and information used to make decisions to impose or relax public health measures were not clearly communicated to the public. On April 27, 2020 the province of Ontario published the document, *A framework for reopening our province* (Reopening Framework), which detailed the three stages of recovery that Ontario would go through to reopen businesses and loosen public health restrictions. The Reopening Framework identifies the indicators that the Chief Medical Officer of Health is to consider when advising the province on the easing of public health measures. The indicators include a consistent decrease in the number of new COVID-19 cases over a two-to-four-week period and a decrease in the number of new COVID-19 cases in hospitals. However, a specific target had not been developed for each of these indicators to identify when public health measures can be relaxed or should be further restricted. As well, it is not clear whether this same approach will be used when the number of COVID-19 cases fluctuates. Further, directional information is also not shared publicly to help Ontarians understand exactly why public health measures have been restricted or what needs to occur for the further relaxing of such measures. While the province did publicly release its *COVID-19 Response Framework: Keeping Ontario Safe and Open* on November 3, 2020, which identified the indicators for moving public health regions through its five stages [Prevent (Green), Protect (Yellow), Restrict (Orange), Control (Red) and Lockdown (Grey)] no clear targets were provided for four out of the seven of them, reducing the clarity of the framework.

Proactive Planning and Analysis of Potential Consequences and Risks

- **Consequences and risks must still be analyzed, despite the need for quick decisions to be made in an emergency situation.** We noted the following two areas where there could have been more contemplation of consequences and risk, and more public transparency about the basis of decisions made:
  - **Stopping non-essential hospital services resulted in significant backlogs of elective surgeries.** On March 19, 2020, the Chief Medical Officer of Health issued a directive to hospitals and other health-care providers requiring that all non-essential and elective services cease or be reduced to minimal levels until further notice. The directive remained in place until May 26, 2020, when the Chief Medical Officer of Health amended it to allow deferred and non-essential and elective health-care services to be gradually restarted. The directive did help prevent hospitals from exceeding their bed capacity, but it also resulted in numerous patients being unable to access routine or elective medical services for about 10 weeks, which created substantial backlogs in the health-care system. According to a study published in the *Canadian Medical Association Journal*, between March 15 and June 13, Ontario had an estimated backlog of over 148,000 surgeries, which would take 84 weeks (about 20 months, or almost two years) to clear. As hospital capacity differed throughout the province, there was an opportunity to bring back hospital services faster in some regions, which, with some real-time strategic

decision-making, could have helped reduce some of the backlog.

- **Race-based information was not collected and factored into decision-making to target high-risk populations for COVID-19 prevention and containment measures.** Immigrant populations have experienced disproportionately higher rates of COVID-19, including higher rates of hospitalization and death due to COVID-19. However, the Ministry did not collect race-based information on individuals tested for COVID-19 until June 26, 2020. As a result, such information was not factored into decisions to better target populations with a greater risk of getting infected. A study published by the Institute for the Clinical Evaluation of Science in September 2020 showed that although immigrants, refugees and other newcomers, those who have arrived from other countries since 2017, to Ontario make up just over 25% of the population, they accounted for almost 44% of all COVID-19 cases up to June 13, 2020.

Health Emergency Response Plans

- **Health emergency response plans have not been updated since 2013.** The Ministry has two response plans—the Ministry of Health and Long-term Care Emergency Response Plan (Health Response Plan) and the Ontario Health Plan for an Influenza Pandemic (Health Pandemic Plan). However, neither of these plans have been updated since 2013. This appears to be a violation of the *Emergency Management and Civil Protection Act* except for a nuance in the act that a review must be performed annually of the Ministry's emergency management program and plan, but that these be updated only if necessary. Since both response plans were outdated, roles and responsibilities were not clearly defined and assigned in advance of COVID-19. In contrast, British Columbia updated its influenza pandemic plan throughout the month of February 2020 to tailor it to the COVID-19 pandemic so as to be better prepared to respond. Its updated pandemic plan was released to the public on March 6, 2020.
- **The Ministry did not implement our recommendations from 13 years ago to regularly update its emergency response plans.** As part of our 2007 audit Outbreak Preparedness and Management, we recommended that the Ministry review both the Health Pandemic Plan and the Health Response Plan regularly to update them as necessary. Our 2009 follow-up review of these recommendations found that the Ministry did update the plans that year, and that the updates included clarifying and summarizing roles and responsibilities in the Health Pandemic Plan. However, the Ministry has not updated the Plans since 2013. This is discussed further in **Chapter 1 Emergency Management in Ontario—Pandemic Response**.

Ontario's Public Health System

- **Variations in management and operations among public health units contributed to fragmentation and inconsistencies across Ontario.** There are currently 34 public health units in Ontario. Each public health unit is governed by a Board of Health. The public health units vary significantly in terms of their geographic coverage, organizational structure and governance. In contrast, public health in other jurisdictions (such as British Columbia, Alberta and Quebec) is simpler, with less fragmentation and fewer variations. For example, while British Columbia's population (about 5.1 million in 2019) is about one-third that of Ontario (about 14.6 million in 2019), public health in British Columbia

is delivered by only five Regional Health Authorities, one Provincial Health Authority and one First Nations Health Authority. Alberta's Regional Health Authorities were eliminated in 2008 in favour of a single health authority that centrally manages all public health programs and services. We also noted that Ontario's public health units were not consistently sharing and following each other's best practices and lessons learned. This was one reason why the public health units responded differently to the pandemic.

- **Public health reform recommended over 15 years ago was not completed.** The 2003 *Initial Report of the Ontario Expert Panel on SARS and Infectious Disease Control*, the 2004 First Interim of the SARS Commission and the 2006 Final Report of the SARS Commission identified the need to reform Ontario's public health system and specific ideas for how to do so, such as considering consolidating the then 37 public health units to between 20 and 25. In April 2019, the Ministry announced a proposal to modernize Ontario's public health system, which was expected to be completed by April 2020. However, this was paused as the Ministry prioritized its response to COVID-19. As a result, public health units' operations continued to differ from each other. As of the writing of this report, the public health units were still operating independently and their best practices were still not always being shared. For example, the Kingston, Frontenac, Lennox & Addington Public Health Unit had been conducting an annual influenza preparedness workshop (most recently on August 16, 2019) with health-care providers (such as long-term care home staff) and started performing compliance health audits at each long-term-care home in early March 2020 to ensure that proper infection prevention and control procedures were in place. Having implemented such practices prior to and in the early stages of the pandemic, the Kingston, Frontenac, Lennox & Addington Public Health Unit had not reported any long-term-care residents diagnosed with COVID-19 (as of August 31, 2020). However, these practices were not in place at other public health units. For example, 71% of the public health units that responded to our survey (20 of 28) said that they do not hold annual influenza preparedness workshops with health-care providers.

International Travellers to Ontario

- **Ontario did not contact the majority of travellers entering the province due to lack of resources as well as not taking action to have accurate, complete and timely information.** The provinces rely on the federal government, including emergency orders made by the federal Minister of Health, to develop and enforce rules over who is allowed into the country (and Ontario) as well as to provide information on travellers to provinces (in this case, Ontario). The Ontario Ministry of Health (Ministry) is to follow up with travellers who entered Canada without COVID-19 symptoms (the Public Health Agency of Canada is to tell the Ministry who these travellers are). Specifically, the Ministry is to phone or email these people to discuss isolation requirements and provide resources for support if needed. However, the Ministry was not able to reach about 50% of travellers about whom it received information from the Public Health Agency of Canada between April 5 and August 31. This was partially due to a lack of dedicated staff to do this work. But it was also because staff learned about them so many days after they'd entered Ontario that the 14 days they would have been deemed infectious if they had COVID-19 were past or almost past. Additionally, information from the Public Health Agency of Canada is often not provided on a timely basis or is incomplete. For example:

- Between April 5 and August 31, 2020, over 45% of the records received by the Ministry were for travellers more than halfway through their 14-day self-isolation period, resulting in delayed support to those travellers.
- The Ministry is not sure it has received complete information on travellers and has not taken action to understand if this is the case. About 2.5 million international travellers came to Ontario between April and August (primarily returning Canadian citizens or other travellers such as foreign and resident crew members, military personnel, immigrants and former residents), but the Ministry received information from the Public Health Agency of Canada on only about 233,300 of them or less than 9%. About 2.5 million international travellers over that period of time equates to about 500,000 people per month entering Ontario from other countries (primarily the United States), which is more than the population of the City of London, Ontario coming into the province each month.

Overall Conclusion

Our audit found that the Ministry of Health (Ministry) did not yet have fully effective systems and procedures in place to identify and respond to the COVID-19 pandemic on an organized and timely basis, in accordance with applicable legislation and international best practices. The Ministry's emergency response plan had not been updated since 2013. An outdated and incomplete emergency response plan left roles and responsibilities of key parties undefined; therefore, the Ministry set up a Health Command Table, which took on an increasingly complex structure with numerous participants involved, including many who did not have public health expertise. The Chief Medical Officer of Health neither played a leadership role nor fully exercised his powers under the *Health Protection and Promotion Act* to ensure timely and consistent responses by local public health units and healthcare providers.

Our audit also found that the Ministry did not identify, assess and implement lessons learned for continuous improvement over the last many years. The key lesson learned from the Severe Acute Respiratory Syndrome (SARS) outbreak in Ontario in 2003 is to take precautionary steps to fight the spread of infectious disease, even if scientific evidence is not yet available to support them. Ontario did not follow this lesson, as demonstrated by: establishing its COVID-19 response structure more slowly than other provinces; encouraging travel before March break even when other provinces and the federal government were discouraging it; delaying its acknowledgement of community transmission of COVID-19; and delaying when it restricted long-term-care home staff from working at multiple facilities. Ontario also did not always follow expert advice. This was evidenced in Ontario's decisions to expand testing to individuals without symptoms despite limited value in doing so, and to require all visitors to long-term-care homes to provide proof of a negative COVID-19 test result.

In addition, our audit found that the Ministry did not measure and report on a timely basis the results and effectiveness of the province's pandemic preparedness and management activities. Communication within the Health Command Table was not fully effective, as its meetings were held via teleconference with no documentation on the discussions that led up to the advice, recommendations and eventual decisions made. Communication with external stakeholders was also not timely, as they sometimes found out about changes that directly impacted them only when the decisions were announced publicly. The Ministry also did not provide clear indicators and information to help the public understand how specific decisions were made on relaxing or imposing new public health measures for most of the year. The Ministry

did not initially collect race-based information to enable it to target its prevention and containment measures to populations with a higher risk of getting COVID-19. It also did not receive (and still does not receive) from the federal government accurate, complete and timely information on travellers, resulting in most travellers not being contacted to ensure they knew about their self-isolation obligations and that supports were available to them.

This report contains nine recommendations, consisting of 29 action items, to address our audit findings.

CONSOLIDATED OVERALL RESPONSE FROM MINISTRY AND SECRETARY OF CABINET

Cabinet Office and the Ministries of Health and Long-Term Care appreciate the work of the Office of the Auditor General as we continue to improve our processes and responses to support the safety and health of Ontarians. As noted in the report, COVID-19 has presented a challenge to health experts and government decision-makers around the world due to its unprecedented impact and complexity.

The recommendations offer helpful guidance as we respond to an evolving pandemic, and move ahead with planning, analysis, implementation, assessment of impact, and adjustment of strategies. Our outbreak planning and decision-making approach has included:

- a Health Command Table (that has been renamed the Health Co-ordination Table) for leaders across the health system to provide advice related to pandemic response to the Ministers of Health and Long-Term Care, and associated advisory tables to provide specialized expertise;
- a Central Co-ordination Table to facilitate a whole-of-government response to the pandemic that monitors progress, removes barriers, and drives inter-ministerial collaboration and execution of government direction;
- application of evidence and information, as well as modelling projections, to the pandemic response; and
- consistent application of the expertise and advice of Ontario's Chief Medical Officer of Health to guide the pandemic response.

Since the onset of this pandemic, the health and well-being of Ontarians has remained our priority. It is the government's responsibility to take into account several indicators of health, including mental health, social isolation, job loss and the overall livelihood of the people of Ontario.

As this report notes, Ontario's pandemic response has highlighted opportunities to enhance the responsiveness and consistency of public health actions across the province. Once the pandemic is contained and risks to the public are mitigated, the Ministry of Health will be in a position to move ahead with public health modernization, incorporating the findings and recommendations from this report.

OVERALL RESPONSE FROM PUBLIC HEALTH ONTARIO

Public Health Ontario (PHO) acknowledges and appreciates the Report and recommendations of the Auditor General related to the effectiveness and timeliness of Ontario's response to the Pandemic. Established in the aftermath of a series of major public health events in the early 2000s, including Walkerton and the Severe Acute Respiratory Syndrome (SARS) epidemic, PHO's legislative objects include providing "scientific and technical advice and operational support to any person or entity in an emergency or outbreak situation that has health implications." This includes conducting public health and laboratory surveillance and epidemiology to better understand the disease, operating a reference laboratory and performing clinical testing

services, and providing scientific and technical advice to public health, the health care system and the Government of Ontario.

We note the challenges faced in responding to the pandemic, and look forward to working with the Ministry of Health, other Ministries, Ontario Health, public health units and the health care system in the implementation of the Auditor General's recommendations in support of the response to and recovery from this pandemic and to better prepare the province to address future events of this kind.

2.0 Background

2.1 Timeline of COVID-19

The Coronavirus Disease 2019 (COVID-19) pandemic has spread quickly. Less than a month after the first case was identified in late December 2019, COVID-19 had spread from China to neighbouring countries and soon after to Europe and North America. On January 25, 2020, the first presumed COVID-19 case in Canada was identified in Toronto, Ontario and the case was confirmed on January 27, 2020. Cases were identified throughout all provinces and territories of Canada, with the exception of Nunavut, as of August 31, 2020. **Figure 2a** provides a timeline of the dates of the first COVID-19 cases by province and territory. **Figure 2b** shows where the first case in each province or territory originated from. **Appendix 1** provides a summary of key events in relation to COVID-19 around the world and in Ontario.

Since COVID-19 emerged outside of Canada, the federal, provincial and territorial governments have shared information through the Pan-Canadian Public Health Network (Network) to help inform their understanding of the disease. The Network, which was established in 2005, comprises federal, provincial and territorial government officials who are responsible for public health, including the Chief Public Health Officer of Canada and the Chief Medical Officer of Health (or equivalent) from each province and territory. The Network provides advice to the Conference of Federal/Provincial/Territorial Deputy Ministers of Health for discussion on issues of mutual interest. As shown in **Figure 3**, the Network created a Special Advisory Committee on COVID-19 in late January 2020. The Network allows the provinces and territories to learn and compare practices and policies in other jurisdictions before making decisions based on their needs and situations.

2.2 Lessons Learned from SARS Outbreak

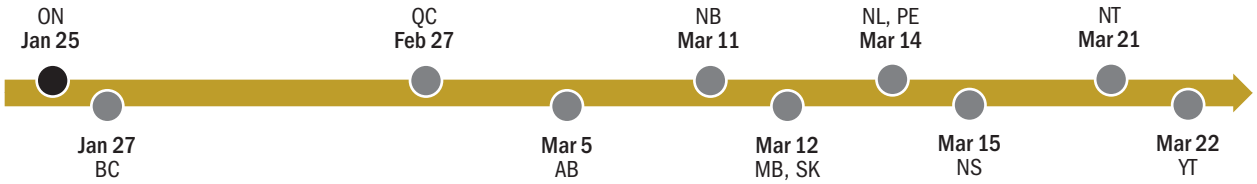
The 2003 SARS (severe acute respiratory syndrome) outbreak in Ontario infected over 400 Canadians and resulted in 44 deaths during the four-month duration of the outbreak. The majority of SARS cases were in Ontario and all deaths were in Toronto. In comparison with the SARS outbreak, Ontario has faced a much more dire situation in the COVID-19 pandemic, with more than 70,000 COVID-19 cases and over 3,000 deaths in the eight months from when it began in mid-March 2020 up to November 1, 2020.

Ontario's experience with SARS demonstrated the need to be prepared for widespread disease outbreaks. In the years that followed the SARS outbreak, a number of reports were commissioned by the provincial government to review and investigate Ontario's response. These reports not only identified valuable lessons but also provided recommendations and principles for improving the public health system and enhancing preparedness for and responses to future outbreaks of infectious diseases. The following are the key reports:

- *Initial Report of the Expert Panel on SARS and Infectious Disease Control* by Dr. David Walker (released December 2003)
- *Final Report of the Expert Panel on SARS and Infectious Disease Control* by Dr. David Walker (released April 2004);

Figure 2a: First COVID-19 Cases* Announced by Canadian Provinces and Territories

Prepared by the Office of the Auditor General of Ontario



* For each province and territory, the first COVID-19 case refers to an individual who tested positive at the provincial level but whose test had yet to be confirmed by the National Microbiology Laboratory in Winnipeg, Manitoba (this was the initial requirement before provinces and territories started developing the capacity to perform testing independently). The first presumptive case in Ontario was confirmed on January 27, 2020.

Figure 2b: Origins of First COVID-19 Case by Province and Territory

Prepared by the Office of the Auditor General of Ontario

Province or Territory (Date of First Case)	Origin
ON (Jan 25)	A man from Toronto in his 50s, who had returned from Wuhan, China.
BC (Jan 27)	A man from Vancouver in his 40s, who had travelled regularly to China for work and was in Wuhan city on his most recent trip.
QC (Feb 27)	A woman from Montreal, who had returned from Iran.*
AB (Mar 5)	A woman from Calgary in her 50s, who had returned from travel on a Grand Princess cruise ship.
NB (Mar 11)	A woman from the southeastern part of the province in her 50s to 60s, who had returned from France.
MB (Mar 12)	A woman from Winnipeg in her 40s, who had returned from the Philippines.
SK (Mar 12)	A person in their 60s, who had returned from Egypt.*
NL (Mar 14)	A woman who had returned from travel on a Caribbean cruise.*
PE (Mar 14)	A woman from the Queens County area in her 50s, who had returned from travel on a cruise ship.
NS (Mar 15)	Three travel-related cases that were not connected: • a woman from Kings County in her 60s, who had returned from Australia; • a male from Halifax in his late 50s, who had attended a conference in California; and • a man from Halifax in his 30s, who had returned following travel throughout Europe.
NT (Mar 21)	A person from Yellowknife, who had travelled to British Columbia and Alberta.*
YT (Mar 22)	A couple from Whitehorse, who had attended a conference in the US.

* The province/territory publicly released limited information about this case.

- *First Interim Report of the SARS Commission* by Mr. Justice Archie Campbell (released April 2004);
- *Second Interim Report of the SARS Commission* by Mr. Justice Archie Campbell (released April 2005); and
- *Final Report of the SARS Commission* by Mr. Justice Archie Campbell (released December 2006).

Appendix 2 provides a summary of relevant recommendations from the key SARS reports. The government of Ontario made a number of changes based on recommendations from these reports, including:

- establishing the Ontario Health Protection and Promotion Agency, now known as Public Health Ontario (see **Section 4.1.4**);
- giving the Chief Medical Officer of Health the authority to issue directives, including to health-care providers and health-care entities (see **Section 4.2.2**); and

Figure 3: Key Information-Sharing Activities on COVID-19 in January 2020*

Prepared by the Office of the Auditor General of Ontario

Date	Event
Jan 3 and Jan 8	Ontario's Chief Medical of Health shares information on the outbreak in China and other parts of Asia by email with Ontario's 34 Public Health Units, indicating that: • a cluster of viral pneumonia that is not yet diagnosed is being investigated in Wuhan, China; and • additional information is being shared with the province by the federal government through the Public Health Agency of Canada, which is in contact with the World Health Organization (an agency of the United Nations responsible for international public health).
Jan 9	The World Health Organization publishes a statement on a cluster of pneumonia cases in Wuhan, China.
Jan 23	Ontario's Associate Chief Medical Officer of Health issues a memo to health system partners that includes a COVID-19 case definition and that notifies them that COVID-19 is now an illness that must be reported to public health officials.
Jan 28	The Pan-Canadian Public Health Network establishes a Special Advisory Committee to advise the Conference of Federal, Provincial and Territorial Deputy Ministers of Health on co-ordination, public health policy and technical content related to COVID-19. The Committee discusses the co-ordination of preparedness and response across Canada's health system.
Jan 30	The World Health Organization announces that COVID-19 represents a Public Health Emergency of International Concern.

* Information shared by organizations, committees and individuals globally across Canada and within Ontario.

- giving the Chief Medical Officer of Health the ability to investigate and take action where there is a risk to health by exercising the powers of a Board of Health or Medical Officer of Health (see **Section 4.2.2**).

2.3 Roles and Responsibilities of Key Players

In Ontario, the Ministry of Health (Ministry) is responsible for administering the province's health-care system. Under Order in Council 1157/2009, it has been designated as the lead for human health, disease and epidemics, as well as for health services during an emergency. Accordingly, it has been the designated primary lead on measures and responses, both before and throughout the provincial declaration of a state of emergency caused by COVID-19.

The Health System Emergency Management Branch of the Ministry of Health is responsible for serving the Ministry and the health sector to respond to urgent and/or emergency situations. This Branch (up to August 31, 2020) reported to the Chief Medical Officer of Health (who, as an Assistant Deputy Minister, reports to the Deputy Minister of Health) and provides advice on public health matters to the health sector and the provincial government (see **Figure 4**).

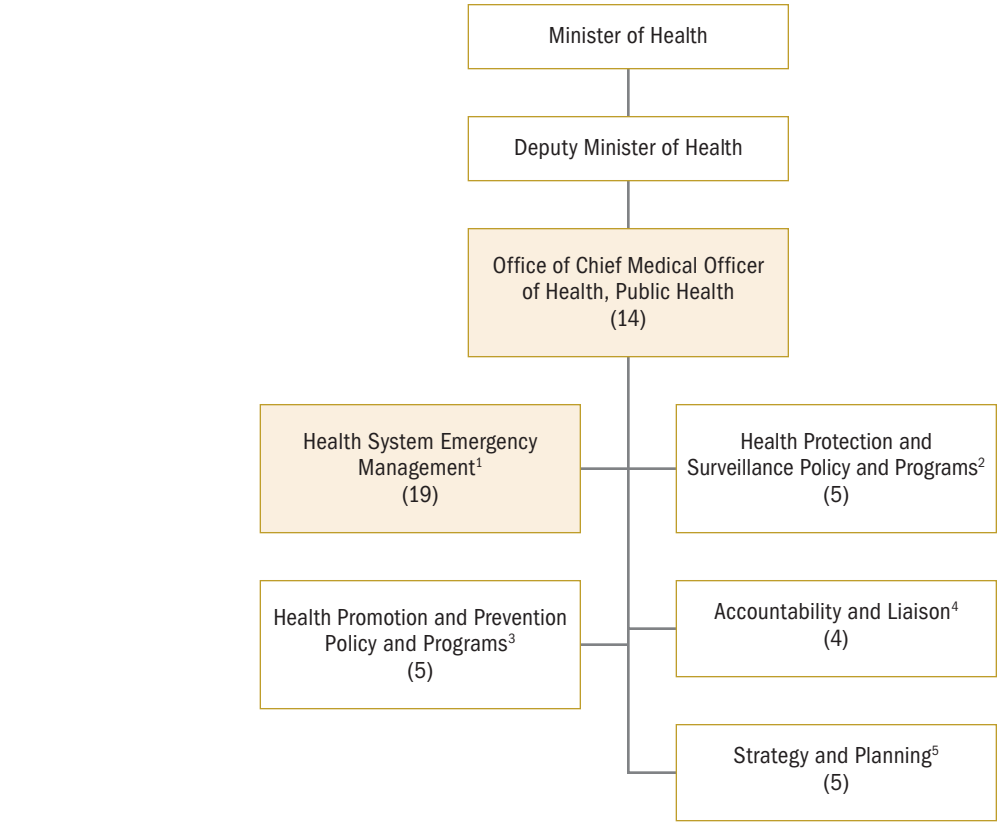
While the Ministry of Health is the lead, pandemic preparedness and management require an inter-governmental and province-wide effort, with many individuals and organizations involved, including, but not limited to:

- other provincial ministries (such as the Ministry of Long-term Care and the Ministry of the Solicitor General);
- provincial health agencies (such as Public Health Ontario and Ontario Health);
- federal and municipal governments;
- local public health units; and
- health-care organizations and service providers (such as hospitals, primary-care providers and laboratories).

Appendix 3 provides a summary of the key parties involved. Ultimate decision-making authority (including changes to legislation and approval of new funding) is held by the Premier and Cabinet.

Figure 4: Ministry of Health's Division and Branches Responsible for Health-Sector Emergencies, up until August 31, 2020

Source of data: Ministry of Health



Note: The Ministry of Health re-organized the divisions and branches responsible for health-sector emergencies on August 31, 2020. See **Figure 9** for the updated organization structure.

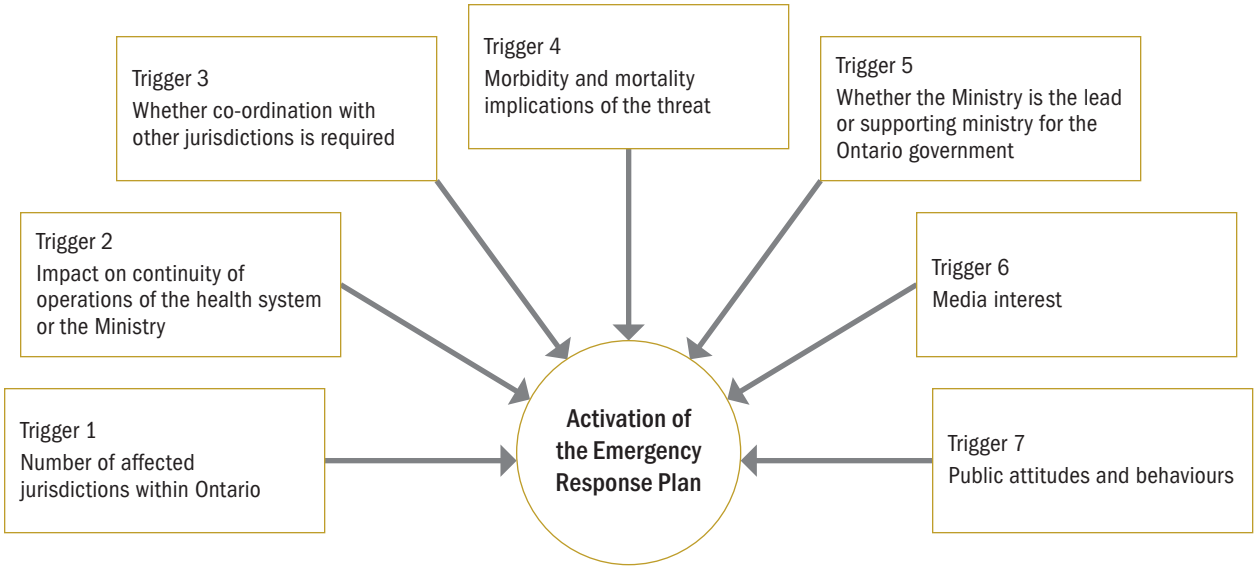
1. The Health System Emergency Management Branch is responsible for responding to urgent and/or emergency health situations. The Branch also develops Ministry emergency readiness plans, informs health-sector planning and directs, as necessary, health sector emergency response and recovery.
2. The Health Protection and Surveillance Policy and Programs Branch develops, implements and evaluates Ontario's public health protection and prevention policies and legislation involving immunization, environmental health and infectious diseases. The Branch also provides oversight of public health programs, identified in the Ontario Public Health Standards, and supports public awareness and educational campaigns for public health.
3. The Health Promotion and Prevention and Policy and Program Branch leads the design/development, funding, implementation and evaluation of strategic population-based policies and programs in the areas of health promotion and prevention.
4. The Accountability and Liaison Branch develops policy and plans to support the implementation of divisional programs and priorities for public health. The Branch also informs program and divisional priorities.
5. The Strategy and Planning Branch is responsible for leading enhanced and integrated divisional and public-health-sector strategic planning and priority setting; research, evidence synthesis, knowledge dissemination and evaluation; and the development, implementation and co-ordination of integrated policies and strategies.

2.4 Response Plans and Powers during a Public Health Emergency

To prepare for health-sector emergencies, the Ministry has emergency response plans in place, which were last updated over seven years ago in May 2013 (see **Section 4.7.1**). The plans describe how the Ministry leads or supports the response to an emergency through health system co-ordination and direction, and how the Ministry identifies the triggers to activate the plans (see **Figure 5**). On January 27, 2020, the Ministry activated the intent of the plans in response to growing concern over COVID-19.

Figure 5: Triggers to Consider for Activation of the Ministry of Health and Long-Term Care's Emergency Response Plan*

Source of data: Ministry of Health



Note: All of these triggers are relevant to COVID-19.
* The plan was last updated in May 2013, when the Ministry of Health and the Ministry of Long-Term Care were part of one consolidated Ministry.

A number of different powers and tools allow various parties to impose public health measures and restrictions on Ontarians, including visitors to and organizations operating in the province:

- The Lieutenant Governor in Council (instructed by the Premier and Cabinet) can issue emergency orders to impose rules on businesses and other organizations operating in Ontario as well as on the general population.
- The Chief Medical Officer of Health may issue directives to health-care providers, health-care entities, Boards of Health and local Medical Officers of Health in the province to mandate infection prevention and control measures, or to ensure a consistent and co-ordinated approach from the public health community.
- The Ministry of Health and others (including local Medical Officers of Health) can also issue guidance, which is optional and relies on individuals to use judgment to apply.
- Local Medical Officers of Health may issue orders to Ontarians or businesses located in their public health jurisdiction to act or refrain from acting in a way specified in the order in respect to a communicable disease.

Appendix 4 provides a comparison of the powers available by different parties to impose public health measures and restrictions during the COVID-19 pandemic.

2.5 Why We Are Issuing This Special Report

While Ontario has performed better on a per capita basis than many states in the United States and some European countries, Ontario is one of the Canadian jurisdictions most affected by COVID-19. In comparison with other provinces and territories, as of August 31, 2020, Ontario had the third-highest number of cases per 100,000 residents (see **Figure 6a**) and the second-highest number of deaths per 100,000 residents (see **Figure 6b**). **Appendix 5** compares populations, COVID-19 cases and deaths by province and territory as of August 31, 2020.

Figure 6a: Number of COVID-19 Cases per 100,000 Residents by Province and Territory, as of August 31, 2020

Prepared by the Office of the Auditor General of Ontario

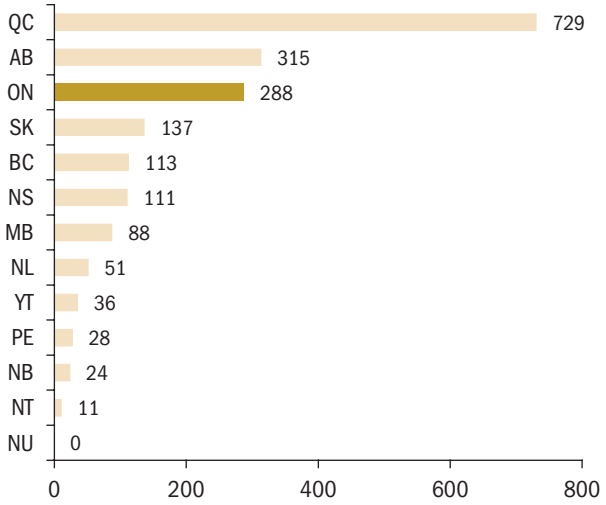
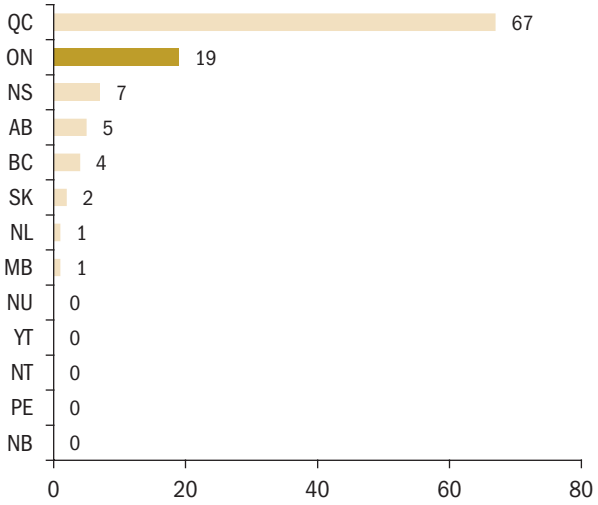


Figure 6b: Number of COVID-19 deaths per 100,000 Residents by Province and Territory, as of August 31, 2020

Prepared by the Office of the Auditor General of Ontario



Note: Numbers are rounded to the nearest whole numbers. As a result, some provinces and territories identified as having zero deaths per 100,000 residents did have COVID-19 deaths.

COVID-19 has impacted the lives of all Ontarians. While all Canadian provinces and territories have had to address their own pandemic struggles (with supports from the federal government), Ontario has been facing significant and unique challenges given its decentralized public health and health systems, and has longstanding issues identified in our past audit reports, especially the 2007 audit report, Outbreak Preparedness and Management. Ontario also has unique demographics, including a significant immigrant population, high population density, and significant issues with poverty (particularly in southern Ontario). These factors increase the risk of community transmission of COVID-19. Such community spread has occurred, with a significant number of COVID-19 cases in Ottawa, Peel Region and Toronto, and will continue to be a significant risk going forward. In light of these challenges, it is essential to have a clear command structure, with strong public health leadership in which the roles and responsibilities of all parties involved are well-defined and understood. Only this will enable timely, appropriate and effective decision-making. This is all the more imperative in light of the speed at which the pandemic's first and second waves spread and the potential for subsequent waves. The purpose of this report is to present information to help interpret what happened provincially with regard to health-related pandemic outbreak planning and COVID-19 decision-making, in order to improve Ontario's preparedness and COVID-19 decision-making going forward.

In this report, we present:

- Ontario's planning and decision-making structure and process throughout the COVID-19 pandemic;
- weaknesses in this structure and process that limited the effectiveness of Ontario's initial response to COVID-19; and
- changes still needed to address those weaknesses in preparation for potential ongoing waves of COVID-19 and future pandemics.

3.0 Audit Objective and Scope

Our audit objective was to assess whether the Ministry of Health (Ministry), in association with

its health-care sector partners, has effective systems and procedures in place to:

- identify and respond to the COVID-19 pandemic in an organized and timely way, in accordance with applicable legislation and international best practices;
- identify, assess and implement lessons learned for continuous improvement; and
- measure and report on a timely basis the results and effectiveness of pandemic preparedness and management activities.

In planning for our work, we identified the audit criteria (see **Appendix 6**) we would use to address our audit objective. These criteria were established based on a review of applicable legislation, policies and procedures, internal and external studies and best practices. Senior management at the Ministry reviewed and agreed with the suitability of our objectives and associated criteria.

Our Office's work on COVID-19 preparedness and management covers six key areas (see **Figure 1**), which will be presented in a series of reports.

This report focuses on the province's planning and decision-making activities between January 2020 (when the first COVID-19 case in Canada was confirmed in Ontario) and August 2020. We conducted our audit between May 2020 and September 2020. We obtained written representation from Ministry senior management that, effective November 13, 2020, they had provided us with all the information they were aware of that could significantly affect the findings or the conclusion of this report.

Our audit work focused primarily on the Ministry's Emergency Health Services Division and the Office of the Chief Medical Officer of Health, and secondarily on Ontario Health and Public Health Ontario. In performing our audit work, we:

- examined the Ministry of Health and Long-Term Care Emergency Response Plan and the Ontario Health Plan for an Influenza Pandemic as well as the associated policies and procedures;
- spoke with senior management at the Ministry and Ontario Health, and examined their correspondence and records, to understand actions taken and decisions made; and
- interviewed senior management at Public Health Ontario and examined their correspondence and records, to understand their advice to the Ministry.

To understand the purpose, operations and records of the Health Command Table, which was established to support Ministry and government decision-making related to COVID-19, we interviewed the Table Chair (the Deputy Minister of Health). We also interviewed members of the Health Command Table to understand their experiences at the Table and to identify areas for improvement. We reviewed documents provided to the Health Command Table. However, our audit experienced a scope limitation in this regard. On July 29, 2020, we requested that the Ministry provide us with all communication and recommendations sent from the Health Command Table to the Cabinet and the Central Co-ordination Table. We followed up on this request eight times between the first request and early November 2020 but were not provided with this information.

Appendix 7 lists key parties we spoke with as part of the audit. They included the Medical Officers of Health, senior management and the staff at 10 (out of 34) public health units (these 10 units accounted for over 75% of COVID-19 cases in Ontario, as of August 31, 2020); the Provincial Health Officer and senior management at British Columbia's Ministry of Health; senior management at Alberta Health Services; experts and frontline health-care providers at hospitals in Ontario; and stakeholder groups in Ontario's health sector.

To further understand the challenges faced by other regions, we also conducted a survey of all 34 public health units and received responses from 28 local Medical Officers of Health, which was an 82% response rate.

We engaged Dr. David Walker, who chaired the province of Ontario's Expert Panel on SARS and

Infectious Disease Control and the subsequent Expert Panel on the Legionnaires' Disease Outbreak in the City of Toronto, as our independent advisor to assist us with our work.

We conducted our work and reported on the results of our examination in accordance with the applicable Canadian Standards on Assurance Engagements—Direct Engagements issued by the Auditing and Assurance Standards Board of the Chartered Professional Accountants of Canada. This included obtaining a reasonable level of assurance.

The Office of the Auditor General of Ontario applies the Canadian Standard on Quality Control and, as a result, maintains a comprehensive quality control system that includes documented policies and procedures with respect to compliance with rules of professional conduct, professional standards and applicable legal and regulatory requirements.

We have complied with the independence and other ethical requirements of the Code of Professional Conduct of the Chartered Professional Accountants of Ontario, which are founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour.

4.0 Detailed Audit Observations

4.1 Ontario Created and Maintains a Complex Response Structure with Numerous Participants; It Is Not Led by Public Health Experts

While the Premier of Ontario and his Cabinet are ultimately responsible for making decisions to respond to COVID-19 (such as spending on new initiatives to respond to COVID-19), they relied upon advice and support from the Health Command Table established and led by the Ministry of Health (Ministry). **Figure 7** provides an overview of Ontario's response structure to COVID-19. The Health Command Table's structure is not only large but also complex, containing 90 participants (33 members and 57 additional attendees) in June 2020 and 83 participants (32 members and 51 additional attendees) at August 31, 2020 (see **Appendix 8**) and 25 sub-tables (see **Appendix 9**) with over 500 participants. This structure is further complicated by other tables, including a Central Co-ordination Table (see **Appendix 10**) and five regional steering committees (see **Figure 8**).

Most importantly, despite the Health Command Table being established to respond to a public health pandemic, it is not lead by public health experts (such as the Chief Medical Officer of Health and members of Public Health Ontario's senior management) and the majority of its members do not have public health expertise.

4.1.1 Health Command Table Kept Expanding and Became More Complicated Over Time

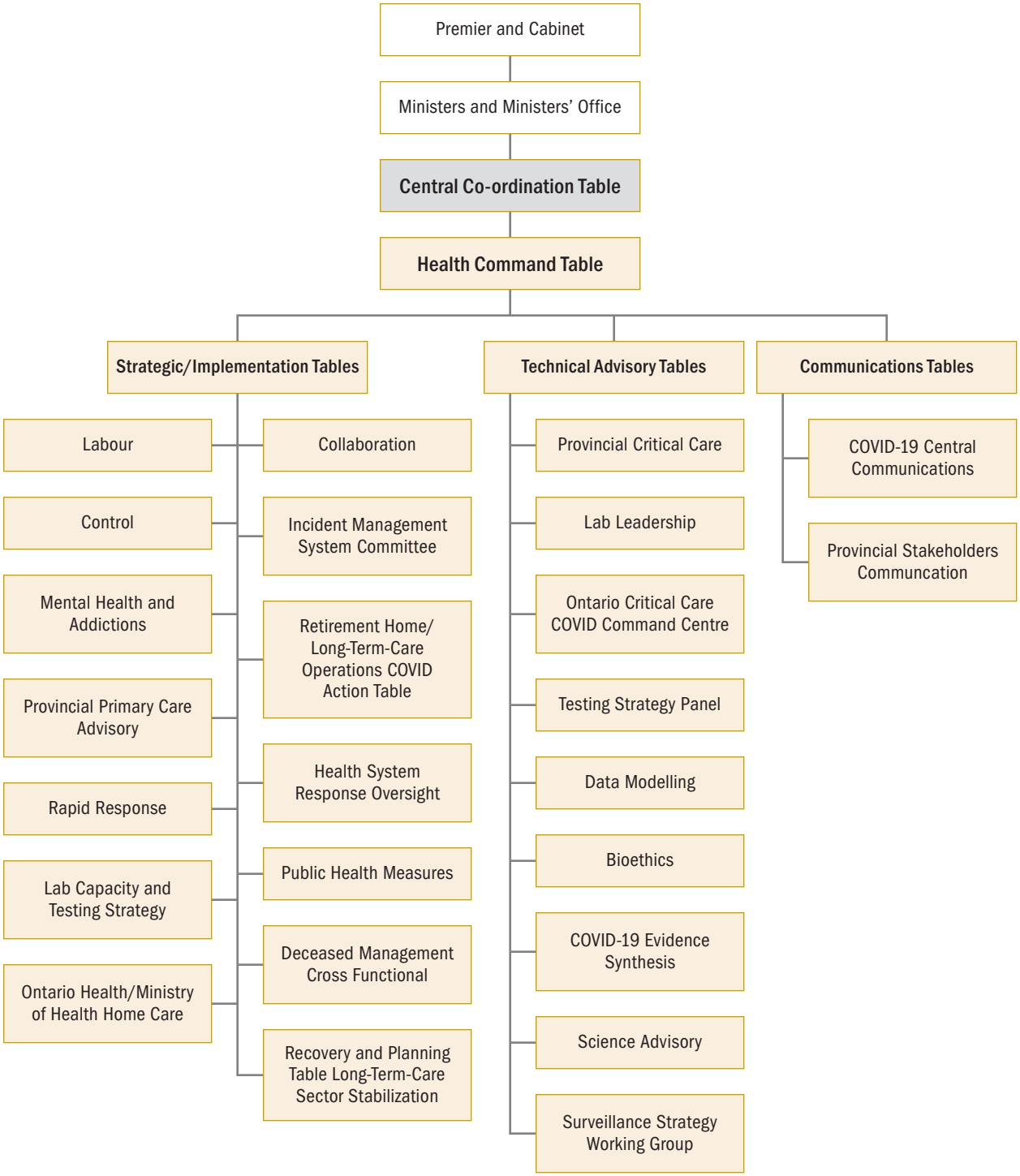
On February 28, 2020, the Ministry established a Health Command Table to support decision-making related to COVID-19. The intent was to provide strategic advice and recommendations to the Minister of Health on how to manage the COVID-19 pandemic. At the time of the Health Command Table's creation, the Ministry was aware of 13 cases of COVID-19 in Canada, including five in Ontario.

According to its terms of reference (presented during the Health Command Table's first meeting on February 28, 2020), the original Health Command Table initially did not have a complex structure. Specifically:

- It was chaired by the Deputy Minister of Health and consisted of 20 senior officials from Ontario health agencies, including the CEO of Ontario Health and a Vice President of Public Health Ontario. **Appendix 8** lists the members of the Health Command Table, with an asterisk that highlights the 21 original

Figure 7: Overview of Ontario's COVID-19 Health Response Structure

Prepared by the Office of the Auditor General of Ontario



Highest levels of authority.

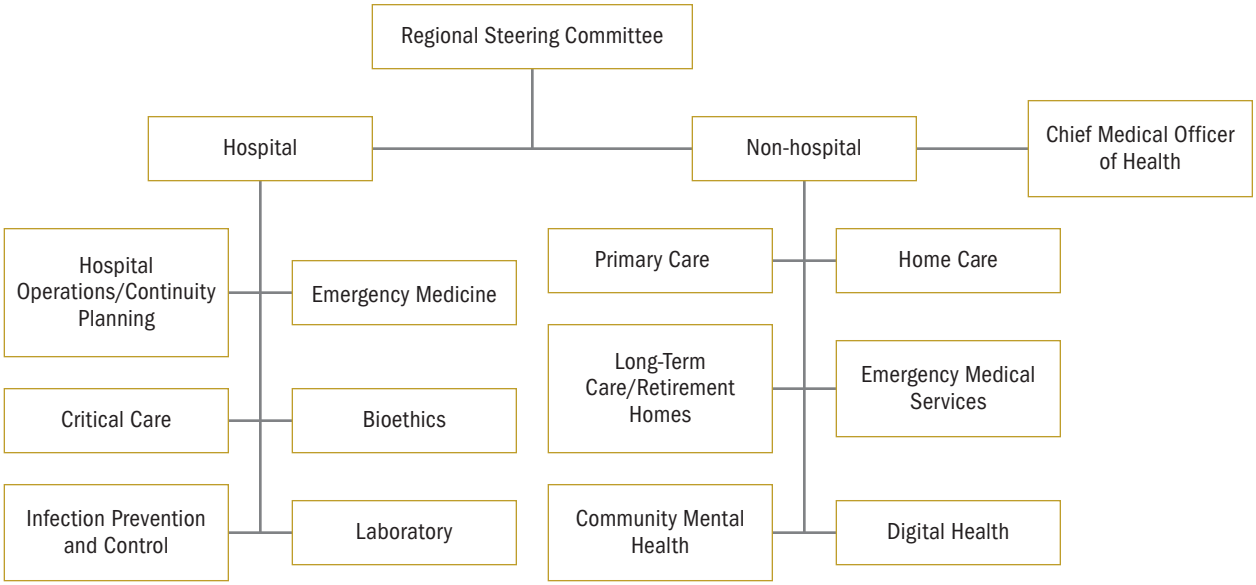
Central Co-ordination Table (chaired by the Secretary of Cabinet and the Chief of Staff to the Premier). **Appendix 10** provides a listing of members of the Central Co-ordination Table.

Health Command Table and its sub-tables. **Appendix 8** provides a listing of members and the dates they were added to the Health Command Table. **Appendix 9** provides a listing of sub-tables and the dates they were formed.

Note: The Central Co-ordination Table does not directly report to Ministers and Ministers' Offices. The structure is shown as it is to indicate the authority hierarchy.

Figure 8: Typical Organizational Structure of a Regional Steering Committee

Source of data: Ontario Health



members (including the Chair) as of February 28, 2020.

- It did not have any sub-tables.

This original structure expanded significantly to a more complex structure with numerous participants and sub-tables.

- As of June 8, 2020, it had 90 participants comprising 33 members and 57 additional attendees, generally including Ministry and Cabinet Office staff, as well as a Ministry Manager as a support staff who were invited to teleconferences to listen to the discussion on Ontario's COVID-19 health response.
- As of August 31, 2020, it had 83 participants comprising 32 members and 51 additional attendees. **Appendix 8** lists the members who were added to the Health Command Table and when they were added.
- The number of sub-tables had also increased to 25 active tables **Appendix 9** lists all of the sub-tables and the dates they were formed. Adding in those participants meant that the Health Command Table as of August 31, 2020 involved over 500 participants.

Although in some cases the addition of specialists filled voids, other changes seemed to result in duplication and inefficiencies. For example, the following changes were made to the Health Command Table and sub-tables to try to facilitate better decisions (such as what advice to provide to Cabinet):

- On March 25, 2020, the Chief Coroner of Ontario was added as a new member to provide input on strategies for transporting and handling the remains of individuals who had died while infected with COVID-19.
- A Public Health Measures Strategy sub-table and a Data Modelling sub-table were formed on April 11, 2020 and March 26, 2020, respectively, to discuss relevant topics (for example, the challenges and appropriateness of reopening or closing public spaces provincially, and the response to technical questions on data models used by the province related to COVID-19).

The Ministry informed us that the Health Command Table expanded over time to address the evolving issues related to COVID-19. However, such expansion resulted in inefficiencies and duplication of work. For example, as of August 31, 2020:

- The Chief Coroner of Ontario, who had already in May 2020 been appointed to be the Executive Lead for the COVID-19 Testing

Approach on top of his normal duties, was later (after moving on from his role in testing) also appointed to be the Co-ordinator of the Provincial Outbreak Response (as of August 26, 2020). Laboratory testing, although led by the Chief Coroner of Ontario, was also formally managed by multiple sub-tables. These included the Lab Leadership Committee, chaired by the CEO of Ontario Health, and the Testing Strategy Panel, which was co-chaired by the Chief of Microbiology and Laboratory Science and who is an infectious disease specialist at Public Health Ontario. In addition to this, there was also a Testing Strategy and Implementation Forum that brought together key parties to talk about testing components.

- The sub-tables under the Health Command Table have similar mandates, including a mandate like the Health Command Table itself, which fosters duplication and inefficiencies through multiple groups having the same discussions. For example:
  - The mandate of the Health Command Table is to "provide executive leadership and strategic direction to guide the Ontario health system's response to COVID-19." This is similar to the mandate of the Health System Response Oversight sub-table, which is to "lead the operational management and co-ordination of the health system response to the COVID-19 pandemic," as well as the mandate of the Collaboration sub-table, which is "to provide strategic advice and direction to guide the Ontario health system's response to COVID-19."
    - The Science sub-table and the Evidence sub-table have similar roles. Both are involved with synthesizing scientific information and collecting input from the scientific community in order to provide timely and relevant information to the Health Command Table to help it provide advice.

Given its overly complex structure with numerous participants, communication was not effective within the Health Command Table: all meetings were conducted via teleconference until mid-July. With such a large number of participants on the call, this was not an effective medium for the discussions. (see **Section 4.5.1**).

4.1.2 Health Command Table Is an Advisory Panel or Information-Sharing Forum with No Ultimate Authority to Make Decisions

The word "command" in the title "Health Command Table" is a misnomer, as the Health Command Table only provides advice and does not command the entire provincial response to COVID-19. That job is done by the Premier and Cabinet, which includes the Minister of Health, who receives advice from the Health Command Table. Thus, the Health Command Table serves as an advisory panel to the decision-makers but does not itself make all the decisions (including on exactly what emergency orders should be issued in response to COVID-19).

When the Health Command Table first began meeting on February 28, 2020, the Deputy Minister of Health provided the Table's advice directly to the Secretary of Cabinet and the Ministry of Health provided its recommendations directly to the Secretary of Cabinet. The Secretary of Cabinet brought this information forward to Cabinet through the internal Cabinet submission process, which the Ministry informed us was expedited as required given the urgency of the pandemic. During the months of March and April, various sub-tables were established and reported to the Health Command Table on a range of strategies to increase capacity in hospitals, COVID-19 laboratory testing capacity and Telehealth Ontario capacity.

On March 25, 2020, the Secretary of Cabinet contracted with a consulting firm to provide advice on the design the organizational structure that

would be used for COVID-19 decision-making. On April 11, 2020, a Central Co-ordination Table was set up, and the consulting firm first presented its recommendations on the structure of the table on April 14, 2020.

Between when it was established on April 11, 2020 and July 6, 2020, the Central Co-ordination Table met five days a week, and since July 6, 2020, it has met three days a week. **Appendix 10** provides a listing of its members. Specifically:

- It is co-chaired by the Secretary of Cabinet and the Chief of Staff to the Premier.
- It includes the Deputy Minister of Health and the Deputy Ministers of eight other ministries.
- Its permanent membership does not include key public health officials, such as the Chief Medical Officer of Health and key representatives of Public Health Ontario (although they have been invited to attend meetings).
- It helps coordinate an integrated approach to Ontario's health and non-heath COVID-19 response.
- It set up sub-tables that were only indirectly focused on health issues, including the Critical Personnel sub-table (focused on identifying and deploying critical personnel throughout the Ontario Public Service and broader public sector), the Public Safety sub-table, and the Supply Chain and Domestic Production Strategy sub-table.

4.1.3 Chief Medical Officer of Health Does Not Play a Leadership Role

As noted in **Section 4.1.1**, the Health Command Table was originally chaired by just the Deputy Minister of Health. The Ministry informed us that the CEO of Ontario Health and the Chief Medical Officer of Health were added as "functional co-chairs" to the Health Command Table as of March 6, 2020. However, the Chief Medical Officer of Health actually does not play a leading role in the Health Command Table. Specifically, we noted the following:

- The terms of reference for the Health Command Table were never updated to formalize the change of adding the CEO of Ontario Health and the Chief Medical Officer of Health as co-chairs. We saw no discernible difference in the role and responsibilities of the Chief Medical Officer of Health in relation to the Health Command Table after the change was identified.
- Some members of the Health Command Table informed us that they were not aware that the Chief Medical Officer of Health was a co-chair. They also informed us that the Chief Medical Officer of Health did not lead the meetings. When the Deputy Minister of Health was absent, the CEO of Ontario Health led the meetings.
- The Chief Medical Officer of Health did not chair any of the Health Command Table sub-tables.
- The Deputy Minister of Health, instead of the Chief Medical Officer of Health, participated as a member in the Central Co-ordination Table (see **Section 4.1.2**) and was identified in the list of Central Co-ordination Table members as the lead of the Health Command Table.
- Unlike his counterparts in other provinces, the Chief Medical Officer of Health was not the key media spokesperson on COVID-19 in Ontario. Although the Chief Medical Officer of Health often took part in daily media briefings in Ontario on COVID-19 and took questions, most daily updates and press conferences were led by the Premier and included other regular speakers such as the Minister of Health, the Minister of Education and the Associate Chief Medical Officer of Health.
- The role of the Chief Medical Officer of Health was further reduced in August 2020. On August 20, 2020, the Deputy Minister of Health issued a memo to all Ministry staff indicating that the Ministry's Health Services

> Emergency Branch, including the Ministry Emergency Operations Centre (responsible for Ontario's COVID-19 response and co-ordination), had been removed from the Chief Medical Officer of Health's portfolio. It had been transferred to another Assistant Deputy Minister, who would be in charge of a newly created Pandemic Response Division, effective August 31, 2020. **Figure 9** shows the Ministry of Health's new division and branches responsible for health-sector emergencies.

Ontario's choice of not giving the Chief Medical Officer of Health the lead role in its COVID-19 response was unusual given the guidance on this in the Ministry's Health Response Plan (covered in more detail in **Section 4.7**). This plan specifies that "An Executive Lead may lead the MOHLTC's [Ministry of Health and Long-Term Care's] response to an emergency, particularly when the MOHLTC is the lead ministry. The CMOH [Chief Medical Officer of Health] typically plays this role for emergencies that fall under the MOHLTC's Order in Council responsibility of 'human health, disease and epidemics' and for health system emergencies focused on Ontario's public health units (PHUs)." While the Ministry informed us that the Chief Medical Officer of Health did play this role, we did not see evidence of this.

4.1.4 Public Health Ontario's Role in COVID-19 Response Diminished, Despite Its Expertise and Importance

While Public Health Ontario was created after SARS specifically to provide scientific and technical expertise during health emergencies, the Ministry has not used it to its fullest advantage during the COVID-19 pandemic.

The Ontario Agency for Health Protection and Promotion, which has operated under the name Public Health Ontario since 2011, was established in 2008 in response to recommendations by the following SARS reports (see **Appendix 2**):

- In April 2004, the Final Report of the Ontario Expert Panel on SARS and Infectious Disease Control recommended the creation of a Public Health Agency (which was the impetus for the creation of Public Health Ontario), with strategic direction being set by the Chief Medical Officer of Health and day-to-day operational and scientific leadership being provided by a Chief Executive Officer.
- In December 2006, the Final Report of the SARS Commission recommended the provincial government "complete the process of fixing the public health system, including establishing the Ontario Health Protection and Promotion Agency."

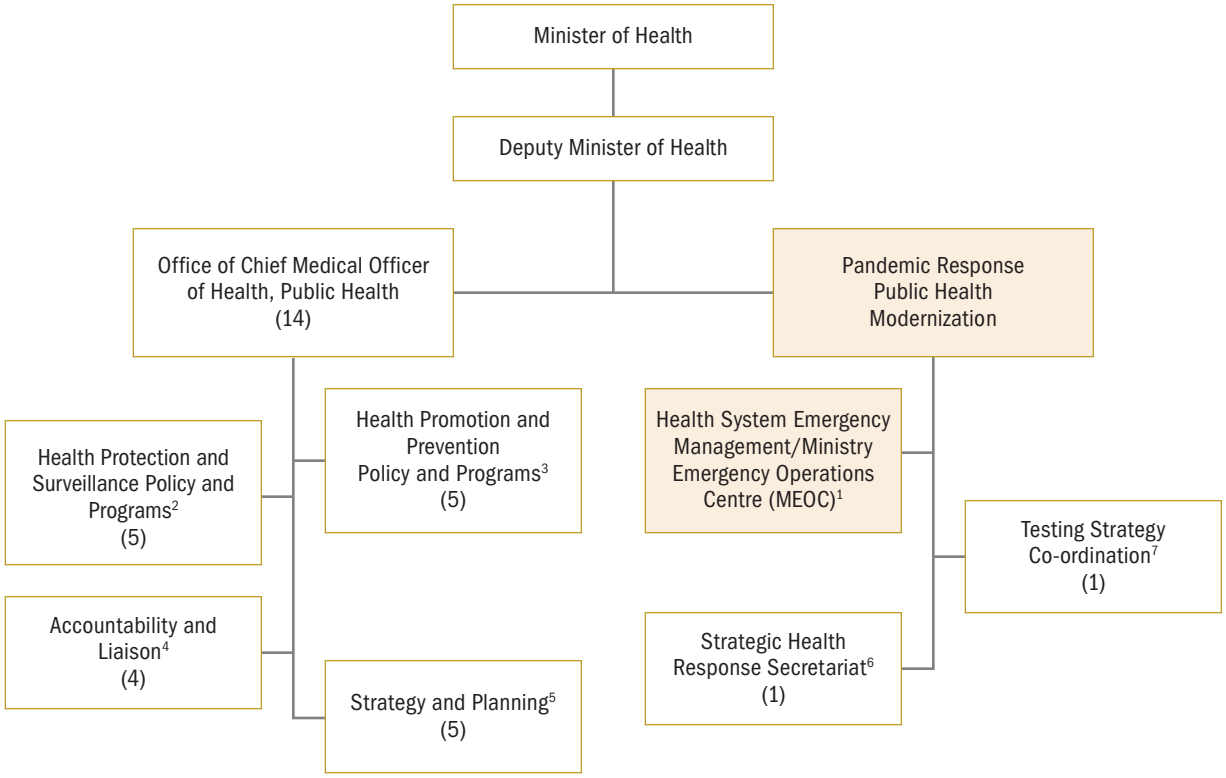
One of Public Health Ontario's responsibilities is to provide scientific and technical advice and operational support during an emergency or outbreak situation that has health implications. This would occur when directed by the Chief Medical Officer of Health, who sits on Public Health Ontario's strategic planning committee and has an ability to attend Public Health Ontario's board meetings.

Public Health Ontario has been recognized for its important role in public health within Ontario. For example, a review was conducted in 2018 by a panel with expertise in public health (including current and former local and provincial medical officers of health and the Medical-Scientific Director of public health laboratories) from across Canada. The purpose of the review was to evaluate whether Public Health Ontario was meeting its mandate. Overall, the panel concluded that:

> Public Health Ontario delivers high quality services to its many clients and that its work is having an important positive impact on the public health system in Ontario and beyond, and on the health of the province's population. The leadership and staff of [Public Health Ontario], as well as its partners and funders should be commended for building an important institution which adds significant value to the health of Ontario's population and the health system which serves it.

Figure 9: Ministry of Health's Divisions and Branches Responsible for Health-Sector Emergencies, Effective August 31, 2020

Source of data: Ministry of Health



Note: The Ministry of Health re-organized the divisions and branches responsible for health-sector emergencies on August 31, 2020. See **Figure 4** for the prior organization structure.

1. The Health System Emergency Management Branch, which manages the MEOC, was realigned in August 31, 2020 from the Chief Medical Officer of Health/Public Health to report into the Pandemic Response Division. Its function is to provide emergency management support to the pandemic response and non-COVID emergencies.
2. The Health Protection and Surveillance Policy and Programs Branch develops, implements and evaluates Ontario's public health protection and prevention policies and legislation regarding immunization, environmental health and infectious diseases. The branch also provides oversight of public health programs, identified in the Ontario Public Health Standards, and supports public awareness and educational campaigns for public health.
3. The Health Promotion and Prevention Policy and Programs Branch leads the design, development, funding, implementation and evaluation of strategic population-based policies and programs in the areas of health promotion and prevention.
4. The Accountability and Liaison Branch develops policy and plans to support the implementation of divisional programs and priorities for public health. The branch also informs program and divisional priorities.
5. The Strategy and Planning Branch is responsible for leading enhanced and integrated divisional and public-health-sector strategic planning and priority setting; research, evidence synthesis, knowledge dissemination and evaluation; and the development, implementation and co-ordination of integrated policies and strategies.
6. The single staff member is the Director, Strategic Health Response Secretariat, who will be responsible for the Secretariat co-ordinating our interactions with the various command tables within the Ministry, sector, federal government, municipalities and the OPS.
7. The single staff member is the Director, Testing Strategy Co-ordination, who will be responsible for leading a centralized, dedicated area to work within the Ministry and the sector on the testing strategy.

As identified in **Appendix 3**, Public Health Ontario has participated in the province's response to COVID-19. This includes operating seven public health laboratories that perform COVID-19 testing, and providing surveillance data, advice and support to public health units related to case management and contact tracing of individuals who tested positive for COVID-19. Public Health Ontario has two

representatives on the Health Command Table (its Chief Health Protection Officer and Chief Microbiologist), but most of the remaining 30 members of the table do not have public health expertise.

Members of the Health Command Table informed us that, although public health issues were frequently discussed, public health experts (including Public Health Ontario) were not always asked for input. One example of a decision made without the advice of health experts was to test all visitors to long-term-care home settings (see **Section 4.4.2**).

Instead of seeking more advice from Public Health Ontario, activities that could have been led by Public Health Ontario were taken on by Ontario Health. For example:

- The Ontario Health Plan for an Influenza Pandemic (Health Pandemic Plan, discussed in **Section 4.7.1**) identifies the roles and responsibilities of various parties in the event of an influenza pandemic. The plan identifies Public Health Ontario's role as leading and communicating the provincial surveillance strategy and performing provincial surveillance data analysis and interpretation. While Public Health Ontario did oversee the collection and reporting of COVID-19 case information to both the Health Command Table and the public, Ontario Health consolidated and analyzed the surveillance information to report on metrics to the Health Command Table, including the surveillance data related to other health-care system areas, such as hospital bed utilization and laboratory test turnaround times.
- The Health Pandemic Plan also identifies that Public Health Ontario's role and responsibilities include co-ordinating and providing provincial influenza laboratory testing and that hospital laboratories should provide testing data to Public Health Ontario. Public Health Ontario did perform COVID-19 laboratory testing, but this was co-ordinated by Ontario Health. All laboratories performing COVID-19 testing (i.e., Public Health Ontario, hospital and community laboratories) had to also provide this data to Ontario Health. Also, as was mentioned in **Section 4.1.1**, the Chief Coroner of Ontario was designated the Executive Lead for the COVID-19 Testing Approach.

Part of this is due to resource constraints at Public Health Ontario, which required Ontario Health to perform these additional roles.

As an agency responsible for providing scientific and technical advice, there is value in Public Health Ontario's advice during public health emergencies being made public. This can give the public comfort that Ministry and government decisions are aligned with the advice that has been received and makes it transparent when such advice is not being followed.

Public Health Ontario's role in Ontario's COVID-19 response may have been impacted by its funding. Since 2013/14, Public Health Ontario's funding for its core operations (about $148 million) has not changed. *Public Health Ontario's Annual Business Plan 2017/18 to 2019/20* warned of a "[l]ack of sustainable funding to continue to deliver on [its] mandate, including [its] ability to comprehensively respond to emerging public health threats." Despite this, no additional funding was provided by the Ministry to Public Health Ontario. **Chapter 3 Laboratory Testing, Case Management and Contact Tracing** provides more details on how this lack of funding impacted Public Health Ontario in the COVID-19 response.

4.1.5 Regional Response Structure Is Not Led by Public Health Experts

Apart from the provincial response structure (including the Health Command Table, discussed in **Section 4.1.1** and the Central Co-ordination Table, discussed in **Section 4.1.2**), Ontario Health also set up a regional response structure. It consists of five Regional Steering Committees that support Ontario Health's pandemic response and support Ontario Health's CEO's participation at the Health Command Table. Each of the five Regional Steering

Committees also set up sub-tables to direct and co-ordinate local resources in accordance with province-wide direction, and provide feedback to inform province-wide decision-making. The Regional Steering Committees began meeting between March 1 and March 3, 2020, and supported Ontario Health's CEO serving as a functional co-chair of the Health Command Table. The Regional Steering Committees vary in size, ranging from 22 to 33 members, and as of August 31, 2020, include 137 individuals in total. **Figure 8** shows a typical organizational structure for a Regional Steering Committee.

Although COVID-19 is a public health pandemic, the Regional Steering Committees are not primarily led by people with public health expertise. Instead, each is generally co-led by a regional lead (who works for Ontario Health) and a hospital CEO from the respective region.

The role that Ontario Health has taken on in this process was an issue raised by several Medical Officers of Health who responded to our survey. They specifically highlighted that Ontario Health's leadership role in these public health matters is confusing given that Public Health Ontario and the Office of the Chief Medical Officer of Health are more experienced in public health. These Medical Officers of Health conveyed that their role as public health experts was being diminished and were concerned that the needs of public health were being made subservient to Ontario Health's direction and requirements. One Medical Officer of Health identified that their biggest challenge during the pandemic was working with their Regional Steering Committee—specifically with the frustration of dealing with a committee leadership attempting to make decisions about issues of which they had no knowledge.

Ontario Health informed us that hospitals co-lead the Regional Steering Committees because of the expectation that COVID-19 would have a significant impact on hospitals and that additional hospital capacity would need to be created quickly (however, at the time of our audit, this had not fully come to pass). As Ontario's COVID-19 response evolved, hospitals were involved, instead, in establishing the assessment centres to test individuals for COVID-19 and forwarding the tests to a hospital or other laboratory.

In our view, public health experts, instead of hospitals, should have played a more significant role in the leadership of the regional response structure. Most significantly, while hospitals provided care for patients with severe cases of COVID-19, most patients actually sought care from other health-care practitioners instead. As of August 31, 2020, almost 90% of people with COVID-19 (37,530 of the 42,421 people identified as having COVID-19 in Ontario) were not hospitalized for it.

4.1.6 British Columbia's COVID-19 Response Was Faster and Led by a Smaller Team

British Columbia's structure to respond to the COVID-19 pandemic involved a smaller group of individuals than Ontario's structure did. The Provincial Health Officer (a role similar to the Chief Medical Officer of Health in Ontario) informed us that British Columbia's COVID-19 response took advantage of existing structures rather than creating a new complex structure with various tables. Its response structure was documented in the British Columbia Pandemic Preparedness Plan, which included clearly defined roles and responsibilities for all participants in the government and the health-care sector. It was updated in February 2020 in anticipation that it would be put into practice.

The health system response structure was coordinated by a Health Emergency Coordination Centre, which is similar to Ontario's Ministry of Health Emergency Operations Centre (see **Section 4.3.1**) in terms of its roles and responsibilities. Overall, the Provincial Health Officer in British Columbia informed us that she, along with the Deputy Ministry of Health have consistently lead the province's COVID-19 response.

This simpler structure appears to have helped British Columbia to act faster and more decisively than Ontario in a number of instances throughout the pandemic. For example:

- British Columbia urged residents to avoid all non-essential travel, including to the United States, on March 12, 2020. On that day, the province of Ontario told the media that although the situation could change, families were advised that it was fine to go away on their vacations and enjoy themselves during the March break (see **Section 4.3.3**).
- On March 27, British Columbia issued a provincial public health order to limit workers at long-term-care homes to working at a single facility. The Ontario government did not follow suit until April 14 (see **Section 4.3.5**).
- On April 14, British Columbia issued a provincial public health order to employers providing accommodation for temporary foreign workers, including those working on farms, to mandate quarantine and other public health measures so as to more effectively and proactively address the risk of their congregate living arrangements. No such formal order was made by Ontario. It was not until June 21 that Ontario's Chief Medical Officer of Health issued a memo to the 34 local Medical Officers of Health, strongly recommending that they individually issue local orders. At that time, 16 outbreaks had already happened at farms across Ontario, with at least 385 people testing positive for COVID-19 (see **Section 4.2.2**).

RECOMMENDATION 1

To operate with a simpler and clearer decision-making structure that can respond more quickly to subsequent waves of COVID-19 in Ontario, we recommend that the Secretary of Cabinet and Ministry of Health:

- streamline and refresh the structure of the Health Command Table and its sub-tables to identify and retain the members and experts who are most critical and appropriate to provide advice to the Government;
- designate the role of Chief Medical Officer of Health, supported by Public Health Ontario and the Public Health Measures Tables, as a co-chair of the Health Command Table and formalize the leadership responsibilities of the Chief Medical Officer of Health in this role;
- review the role of Public Health Ontario as part of the COVID-19 response to determine activities it should take over (such as leading provincial public health surveillance, with support from Ontario Health for health system capacity);
- modify the *Ontario Agency for Health Protection and Promotion Act* to identify under what circumstances (such as during public health emergencies) Public Health Ontario's scientific and technical advice should be made public; and
- establish local Medical Officers of Health from the public health units as co-chairs of the Regional Steering Committees.

CONSOLIDATED RESPONSE FROM MINISTRY AND SECRETARY OF CABINET

Cabinet Office and the Ministries agree with the need to continue to review and update the response structures, to provide timely, evidence-based advice to the government, as the pandemic continues. Ontario's pandemic response, including the structures designed to support it, continues to evolve and adapt to address Ontario's changing needs. Our response has benefitted from advice from a consulting firm on international best practices.

The Health Co-ordination Table, which includes Public Health Ontario, provides advice to the Minister of Health and the Minister of Long-Term Care.

The Chief Medical Officer of Health and/or his associates/delegates regularly attend the Central Co-ordination Table when agenda items require the expertise of the Chief Medical Officer of Health, and will continue to do so, as will key Public Health Ontario and Ontario Health officials.

4.2 Chief Medical Officer of Health neither Led nor Independently Used Full Powers as Part of COVID-19 Response

The Chief Medical Officer of Health must possess expertise and credibility, and be given independence, in order to be a leading voice for public health in Ontario. The Chief Medical Officer of Health must also be given powers to use his or her expertise, free from political interference, to give direction and make decisions that protect the public where its health is at risk. While changes were made to the role of the Chief Medical Officer of Health in response to SARS, not all recommended actions were taken to ensure the Chief Medical Officer of Health is operating independently during a health emergency. While his powers are discretionary, the Chief Medical Officer of Health did not exercise his full powers during Ontario's COVID-19 response, including not issuing directives on behalf of local Medical Officers of Health. In some cases, actions (such as requiring a masking mandate to be followed in each public health unit) were eventually executed by the Premier and Cabinet.

4.2.1 Recommendations for Enhancing Independence of Chief Medical Officer of Health Post-SARS Were Not Fully Implemented

The powers of the Chief Medical Officer of Health are defined in the *Health Protection and Promotion Act* (Act). In 2004, the Act was changed to legislate the independence of the role of the Chief Medical Officer of Health. This was done in response to recommendations from key reports that identified lessons learned from SARS in 2003. **Appendix 2** highlights the recommendations related to the independence of the Chief Medical Officer of Health and their implementation status. **Figure 10** highlights the powers of the Chief Medical Officer of Health, as well as those granted to the Minister of Health and local Medical Officers of Health in the Act. **Appendix 11** shows the relevant sections of the Act associated with these powers.

One of the recommendations by the SARS Commission was that the Chief Medical Officer of Health should retain a position as Assistant Deputy Minister (reporting to the Deputy Minister of Health) in order to remain accountable to the government for overall public health policy and direction and for the expenditure of public funds. However, another recommendation was that during an infectious disease outbreak, the Chief Medical Officer of Health should have operational independence from the Ministry, meaning that the Chief Medical Officer of Health should be able to independently formulate his or her own advice for the Ministry to take. Another recommendation by the SARS Commission that was any ministerial recommendations by the Chief Medical Officer of Health be in writing and publicly available.

However, not all of the recommendations based on lessons learned from SARS were followed in response to COVID-19. For example:

- The Chief Medical Officer of Health did not play a leading role in the Health Command Table (even though he was identified as a "functional co-chair," he did not take on any additional roles or responsibilities that would support this title). Instead, the Deputy Minister of Health was identified as the lead of the table (see **Section 4.1.3**).
- The Chief Medical Officer of Health was not a permanent member of the Central Co-ordination Table (see **Section 4.1.2**).
- Not all of the advice given by the Chief Medical Officer of Health to the Health Command Table was made publicly available.

Figure 10: Summary of the Powers of the Chief Medical of Health, the Minister of Health and Local Medical Officers of Health under the *Health Protection and Promotion Act*

Prepared by the Office of the Auditor General of Ontario

Power	Chief Medical Officer of Health	Minister of Health	Local Medical Officers of Health
Issuing Directives to health-care providers where: • an immediate risk exists to the health of persons in Ontario.	77.7(1)*		
Issuing Orders to health-care providers where: • an immediate risk exists to the health of persons in Ontario from a new or emerging disease.		77.7.1(1)*	
Issuing Directives to Boards of Health and Medical Officers of Health where: • there is an immediate risk of a provincial, national or international public health event, a pandemic or an emergency with health impacts in Ontario; and • policies or measures are necessary to support a co-ordinated response to the situations above.	77.9(1) 77.9(2)*		
Issuing Orders where: • a communicable disease exists or may exist; • a communicable disease presents a risk to the health of persons in the health unit; and • the requirements in the order are necessary to decrease or eliminate the risk to health presented by the communicable disease.	77.1(2)		22(1) 22(2)*

* **Appendix 11** provides details of the relevant sections from the *Health Protection and Promotion Act.*

As shown in **Figure 11**, the Chief Medical Officer of Health did issue five directives to various health-care providers and health-care entities (which oversee health-care providers), but we found that the decisions to issue these directives were not made independently. The Chief Medical Officer of Health confirmed that while he has the independent authority to issue directives, he consulted with the Deputy Minister of Health, the Health Command Table and others before doing so.

4.2.2 Chief Medical Officer of Health Did Not Use All Available Powers during Provincial COVID-19 Response

The Chief Medical Officer of Health did not use the full powers he has under the *Health Protection and Promotion Act* (Act) to lead Ontario's COVID-19 response. Many local Medical Officers of Health indicated that this would have improved Ontario's COVID-19 response. The Act also gives local Medical Officers of Health the power to "make a written order that 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." This power is to be exercised to respond to a local need where a provincial order would not be appropriate or relevant to all jurisdictions. **Figure 10** and **Appendix 11** give more details of the powers of both the Chief Medical Officer of Health and local Medical Officers of Health.

The powers of the Chief Medical Officer of Health to issue directives were expanded over the last decade to include the following:

- **Power to report directly to the Legislature or to the public:** As of 2004, the Act gave the Chief Medical Officer of Health the responsibility to report to the Legislature annually and the authority to make other reports to Ontarians whenever necessary.

Figure 11: Directives issued by the Chief Medical Officer of Health under Section 77.7 of the *Health Protection and Promotion Act*

Prepared by the Office of the Auditor General of Ontario

Directive #	Original Date Issued*	Issued To	Topic	Key Instructions from the Original Directive
1	Mar 12, 2020	Health-care providers and health-care entities	Use of personal protective equipment (PPE) for care of patients with suspected or confirmed COVID-19	Droplet and contact precautions must be taken for routine care. Airborne precautions must be taken when aerosol-generating medical procedures are planned or anticipated.
2	Mar 19, 2020	Health-care providers	Cessation or reduction to minimal levels of all non-essential and elective services	All non-essential and elective services should be stopped. Allowable exceptions can be made for time-sensitive circumstances to avert or avoid negative patient outcomes or a situation that would have a direct impact on the safety of patients. Guidance for clinicians was provided on determining what is an essential service.
3	Mar 22, 2020	Long-term-care homes*	Precautions and procedures for residents of long terms care homes*	Residents should not be permitted to leave the home's property. Wherever possible, employers should work with employees to limit the number of different work locations that employees are working at.
4	Mar 24, 2020	Ambulance services and paramedics	Use of PPE for care of patients with suspected or confirmed COVID-19	Surgical masks are to be used for suspected COVID-19 patients. If a patient suspected of COVID-19 is anticipated to require a necessary aerosol-generating medical procedure (AGMP), paramedics should change into a fluid-resistant N95 respirator. Based on a point-of-care risk assessment, it may be appropriate to use N95 respirators for situations other than COVID-19.
5	Mar 30, 2020	Hospitals	Precautions and procedures for hospitals	A point-of-care risk assessment is required before every patient interaction. Hospitals must provide workers with access to the appropriate health and safety control measures, including an N95 respirator. Hospitals must not unreasonably deny their staff appropriate PPE, including N95 respirators, as needed. Hospitals must assess the available supply of PPE on an ongoing basis and explore all avenues to maintain a sufficient supply.

Note: Revisions were made to the directives subsequent to the original issuance date.

* Directives related to long-term-care homes are covered in a separate chapter of our Office's series of audit reports on COVID-19 (see **Chapter 5**).

This means the Chief Medical Officer of Health is able to speak directly to the people of Ontario and to act in the best interest of public health and safety.

- **Power to act on behalf of Medical Officers of Health:** As of 2004, the Act granted the Chief Medical Officer of Health the power to exercise, anywhere in Ontario, any of the powers of a Board of Health or a Medical Officer of Health, in order to investigate or act where they consider it necessary to prevent, eliminate or decrease a risk to the health of any individuals. This means that the Chief Medical Officer of Health can issue a written order to require any person or business to take or to refrain from taking any action that is specified in the order in respect of a communicable disease.
- **Power to issue directives to health-care providers and health-care entities:** As of 2007, the Act granted the Chief Medical Officer of Health the power to issue mandatory directives that health-care providers and health-care entities must comply with. This power was used in 2015 to issue five directives to health-care providers and health-care entities in response to Ebola, which was a virus spreading from West Africa.
- **Power to issue directives to local Medical Officers of Health:** In 2011, subsequent to the H1N1 virus outbreak in 2009, the Act was amended to allow the Chief Medical Officer of Health to issue directives to the Boards of Health and the Medical Officers of Health at local public health units, "requiring the adoption or implementation of policies or measures concerning the matters" such as "infectious diseases, health hazards, and public health emergency preparedness" if the Chief Medical Officer of Health is of the opinion:
  - that there exists, or there is an immediate risk of, a provincial, national or international public health event, a pandemic or an emergency with health impacts anywhere in Ontario; and
  - that the policies or measures are necessary to support a co-ordinated response to the situations or to otherwise protect human health.

While the power to issue directives to Boards of Health and Medical Officers of Health or on behalf of Medical Officers of Health remained in place in 2020, at the time of our audit it had not been exercised by the Chief Medical Officer of Health in response to the COVID-19 pandemic.

The Chief Medical Officer of Health has discretion to determine when and how to use his power of issuing directives or acting on behalf of local Medical Officers of Health. The Chief Medical Officer of Health informed us that issuing directives to local Medical Officers of Health was not necessary during the pandemic because he believed the local Medical Officers of Health would each enforce measures that were appropriate for their respective regions. The Chief Medical Officer of Health also indicated he did not believe that his role was to force local Medical Officers of Health to issue the written orders they are empowered to issue under the Act.

In place of provincial directives, local Medical Officers of Health can issue their own orders to cover individuals and organizations operating in that specific region. However, certain actions may be more appropriate for the entire province or even multiple regions of the province. For example, it is common for people to commute between multiple public health unit regions in the same day, suggesting that it is appropriate for orders to be consistent in those regions. This is also reflected in advice provided by the Public Health Measures sub-table to the Chief Medical Officer of Health: "[t]here is significant movement of populations for work and other activities; the location of acquisition is not the same as the location of residence," and "[a] provincial or large geographic application reflects a population health approach."

Without additional provincial directives, each of the 34 public health units had to make decisions independently, resulting in different responses and measures across the province. Local Medical Officers of Health told us that the Chief Medical Officer of Health could have used his power to issue province-wide directives in order to ensure provincial consistency in the COVID-19 response, especially on requirements to wear masks and precautions for temporary foreign farm workers.

No Consistent Provincial Message and Requirement on Wearing Masks until October 2020

All 34 public health units, or the municipalities they reside in, issued orders or bylaws that required people in their regions to wear masks in indoor public spaces (in one case—the municipality where the Lambton public health unit resides—the municipality issued bylaws for only certain areas of the region).

However, the orders were not only issued at different times (ranging from June 26 to August 17) but also varied significantly in terms of requirements on ages and locations, and in terms of religious exemptions. For example:

- While Toronto Public Health unit required masks to be worn by children over the age of two, Middlesex-London Health Unit required individuals over the age of 12 to wear masks.
- Each public health unit or municipality has its own unique list of locations where masks are mandated and exempted.

Figure 12 identifies the differences in masking orders in each public health unit. Such regional variations can create confusion for those who commute or make visits or trips to different public health regions. While the Chief Medical Officer of Health did issue several directives to health-care workers, including those in hospitals, ambulances and long-term-care home settings (see **Figure 11**), he did not issue directives that covered the general public.

About 68% (19 of 28) of the Medical Officers of Health who responded to our survey indicated that the Chief Medical Officer of Health should have issued a directive related to community masking protocols to provide a consistent message across the province. Local Medical Officers of Health indicated that, without such a provincial directive in place, they spent a significant amount of time and resources developing their own orders. While a requirement to use face coverings in all public indoor spaces became mandatory across the province effective October 3, this was done through a modification to the emergency order related to COVID-19 and not through a Chief Medical Officer of Health directive.

We noted that across Canada, not all provincial jurisdictions had a provincial masking order in place. **Figure 13** identifies the status of such orders across Canada.

No Provincial Order to Protect Foreign Farm Workers

On April 14, 2020, the Public Health Officer in British Columbia issued an order to travellers and employers, including employers that provided accommodations to temporary foreign workers such as farm workers. The order required the employers to develop a COVID-19 protocol and to ensure that workers self-isolated for 14 days, were housed in hygienic conditions, and were provided with medical care. In contrast, no provincial directive was ever issued in Ontario, even after the first farm outbreak was reported on April 27.

Ontario's public health units used various methods to manage the risk of COVID-19 in congregate living settings on farms. Some issued mandatory orders to farms in their regions, others issued guidance and still others contacted farms directly to discuss the conditions they were facing. **Figure 14** identifies the differences in the orders or guidance issued by public health units for foreign farm workers.

Figure 12: Orders Issued by Public Health Units, Municipal Governments and the Province of Ontario Mandating the Use of a Mask in Indoor Public Spaces across Ontario

Prepared by the Office of the Auditor General of Ontario

Issuing Authority	Order Issued Through *Health Protection and Promotion Act*	Order Issued Through Municipal Bylaw	Effective Date in 2020	Age Requirement
City of London		✓	Jul 21	>12 years old
Middlesex-London Health Unit	✓		Jul 21	>12 years old
Municipality of North Middlesex		✓	Jul 22	>12 years old
Municipality of Strathroy Caradoc		✓	Jul 20	>12 years old
Haldimand County		✓	Jul 27	>10 years old
Municipality of Chatham-Kent		✓	Aug 14	>9 years old
Brant County		✓	Jul 20	>5 years old
City of Waterloo		✓	Jul 13	>5 years old
County of Lambton[1]		✓	Jul 31	>5 years old
Niagara Regional Council		✓	Jul 31	>5 years old
Prince Edward County		✓	Jul 10	>2 years old
York Region Public Health		✓	Jul 17	>5 years old
Halton Region		✓	Jul 22	>5 years old
Durham Region Health Department	✓		Jul 10	>2 years old[2]
Eastern Ontario Health Unit	✓		Jul 7	>2 years old[2]
Grey Bruce Health Unit	✓		Jul 17	>2 years old[2]
Haliburton, Kawartha, Pine Ridge District Health Unit	✓		Jul 17	>2 years old[2]
Kingston, Frontenac, Lennox and Addington Public Health	✓		Jun 27	>2 years old[2]
North Bay Parry Sound District Health Unit	✓		Jul 24	>2 years old[2]
Northwestern Health Unit	✓		Aug 17	>2 years old[2]
Peterborough Public Health	✓		Aug 1	>2 years old[2]
Porcupine Health Unit	✓		Jul 23	>2 years old[2]
Public Health Sudbury and Districts	✓		Jul 17	>2 years old[2]
Renfrew County and District Health Unit	✓		Jul 14	>2 years old[2]
Simcoe Muskoka District Health Unit	✓		Jul 13	>2 years old[2]
Southwestern Public Health	✓		Jul 30	>2 years old[2]
Thunder Bay District Health Unit	✓		Jul 24	>2 years old[2]
Timiskaming Health Unit	✓		Jul 24	>2 years old[2]
Wellington-Dufferin-Guelph Public Health	✓		Jul 17	>2 years old[2]
Algoma Public Health	✓		Jul 17	>2 years old[3]
City of Brampton		✓	Jul 10	>2 years old[3]
City of Hamilton		✓	Jul 20	>2 years old[3]
City of Ottawa		✓	Jul 15	>2 years old[3]

Issuing Authority	Order Issued Through *Health Protection and Promotion Act*	Order Issued Through Municipal Bylaw	Effective Date in 2020	Age Requirement
Norfolk County		✓	Jul 24	>2 years old[3]
Town of Caledon		✓	Jul 10	>2 years old[3]
City of Mississauga		✓	Jul 10	>2 years old
City of Toronto		✓	Jul 7	>2 years old
Huron Perth Public Health	✓		Jul 17	>2 years old
Leeds, Grenville and Lanark District Health Unit	✓		Jul 7	>2 years old
Windsor-Essex County Health Unit	✓		Jun 26	>2 years old
Province of Ontario[4]			Oct 3	>2 years old

Note: See **Appendix 4** for the differences between orders issued through the *Health Protection and Promotion Act* and orders issued through a municipal bylaw.

1. Applies only to Sarnia, Lambton Shores Town of Petrolia and the Village of Point Edward.
2. Any child under the age of 5 (either chronologically or developmentally) who refuses to wear a face covering and cannot be persuaded to do so by their caregiver is also exempt.
3. Any child under the age of 5 who refuses to wear a face covering and cannot be persuaded to do so by their caregiver is also exempt.
4. Implemented as part of an amendment to Ontario Regulation 364/20 (Rules for Areas in Stage 3 under the *Reopening Ontario [A Flexible Response to COVID-19] Act, 2020*).

While the Chief Medical Officer of Health did issue a memo on June 21 to all public health units, it was only "strongly recommending that Medical Officers of Health use their authority under Section 22 of the *Health Protection and Promotion Act* to issue class orders to ensure that employers of temporary workers take actions to decrease the risk of transmission of COVID-19 virus on farms." We found that most of the 34 public health units (62%) did not follow this recommendation. Only 13 (38%) issued an order, while another 16 (47%) issued only guidance (there is no legal requirement for guidance to be followed). Of the five public health units (15% of the total) that did nothing, some told us they either had few or no farms in their region housing foreign workers.

Also, the orders and guidance issued by the 27 public health units varied. For example, seven of the 13 specifically identified that farm workers should work exclusively at one farm.

Only five (18%) of the 28 local Medical Officers of Health who responded to our survey indicated that they agreed with not having a provincial order related to foreign farm workers. Eleven of the 28 (39%) indicated there should have been a provincial order; another 11 (39%) were uncertain; and one stated the question was not applicable to them.

By August 31, farm outbreaks had occurred in seven public health units, resulting in 1,335 COVID-19 cases. Of the seven units, apart from Windsor-Essex County Health Unit (which implemented its own directive), four (Chatham-Kent, Haldimand-Norfolk, Niagara and Southwestern Public Health) issued an order, while no order was issued by the remaining two (York and Middlesex-London).

4.2.3 Public Health Officers in Other Jurisdictions Have Clearer Roles and Powers

British Columbia and Quebec have public health officers (respectively called the Provincial Health Officer and the National Public Health Director) which are roles similar in structure to Ontario's Chief Medical Officer of Health and work under a similar model as Ontario. As in Ontario, they work under their respective health ministries and can issue orders or directives to other parties. However, we noted some important differences in their roles as the senior public health official in their province. **Figure 15** compares the roles and powers of the

Figure 13: Provincial or Territorial Masking Orders across Canada, as of October 31, 2020

Prepared by the Office of the Auditor General of Ontario

Province or Territory	Mandatory Masking Order in Place for the Entire Province or Territory?	Date Implemented
AB	No	—[1]
BC	No	n/a
MB	No	—[2]
NB	Yes	Oct 9, 2020
NL	Yes	Aug 24, 2020
NT	No	—
NS	Yes	Jul 31, 2020
NU	No	—
ON	Yes	Oct 3, 2020[3]
PE	No	—
QC	Yes	Jul 18, 2020
SK	No	—
YT	No	—

Note: Changes to provincial/territorial/municipal masking orders and guidance have occurred since November 1, 2020.

1. The following municipalities enacted bylaws to make masks mandatory in public spaces: Banff (effective July 31), Beaumont (effective August 14), Calgary (effective August 1), Canmore (effective August 7), Edmonton (effective August 1), Fort Mckay First Nation (effective July 11), Fort Saskatchewan (effective October 13), Grand Prairie (effective October 26), Jasper (effective August 5), Lethbridge (effective August 24), Leduc (effective October 8), Okotoks (effective October 26), Regional Municipality of Wood Buffalo (effective October 26), Spruce Grove (effective October 23), St. Albert (effective August 8, 2020), Stony Plain (effective October 27), Strathcona County (effective October 5) and Sturgeon County (effective August 20).
2. The city of Winnipeg enacted a bylaw to make masks mandatory in public spaces, effective September 28, 2020.
3. Municipalities across Ontario had implemented masking bylaws before the provincial order came into effect. See **Figure 12** for the dates of implementation.

Chief Medical Officer of Health (or equivalent) in British Columbia, Quebec and Ontario.

The most relevant difference is the clarity in British Columbia and Quebec legislation on the public health officer's ability to issue directives. Ontario's legislation indicates that the Chief Medical Officer of Health can issue directives directly to health-care service providers, health-care entities, Boards of Health or Medical Officers of Health, but not to parties not related to the health-care sector or residents of Ontario, unless he is exercising his right to use the powers of a Medical Officer of Health or Board of Health in response to a risk. Medical Officers of Health have the right to issue orders to any person in their region to act or refrain from acting in response to a risk from a communicable disease. This is a more complex process than in British Columbia and Quebec, where the public health officers can issue directives or orders to any person for the purpose of having them take or refrain from taking action.

Another important difference is the power to declare a public health emergency. The *Health Protection and Promotion Act* in Ontario does not include a mechanism to declare a Public Health Emergency that would lead to emergency measures. The directive issuance powers of the Chief Medical Officer of Health and Medical Officers of Health discussed above may be used whenever they discern a "risk to health." The COVID-19 pandemic was declared an emergency by the Lieutenant Governor in Council under the *Emergency Management and Civil Protection Act* on March 17, 2020 and emergency orders related to health were issued as regulations under that Act, in addition to the Chief Medical Officer of Health directives. In contrast, under the British Columbia and Quebec Public Health Acts, a public health emergency must be

Figure 14: Orders and Guidance Issued by Public Health Units to Farms and Congregate Living Facilities for Foreign Workers

Prepared by the Office of the Auditor General of Ontario

Public Health Unit	Order Issued through *Health Protection and Promotion Act* [1]	Guidance Issued[1]	Effective Date in 2020
Algoma Public Health		✓	Jul 27
Brant County Health Unit	✓		Jul 24
Chatham-Kent Public Health	✓		Jul 24
City of Hamilton Public Health Services		✓	Apr
Durham Region Health Department	✓		Jun 24
Eastern Ontario Health Unit	✓		Jul 10
Grey Bruce Health Unit		✓	Apr 2
Haldimand-Norfolk Health Unit	✓		Mar 24
Haliburton, Kawartha, Pine Ridge District Health Unit	✓		Jul 9
Halton Region Health Department		✓*	–
Hastings Prince Edward Public Health	✓		Jul 3
Huron Perth Public Health	✓		Jun 30
Kingston, Frontenac, Lennox and Addington Public Health			–
Lambton Public Health		✓	Apr 3
Leeds, Grenville and Lanark District Health Unit		✓	Jun 17
Middlesex-London Health Unit		✓	Apr 1
Niagara Region Public Health	✓		–
North Bay Parry Sound District Health Unit		✓	Apr 17
Northwestern Health Unit			–
Ottawa Public Health		✓	Apr 6
Peel Public Health		✓	Apr 9
Peterborough Public Health		✓*	–
Porcupine Health Unit			–
Public Health Sudbury and Districts		✓	Jun 23
Region of Waterloo Public Health and Emergency Services	✓		Jun 29
Renfrew County and District Health Unit		✓	Jun 24
Simcoe Muskoka District Health Unit	✓		Jun 24
Southwestern Public Health	✓		Jul 8
Thunder Bay District Health Unit			–
Timiskaming Health Unit		✓	Jul 7
Toronto Public Health			–
Wellington-Dufferin-Guelph Public Health		✓	Apr 3
Windsor-Essex County Health Unit	✓		Jun 13
York Region Public Health		✓	Apr 24
Total	**13**	**16**	

Note: See **Appendix 4** for the differences between orders issued through the *Health Protection and Promotion Act* and guidance.

* The public health units contacted farms directly to either identify pre-existing guidance that farms can refer to or answer specific questions of the farm operators.

Figure 15: Comparison of the Role of the Chief Medical Officer of Health (or Equivalent) in Ontario, British Columbia, and Quebec

Prepared by the Office of the Auditor General of Ontario

Details of the Role	ON	BC	QC
Position title	Chief Medical Officer of Health	Provincial Health Officer	National Public Health Director
Enabling legislation	*Health Protection and Promotion Act*	*Public Health Act*	*Public Health Act*
Is the role explicitly designated as a Senior Public Health Official?	No	Yes	No
Can the role act or direct the actions of local Medical Officers of Health?	Yes	Yes	Yes
Whom does the role issue directives or orders to?	Health-service providers and Boards of Health*	Any person for the purpose of having them take preventative measures	Any person for the purpose of having them take preventative measures or to eliminate a threat unless a government department, a local municipality or a body has the same power and is able to exercise it.
Does the role report to the Legislature?	Yes	Yes	No

* The Chief Medical Officer of Health can act as a Medical Officer of Health and issue an order to any person for the purpose of having them take preventative measures.

declared in order for all of the emergency powers of the Acts to be used.

- The COVID-19 pandemic was declared an emergency in British Columbia by the Provincial Health Officer under the *Public Health Act* on March 17, 2020, activating her ability to issue emergency orders. The British Columbia provincial government also declared an emergency under the *Emergency Program Act* on March 18, 2020, which allowed them to issue additional regulations such as enforcement measures for gatherings and events.
- In Quebec, a public health emergency was declared under the *Public Health Act* on March 13, 2020. The National Public Health Director does not need an emergency to be declared to issue orders to the public; however, after declaration of an emergency, the Minister is able to use their additional emergency powers. The Quebec *Public Health Act* emergency measures cover a wide range of areas, such as the ability to close schools and daycares and limit indoor gathering size.

British Columbia's Provincial Health Officer, clearly empowered by the province's *Public Health Act* and Pandemic Plan to provide leadership during the COVID-19 pandemic, issued 10 orders on behalf of the Medical Officers of Health for all five regional health authorities between March and August 2020 (see **Figure 16**). These orders were related to public health measures such as limiting long-term-care home staff movement between facilities as well as developing protocols for returning travellers, employers with essential staff who must travel, and employers who provide accommodations to foreign workers. As shown in **Figure 16**, the Chief Medical Officer of Health in Ontario did not issue directives with mandatory measures related to any of these areas; however, in one directive he instructed long-term-care facilities to work to limit staff work locations, where possible.

Figure 16: Listing of Directives and Orders Issued by the Provincial Health Officer in British Columbia, as of August 31, 2020

Prepared by the Office of the Auditor General of Ontario

Provincial Health Officer Order in British Columbia			Same Directive or Order in Ontario?	
Date Issued in 2020	**Order**	**Description**	**Directive Issued by Chief Medical Officer of Health**	**Order Issued by the Lieutenant Governor on Behalf of the Government**
Mar 26	Information Collection from Long Term Care Facility Staff in order to allocate staff to one workplace at one site	Issued to long-term-care facilities, private hospitals, assisted-living residences and designated hospitals requiring personal and work-related information collection to allocate staff working in facilities. Staffing decisions will be supported by ongoing dialogue and problem-solving among the Provincial Health Officer, Ministry of Health, Health Employers Association of BC (HEABC), Bargaining Associations and unions representing employees at non-HEABC employers. Each staff will for the most part only be allowed to work at one site.		
Mar 27	To restrict employees from working in more than one Long-Term-Care Home	Issued to long-term-care homes and private hospitals, which must restrict the movement of staff between facilities by ensuring that staff work in only one facility. Homes may seek approval from the medical officer of health to permit a staff member to work in more than one facility if they are unable to ensure adequate staffing levels in a facility as a result of complying with the direction of the medical officer of health. Homes must not terminate the employment of, or otherwise penalize, staff, and must preserve all benefits, coverage and other perquisites for staff who comply with the direction of the medical officer of health with respect to where they are to work.		✓[1] (Apr 14, 2020)
Apr 14	Travellers and Employers	Issued to all travellers, employers who provide accommodation to temporary foreign workers and employers of travellers who are essential workers, requiring 14-day isolation and other protocols after entering British Columbia.		
Apr 15	Long-term Care Facility Staff Assignment	Issued to Regional Health Boards and the long-term-care sector to requiring them to create working groups to allocate staff to one long-term-care and other congregate living facilities to ensure staff, volunteers and students are only placed in one facility. Medical Officers of Health will make orders assigning staff after considering the information provided by the working group.		
Apr 16	Personal Services	Issued to operators of personal service establishments and persons who provide personal services, requiring them to close/suspend service.		

Provincial Health Officer Order in British Columbia			Same Directive or Order in Ontario?	
Date Issued in 2020	**Order**	**Description**	**Directive Issued by Chief Medical Officer of Health**	**Order Issued by the Lieutenant Governor on Behalf of the Government**
May 7	Licensed Practical Nurse Swabbing	Issued to Licensed Practical Nurses authorizing them to conduct CoV-2 swabbing.		
May 14	Workplace Safety Plans	Issued to employers to require them to post a copy of their COVID-19 safety plan on their website and at their workplace, and provide a copy to a health officer or WorkSafe BC officer on request.		
May 28	Vending Merchandise at Markets	Issued to merchandise vendors at markets and market managers, providing regulations for handling, providing and selling products.		
May 29	Overnight Camps for Children and Youth	Issued to persons who own, occupy or are otherwise responsible for overnight camp facilities that cater to children and youth, requiring them to not operate and not permit anyone else to operate the facilities for the purpose of providing overnight camps for children and youth.		✓[2] (Jun 11, 2020)
Jul 2	Industrial Camps	Issued to persons who employ workers in the agricultural, forestry and resource sectors and/or who provide accommodation for them in an industrial camp or other congregate setting, including a motel, hotel or tents, requiring them to develop a COVID-19 infection prevention and control protocol to prevent and control the risk of transmission of COVID-19 to workers.		

1. The Emergency Order, issued under the Emergency Measures and Civil Protection Act (later moved to the *Reopening Ontario: A Flexible Response to COVID-19 Act*), required employees to disclose work locations and employers to ensure they were limited to one. Data collection and central allocation was not part of the order.
2. Per the Rules for Areas in Stage 2 regulation in the *Reopening Ontario (A Flexible Response to COVID-19) Act, 2020*, camps that provide supervised overnight accommodation for children are closed.
3. Per the *Reopening Ontario: A Flexible Response to COVID-19 Act*, workplaces are required to follow the *Occupational Health and Safety Act* and various other protocols to protect staff and patrons from COVID-19.

Legislation in British Columbia also explicitly makes clear that the role of the province's Public Health Officer is to be the senior public health official in the province. Ontario's legislation does not state the same for Ontario's Chief Medical Officer of Health.

RECOMMENDATION 2

To empower public health leadership in the province, we recommend that the Central Coordination Table, co-chaired by the Secretary of Cabinet and the Chief of Staff to the Premier and Ministry of Health:

- immediately assess the role and strength of the Chief Medical Officer of Health to lead Ontario's response in addressing subsequent waves of COVID-19; and
- strengthen the powers of the Chief Medical Officer of Health to align the authority of the role with the equivalent positions in British Columbia and Quebec, such as more clearly defining in legislation the Chief Medical Officer of Health's role, and explicitly authorizing the role to issue directives to anyone during an emergency.

CONSOLIDATED RESPONSE FROM MINISTRY AND SECRETARY OF CABINET

Cabinet Office notes that the Central Coordination Table is not a decision-making body. Rather, Ministers, supported by their Deputy Ministers and ministries, make recommendations directly to Cabinet for approval or endorsement. Funding decisions are made by Treasury Board (TB) based on submissions from ministries, and all TB decisions are confirmed by Cabinet.

The Ministry of Health will consider the recommendations regarding the role and authority of the Chief Medical Officer of Health as we move forward with public health modernization.

In November 2019, the Ministry of Health, in partnership with an advisor initiated consultations on strengthening and modernizing public health and emergency health services.

Consultations were put on hold in mid-March 2020 to allow public health to respond to the COVID-19 pandemic.

Once the COVID-19 pandemic is contained and risks to the public are mitigated, consultations will resume and the Ministry will move forward with public health modernization.

Recommendations from that review will be provided to the Minister of Health and reviewed by Cabinet through the regular decision-making processes.

4.3 Key Lesson from SARS—the Precautionary Principle—Could Have Prevented COVID-19 Spread, but Was Not Followed

The final report issued by the independent Commission established by the government of Ontario to investigate the introduction and spread of Severe Acute Respiratory Syndrome (SARS) stated:

> Perhaps the most important lesson of SARS is the importance of the precautionary principle. SARS demonstrated over and over the importance of the principle that we cannot wait for scientific certainty before we take reasonable steps to reduce risk.

The Commission recommended that the precautionary principle "be expressly adopted as a guiding principle throughout Ontario's health, public health and worker safety systems." This recommendation aligns with one of the guiding principles listed in the terms of reference for the Health Command Table; it specifically identified the precautionary principle and the need to not await scientific certainty before acting to protect the health of Ontarians. However, this guiding principle was not always followed by the Ministry. We identified several areas where earlier action could have been taken (particularly when compared with British Columbia), instead of waiting for certainty, and that such action would have likely reduced the spread of COVID-19 and associated deaths from it. Besides a delay in addressing the foreign farm worker situation as discussed in **Section 4.2.2**, some other areas included:

- an assessment of the risk of COVID-19 to Ontarians as low despite evidence of spread in multiple countries (see **Section 4.3.1**);
- restrictive testing criteria for COVID-19, excluding most people with travel history (see **Section 4.3.2**);
- a delay in advising Ontarians against non-essential travel (See **Section 4.3.3**)
- a delay in acknowledging community transmission of COVID-19 (see **Section 4.3.4**);
- a delay in requiring long-term-care home staff to wear personal protective equipment and restricting them from working at multiple facilities (see **Section 4.3.5**); and
- a delay in issuing an emergency order for retirement homes (see **Section 4.3.6**).

4.3.1 Ministry Assessed the Risk of COVID-19 to Ontarians as Low in January 2020, despite Evidence of Spread in Multiple Countries

The Ministry was monitoring the COVID-19 situation around the world and consulting with the federal government on the threat of the virus, but it did not perceive the threat to Ontario to be high in January 2020, despite evidence showing that COVID-19 had already spread outside of China. Alberta established a response structure to COVID-19 faster than Ontario, even though its first case of COVID-19 occurred more than a month after Ontario's.

The Ministry of Health Emergency Operations Centre is part of the Ministry's Emergency Management Branch and reported to the Chief Medical Officer of Ontario until August 31, 2020 (see **Section 4.1.3**). The Health Operations Centre is responsible for monitoring developing situations that may threaten the health system or health of Ontarians. On January 3 and January 8, 2020, the Office of the Chief Medical Officer of Health emailed Ontario's 34 public health units about the developing outbreak in China and other parts of Asia. The January 3 email identified that a cluster of viral pneumonia that was not yet diagnosed was being investigated in Wuhan, China. The January 8 email also indicated that additional information was being shared with the province by the Public Health Agency of Canada, which was in contact with the World Health Organization.

On January 22, 2020, the Health Operations Centre sent an email related to COVID-19 to the Provincial Emergency Operations Centre, which is operated by the Ministry of the Solicitor General to monitor situations inside and outside of Ontario in order to help identify and co-ordinate Ontario's response to major emergencies. While the email noted the reporting of cases in other Asian countries and the United States, it nevertheless stated that "the risk to Ontarians is considered low:"

> The Ministry of Health is actively monitoring novel coronavirus cases (2019-nCoV) that have been reported in Wuhan, China. Cases have also been reported in neighbouring countries (e.g., Japan, South Korea, Thailand and Taiwan) and the United States reported its first confirmed case on January 21. All infections outside of China have occurred in travellers to Wuhan and the risk to Ontarians is considered low. Ontario's health system has robust measures in place to detect and handle a potential case of 2019-nCoV, and the [M]inistry continues to actively monitor the situation and advance preparedness measures as necessary.

The next day (January 23, 2020) as part of a speech, the World Health Organization's Director-General spoke about the World Health Organization's monitoring of COVID-19 around the world. He identified that "WHO's risk assessment is that the outbreak is a very high risk in China, and a high risk regionally and globally".

Two days later, on January 25, 2020, the first presumptive COVID-19 case was identified in Toronto, Ontario, which was confirmed to be COVID-19 two days later. By the end of January 2020, more cases had been confirmed in about 20 countries, including Canada. By the end of February, COVID-19 had spread to over 50 countries. **Appendix 12** lists the first confirmed cases by country in January and February 2020. During this period, the Ministry's efforts focused on assisting the federal government with repatriation of Canadians from affected areas around the world and monitoring the prevalence of COVID-19

The Health Operations Centre activated its emergency plans on January 27, 2020 (see **Section 4.7.1**), but the Ministry did not establish the Health Command Table and COVID-19 response strategies until February 28, 2020.

In contrast, one month earlier, on January 29, 2020, the Alberta Health Service activated its emergency co-ordination centre to establish organizational leadership over COVID-19, help co-ordinate

between the five geographic regions and manage provincial information and communications. This action was more than one month before the first case was identified in Alberta on March 5, 2020. Overall decision-making for Alberta's COVID-19 response was made by the Emergency Management Cabinet Committee, which included Alberta's Premier and the Minister of Health. We were informed that the Committee started meeting in January 2020 and met as often as three times per week.

Creating a response structure earlier in Ontario could have allowed Ontario to better prepare and respond to COVID-19 and potentially prevent loss of life. For example, as shown in **Figure 6a** and **Figure 6b**, as of August 31, 2020, Alberta had more COVID-19 cases per capita (315 cases per 100,000 residents) compared to Ontario (288 cases per 100,000 residents); however, the COVID-19 death rate in Ontario (19 deaths per 100,000 residents) was more than three times higher than in Alberta (five deaths per 100,000 residents).

As identified in **Chapter 3 Laboratory Testing, Case Management and Contact Tracing**, Alberta began testing all symptomatic individuals for COVID-19 about a month prior to Ontario, meaning it was able to identify more of the actual COVID-19 prevalence in the province through testing than Ontario was.

4.3.2 Ministry Discouraged Having Most Travellers Tested for COVID-19, Despite COVID-19 Being Found in Many Countries

The Ministry asked hospitals to limit COVID-19 testing to people who had travelled to, or had been in close contact with someone from, China in February, despite COVID-19 having been confirmed in about 20 countries outside of China and Canada at that time (see **Appendix 12**). Similar restrictions were not in place in British Columbia, which allowed for testing for COVID-19 based on people's travel from, or contact with people from, other countries.

The Ministry first released a COVID-19 case definition on January 24, 2020. It provided health-care practitioners with guidance on what constituted a probable case of COVID-19. While testing guidance had not been issued, the case definition could be used to decide who should be considered for a COVID-19 test. At that time, probable cases were defined as individuals who had COVID-19 symptoms (including a fever, cough or difficulty breathing) or evidence of severe illness progression, and (1) who had travelled to Wuhan, China within 14 days of symptom onset or (2) who were in close contact with someone who either had COVID-19 or acute respiratory illness and had been to Wuhan, China within 14 days of their illness. As detailed in **Chapter 3 Laboratory Testing, Case Management and Contact Tracing**, the Ministry updated its testing guidance as more information was learned about COVID-19 and Ontario's laboratory testing capacity grew.

On February 7, 2020, the Ministry's COVID-19 case definition was updated to expand to travellers from mainland China, but still excluded travellers from other countries. As identified in **Appendix 12**, at that time COVID-19 had spread to 18 countries (in addition to China and Canada). Out of concern that hospitalized patients who had travel history to countries other than China could have COVID-19, some hospitals started testing these patients.

On February 16, 2020, the Health Operations Centre sent an email to health stakeholders identifying that it was aware that some hospitals wanted to test patients who had travelled to countries other than China for COVID-19 (including Japan, Taiwan and Thailand) and that this was against the Ministry's COVID-19 case definition. **Appendix 13** shows the email in full. The Health Operations Centre raised the concern that this could lead to possible confusion in the health-care system, with different hospitals doing different things. The e-mail said this would make laboratory testing and the health response more difficult to manage and co-ordinate, but did not clearly explain why. The e-mail concluded by identifying that:

> all health system providers should use the current Ontario case definition on the ministry website as part of the ongoing efforts to safeguard the health and safety of all Ontarians [as] we work to address the evolving COVID-19 situation.

In response to the February 16 e-mail, a group of 10 hospital epidemiologists sent a letter to the Chief Medical Officer of Health on February 21, identifying that as a result of the continued growth of COVID-19 cases in countries outside of China, their hospitals would be testing patients with COVID-19 symptoms who had recently travelled from countries where COVID-19 was spreading in local communities. The letter recommended that the Chief Medical Officer of Health start broader COVID-19 testing (such as for all hospital patients with COVID-19 symptoms) and increase the capacity for COVID-19 testing. As detailed in **Chapter 3 Laboratory Testing, Case Management and Contact Tracing**, while laboratories did start to increase their testing capacity, it was not until late March that a Provincial Laboratory Network was established under Ontario Health to facilitate co-ordination among the laboratories testing for COVID-19.

On February 21, 2020, the Health Operations Centre sent another e-mail to health stakeholders stating:

> The ministry has received numerous questions regarding when COVID-19 testing is appropriate. COVID-19 testing should be conducted when the patient meets the national case definition. While it is recommended that providers test in accordance with the current case definition, information about this virus continues to evolve. Therefore, providers may determine, based on assessment and clinical judgement, that testing for COVID-19 is appropriate outside of the case definition.

As of February 21, 2020, COVID-19 had spread to 23 countries (outside of China and Canada).

We heard concerns from provincial health stakeholders that the guidance and advice from the February 21 e-mail was confusing and not consistent with the message from the February 16 email. Concerns were also raised about the appropriateness of the February 16 e-mail not allowing testing where there was suspicion of COVID-19.

Unlike Ontario, British Columbia did not restrict testing. Staff at the British Columbia Centre for Disease Control informed us that health-care practitioners were specifically informed by Medical Health Officers (each of whom are associated with one of British Columbia's five regional health authorities and have their standards of practice established by the Provincial Health Officer) that they could test beyond the case definition if COVID-19 was suspected. This helped British Columbia identify COVID-19 in a woman in her 30s who returned to the province after travel to Iran. This case was confirmed on February 20, 2020 and was the sixth COVID-19 case identified in the province at the time. As British Columbia's approach shows, more widespread testing allows for COVID-19 cases to be identified earlier, which provides better information for decision-making.

4.3.3 Ontario's Travel Advice Prior to March Break Conflicted with That of Other Provinces and the Federal Government

On March 11, 2020, the World Health Organization declared COVID-19 to be a worldwide pandemic. On March 12, with Ontarians relying on the Ontario government to provide advice on the safety of international travel prior to March break (which started on March 16), the province advised Ontarians to travel and enjoy themselves on March break vacations.

The following day, March 13, health-care stakeholders (such as associations and bodies representing different types of health-care providers) received a daily situation report from the Ministry of Health. This included a memo from the Chief Medical Officer of Health, dated March 12, advising

that the people of Ontario avoid all non-essential travel outside Canada. Similarly, the federal government and other provincial governments urged people around this same time frame to avoid travelling given the risk of COVID-19. For example:

- **March 9:** Canada's Chief Public Health Officer warned Canadians to avoid all cruise ship travel.
- **March 11:** Alberta's Chief Medical Officer of Health recommended that anyone over the age of 65 with chronic health conditions not travel outside of Canada and that anyone else should think carefully about their travel plans.
- **March 12:** British Columbia's Provincial Health Officer urged residents to avoid all non-essential travel, including to the United States. On the same day, Alberta's Chief Medical Officer of Health also advised Albertans against travel outside of Canada.
- **March 13:** the Prime Minister of Canada and Canada's Chief Public Health Officer both advised all Canadians to cancel all non-essential international travel to help stop the spread of COVID-19.
- **March 14:** the federal government urged Canadians abroad to return to Canada immediately while commercial flights remained available.

When March break started in Ontario on March 16, the federal government announced the closing of Canada's borders to most people who were not Canadian citizens or permanent residents. Two days later, on March 18, the federal government further announced the closure of the Canada–US border to all non-essential travel.

If the province's advice had aligned with that of the rest of Canada at this time, Ontarians would likely have taken fewer international flights for March break, travellers would have been less confused and the spread of COVID-19 in Ontario could have been reduced. Instead:

- Between March 6 and March 13, approximately 4,450 international flights left Ontario, including over 1,500 flights on March 12 and March 13.
- Most COVID-19 cases in Canada and Ontario in late February and early March were related to travel. For example, of the 140 COVID-19 cases reported as of March 15, 101 (or 72%) were related to international travel.

4.3.4 Delay in Acknowledging Community Transmission of COVID-19

Despite strong evidence, the Ministry did not publicly acknowledge community transmission of COVID-19 in Ontario on a timely basis. Timely awareness of community transmission was of critical importance, not only to enable members of the Health Command Table to identify appropriate actions, but also to enable the public to take appropriate precautions.

On March 5, 2020, British Columbia announced its first case of apparent community transmission: a woman with no recent travel history and no known contact with an infected person was diagnosed with COVID-19. Strong evidence for community transmission in Ontario emerged shortly afterward. Specifically:

- **March 15:** Public Health Ontario informed the Health Command Table that of 15 COVID-19 cases under investigation, at least five had no travel history and were not linked to anyone who had travelled outside of Canada or known close contact with another case. Instead, they could be traced back to a health-care setting, a long-term-care home or group activity in the community.
- **March 15 to March 19:** a number of Medical Officers of Health at public health units, including Ottawa, Toronto, Simcoe Muskoka and Halton, publicly identified local COVID-19 cases that indicated community transmission.

Despite this evidence, the Chief Medical Officer of Health for Ontario still communicated to the media on March 17 that the province was "still

waiting to see actual examples of community spread." It was not until well over a week later, at a press conference on March 26, when the Associate Medical Officer of Health for Ontario identified that because 25% of cases involved individuals with no travel history or close contact with another COVID-19 case, these individuals had likely contracted COVID-19 via community transmission.

We asked the Office of the Chief Medical Officer of Health for the reason for the delay. The Office informed us:

> At that time, the province was monitoring the trends very closely and was actively discussing the increasing percentage of cases where the information on source of exposure had been unavailable for several days. Having a small number of cases without a clear epidemiological link does not immediately indicate community spread as the ability to identify a clear link is based on the case investigation and the ability to obtain a good history from the case. There was no clear point in time to demonstrate when community transmission started in Ontario; however, the data at that time did begin to show a gradual increase in the number of cases where travel and close contact with a case could not be identified and community transmission was deemed the likely source.

4.3.5 Delay in Requiring Long-Term-Care Home Staff to Wear Personal Protective Equipment and Restricting Them from Working at Multiple Facilities

Ontario did not make timely decisions to require long-term-care home staff to wear personal protective equipment and to not restrict the movement of these staff between long-term-care homes. While this can partially be attributed to concerns about personal protective equipment shortages among health-care workers at the highest risk of contracting COVID-19, this contributed to the significant increase in the number of COVID-19 cases and deaths associated with outbreaks at long-term-care homes. Specifically:

- **Personal protective equipment to be worn by long-term-care home staff:** On March 18, 2020, an Associate Medical Officer of Health at one public health unit emailed the Chief Medical Officer of Health about their concern that, since health-care workers with no travel history and no symptoms could still have COVID-19, all of them should be required to wear surgical masks at all times while working in health-care facilities, which are high-risk settings. The email considered this to be an urgent priority that should be implemented even before any evidence emerged that it would be effective in curbing COVID-19. However, no immediate province-wide action was taken. Internationally, on March 17, an early Italian study confirmed that 88% of COVID-19 deaths were elderly people. It also reported that almost 50% of those who had died had three or more pre-conditions. Deaths of people with no pre-conditions were much lower, at 0.8%. The following day, on March 18, Ontario's first long-term-care home COVID-19 outbreak took place at a Bobcaygeon long-term-care facility, Pinecrest Nursing Home (in the Haliburton Kawartha Pine Ridge District Health Unit). It was not until almost two weeks after the regional Associate Medical Officer of Health's email, on March 30, 2020, that the Chief Medical Officer of Health revised the directive to long-term-care homes for care of residents who were suspected of having or confirmed to have COVID-19. By March 31, the number of long-term-care home outbreaks had increased to 12, involving 230 cases and 12 deaths, which represented about 10% of all cases reported in Ontario and about 30% of all COVID-19 deaths at that time. A directive requiring all long-term-care home workers to wear masks throughout their entire work shifts was not issued until

April 8. At that time, the number of long-term-care home outbreaks had increased further to 69, involving 857 cases and 88 deaths, which represented almost 15% of all cases reported in Ontario and 44% of all COVID-19 deaths.

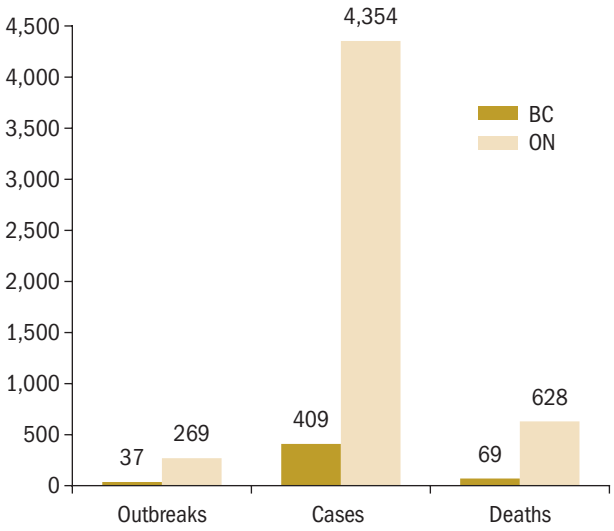
- **Restricting long-term-care home staff from working at multiple facilities:** On March 22, 2020, the Chief Medical Officer of Health issued a directive to long-term-care homes stating that "[w]herever possible, employers should work with employees to limit the number of different work locations that employees are working at, to minimize risk to patients of exposure to COVID-19." While a directive must be followed, this one was worded very generally: it did not identify under what conditions it would be acceptable for an employee to work at multiple long-term-care homes and whether there was a limit to the number of long-term-care homes an employee should enter in a given time period. An emergency order limiting employees to working at only one long-term-care home was put in place on April 14 and came into effect only on April 22, over a month after the first long-term-care home outbreak in Ontario. The order only applied only to employees and not to contract staff, who may have been a source of infection

The number of long-term-care home outbreaks increased to 198 on April 30, involving 3,647 people and resulting in 542 deaths. That represented about 22% of all COVID-19 cases reported in Ontario and almost 50% of all COVID-19 deaths at that time. In contrast, British Columbia enacted an order that restricted long-term-care home staff from working in more than one facility on March 27, three weeks earlier than in Ontario.

On March 31, 2020, British Columbia had outbreaks at 19 care facilities, involving 149 cases and 21 deaths, which was similar to Ontario with 12 long-term care home outbreaks. The numbers in British Columbia remained relatively steady after its March 27 order. The earlier issuance of British

Figure 17: Long-Term-Care and Retirement Home Outbreaks in BC and ON, as of April 30, 2020

Prepared by the Office of the Auditor General of Ontario



Note: Outbreaks in British Columbia include all acute-care, long-term-care and independent living facilities.

Columbia's order was likely at least part of the reason why. As of April 30, 2020, British Columbia had 37 care facility outbreaks, involving 409 cases and 69 deaths. Ontario had a substantially higher number of long-term-care and retirement home COVID-19 cases and deaths compared with British Columbia (see **Figure 17**).

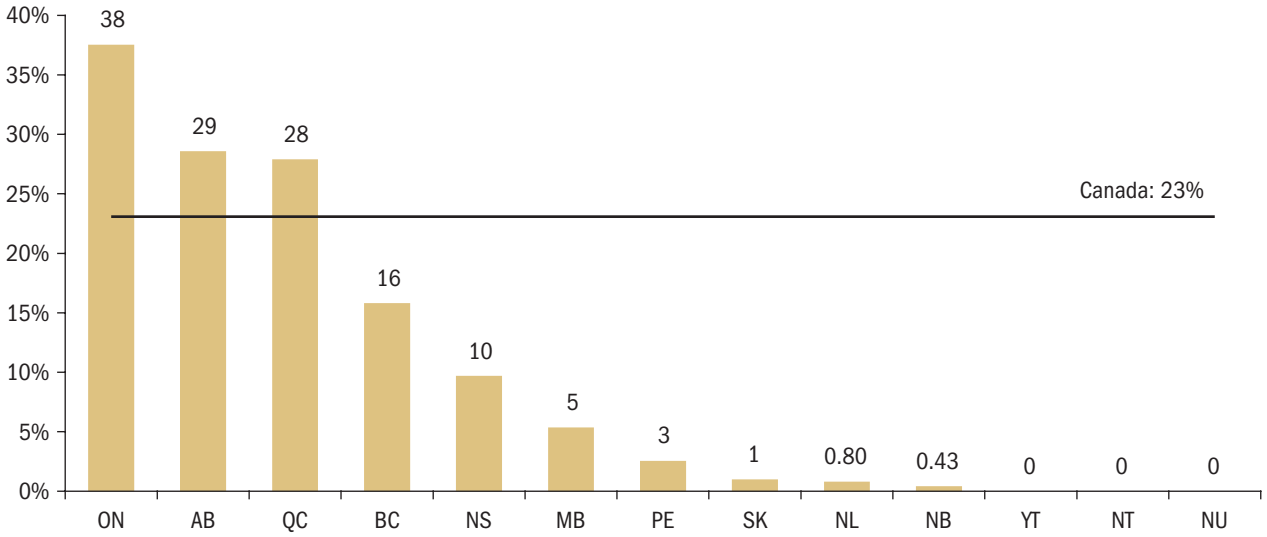
As of September 30, 2020, as shown in **Figure 18** and **Appendix 14**:

- Ontario had the largest percentage of long-term-care and retirement homes with COVID-19 outbreaks (38%), while British Columbia was at 16% and the Canadian average was 23%.
- The percentage of COVID-19 cases associated with long-term-care and retirement homes in British Columbia (7%) was much lower than the percentage in Ontario (20%).
- Ontario ranked second in Canada in the number of cases and deaths associated with long-term-care and retirement homes.

As of October 1, 2020, there were 8,721 cases and 1,917 deaths related to Ontario's long-term-care homes, compared with 860 cases and 169 deaths in British Columbia care facilities.

Figure 18: Percentage of Long-Term-Care and Retirement Homes with COVID-19 Outbreaks by Province and Territory, as of September 30, 2020

Source of data: National Institute on Ageing, Ryerson University



4.3.6 Delay in Issuing Emergency Order for Retirement Homes

As occurred with long-term-care homes, there were delays in making decisions about retirement homes, which are privately owned (see our audit report on the Retirement Home Regulatory Authority in our 2020 Annual Report).

We noted that an emergency order to allow a governing body to temporarily assume the management of, or appoint management for, a long-term-care home in the event of a COVID-19 outbreak was enacted on May 12, 2020. However, a similar order for retirement homes was not enacted until May 29, 2020, more than two weeks later. The Ministry for Seniors and Accessibility advised us that the delay was due to legal considerations, but the government eventually concluded that the benefit would outweigh the legal risk. In comparison, the long-term-care sector is not overseen by an independent regulator, so the legal consideration did not apply.

As of August 31, 2020, there were over 180 COVID-19 outbreaks associated with retirement homes, responsible for about 1,500 cases and about 210 deaths.

RECOMMENDATION 3

To expedite making decisions during subsequent waves of COVID-19 and future health emergencies, we recommend that the Central Co-ordination Table and Ministry of Health:

- request that Public Health Ontario immediately prepare guidance on the appropriate use of the precautionary principle, which was identified by the SARS Commission as the most important lesson of SARS and states that decision-makers cannot wait for scientific certainty before taking reasonable steps to reduce risk and protect the health of the Ontario population; and
- use and support Health Command Table members and key decision-makers in applying and following the precautionary principle as the guiding principle going forward.

CONSOLIDATED RESPONSE FROM MINISTRY AND SECRETARY OF CABINET

The health and well-being of Ontarians has remained our priority. Interpretation of the

available data at the time formed the basis for preventive action to address the spread of the pandemic.

COVID-19 has presented a challenge to health experts and government decision-makers around the world due to its unprecedented impact and complexity. Ontario's pandemic response has been based on evidence, assessment of risks and local context.

Public Health Ontario and the Science Advisory Table continue to advise on scientific advice to support the response.

4.4 Expert Advice and Best Practices Were Not Always Followed

The purpose of setting up the Health Command Table was for the Ministry to make evidence-based recommendations to support the province's decision-making related to COVID-19 (see **Section 4.1**). However, there were instances where decisions were not made based on expert advice, such as:

- the decision to expand COVID-19 testing to any individuals without symptoms (see **Section 4.4.1**);
- the decision to require visitors to long-term-care homes to be tested for COVID-19 prior to visiting (see **Section 4.4.2**); and
- the decision to not follow Public Health Ontario's advice on epidemiological indicators for its COVID-19 Response Framework (see **Section 4.4.3**).

4.4.1 Expanding COVID-19 Testing to Individuals without Symptoms or Known COVID-19 Exposure Was of Limited Benefit and Against Expert Advice

On March 2, 2020, the World Health Organization (WHO) provided guidance on laboratory testing for COVID-19 in suspected human cases. It recommended that testing of individuals meeting the COVID-19 case definition is a priority and testing of asymptomatic individuals can be considered for individuals who have had close contact with a COVID-19 case. The WHO's advice was as follows:

> [T]he decision to test should be based on clinical and epidemiological factors and linked to an assessment of the likelihood of infection. Testing of asymptomatic or mildly symptomatic contacts can be considered in the assessment of individuals who have had contact with a COVID-19 case… Rapid collection and testing of appropriate specimens from patients meeting the suspect case definition for COVID-19 is a priority for clinical management and outbreak control and should be guided by a laboratory expert.

At that time, Ontario's guidance did not identify that asymptomatic individuals (including those with no COVID-19 symptoms and no known exposure to someone who had COVID-19) should be tested.

On March 25, 2020, the Ministry's guidance prioritized the testing of only certain symptomatic individuals: health-care workers; residents and staff in long-term-care and retirement homes; hospitalized patients; members of remote, isolated, rural and/or Indigenous communities; and individuals identified as travellers when they entered Canada.

On May 19, 2020, the Health Command Table was presented with a Progress Update on Asymptomatic Testing in Congregate Care Settings. The presentation showed:

- Only 0.2% (four out of 1,834) of COVID-19 tests were positive in staff and residents at 20 long-term-care and retirement homes who were all asymptomatic and living or working in homes not in outbreak (with no known COVID-19 cases).
- In a different set of tests done across five public health units of asymptomatic staff and residents in certain retirement homes that were not in outbreak, only 0.2% (nine out of 5,598) of tests were positive for COVID-19.

Despite these findings, on May 24, 2020, the province announced that anyone could be tested

for COVID-19, and they were encouraged to do so if they thought they had been in close contact with someone with COVID-19, which is reasonable. However, this announcement also extended to people who wanted to get tested for COVID-19 simply because they just thought they could have it, even though they were not exhibiting symptoms and had not had close contact with anyone who was known to them to have COVID-19.

Between May and August 2020, Ontario Health co-ordinated a series of campaigns to test individuals with no COVID-19 symptoms in different settings. The settings included long-term-care homes and farms. The results of these campaigns indicated that asymptomatic testing has limited value in settings where there are no active outbreaks and the risk of contracting COVID-19 is therefore low. Specifically:

- In settings with no active outbreaks, the percentage of asymptomatic individuals testing positive for COVID-19 was very low (between 0% and 0.2%), and several of those tests were actually "false positives," which meant a positive test result for COVID-19 was wrong and that an individual was led to believe they had COVID-19 when, in fact, they did not.
- In settings with active outbreaks, the percentage of asymptomatic individuals who tested positive for COVID-19 was between 2.5% and 6%.

Almost 90% (25 of the 28) local Medical Officers of Health who responded to our survey identified that there was limited value in testing low-risk, asymptomatic individuals. Specifically, they informed us of the following:

- The tests Ontario used were designed to diagnose people with symptoms, not those without symptoms, and were therefore less reliable in this regard.
- Asymptomatic testing could result in false-positive tests (that is, incorrect results and overstatement of COVID-19 cases).
- The decision to perform asymptomatic testing on people without known COVID-19 exposure was not informed by evidence or expert advice, but rather a desire to increase the number of persons tested each day.
- When the province made the decision to expand testing to asymptomatic individuals, the assessment centres were suddenly overwhelmed by "low-risk, high-anxiety" individuals, who worried that they had COVID-19. In fact, they were unlikely to have it given that they had no COVID-19 symptoms or known COVID-19 exposure.

At the time of our work, the Ministry did not have complete information on how many tests were performed on asymptomatic, versus symptomatic, individuals, and so did not know the extent to which the daily testing data released by the Ontario government included asymptomatic individuals.

As identified in **Appendix 9**, a Testing Strategy Expert Panel (Panel) was formed at the request of the Health Command Table on April 5, 2020. The Panel is responsible for providing recommendations regarding testing to the Chief Medical Officer of Health via Public Health Ontario. Members of the Panel informed us that they never recommended that asymptomatic persons who are not contacts of persons with COVID-19, or part of outbreak investigations, be tested for COVID-19.

On July 5, the Panel provided the Chief Medical Officer of Health with the following recommendations for COVID-19 testing:

- Limit asymptomatic testing in low-prevalence, low-risk (such as those with no known COVID-19 exposure) population.
- Consider targeted asymptomatic testing only for specific vulnerable populations in high-risk areas or institutions and other congregate settings.
- End testing of the general asymptomatic population.

Members of the Panel informed us that these recommendations were based on an ongoing review of the literature, and an in-depth evaluation of where COVID-19 testing added value and minimized harm in the targeted asymptomatic testing

campaigns for May and June 2020. It was noted that data for asymptomatic testing was lacking at times of higher community prevalence and that Ontario could renew an ongoing evaluation if community prevalence increased.

Despite these recommendations, testing criteria were not adjusted to restrict asymptomatic testing until over 11 weeks later, on September 25, 2020. The Ministry announced then that asymptomatic individuals could be tested at a designated pharmacy, but only if they attested to being a contact of a confirmed positive case, living or working in an outbreak location or a high-risk congregate living setting, planning to visit a long-term-care home, or being eligible to participate in a targeted testing campaign by the Ministry of Health or the Ministry of Long-Term Care. As noted in our **Chapter 3 Laboratory Testing, Case Management and Contact Tracing**, Ontario generally did not achieve its laboratory testing turnaround targets (60% of COVID-19 laboratory test results reported to the Ontario Laboratory Information System within one day after a specimen was collected and 80% of such tests being reported within two days of specimen collection) between January and August. These targets would have been easier to achieve if the Panel's recommendation on ending testing of the general asymptomatic population had been followed.

Unlike Ontario, other jurisdictions (both within and outside of Canada) made the decision not to test asymptomatic individuals for COVID-19 much sooner. For example:

- On July 5, the Testing Strategy Expert Panel sub-table identified in its presentation to the Chief Medical Officer of Health that the international jurisdictions that do not perform sustained, continuous testing of asymptomatic individuals included Australia, Finland, France, Germany, Hong Kong, Japan, Netherlands, New Zealand, Singapore and South Korea.
- On August 20, the British Columbia Centre for Disease Control recommended against testing asymptomatic individuals, unless the test is done as part of a public health investigation of a case, cluster or outbreak. This was based on the fact that expanding testing to individuals with no COVID-19 symptoms would have a significant impact on laboratory and other health system costs while providing little benefit in identifying additional COVID-19 cases.
- While on July 30, Alberta started allowing widespread testing of asymptomatic individuals (i.e., those with no symptoms or known COVID-19 exposure) to help make use of its available laboratory capacity at the time, it limited this testing to its pharmacies only on September 17, 2020, after it had found that such testing had identified only about seven positive COVID-19 cases for every 10,000 people tested. Alberta paused asymptomatic testing in its pharmacies for those with no COVID-19 exposure on October 20, 2020.

As noted above, asymptomatic testing continued in Ontario up to September 25, 2020. Since then, designated pharmacies can collect specimens from asymptomatic individuals who want a COVID-19 test, but only as long as they meet certain conditions (such as they want to visit a long-term-care or retirement home). Unconditional testing of asymptomatic individuals, however, has ended.

4.4.2 Requiring All Visitors to Long-Term-Care Homes to Confirm a Negative COVID-19 Test Result Was Not Recommended by Experts

All visitors to long-term-care homes in Ontario have had to be tested for COVID-19 since June 18, 2020. The visitor must confirm to have received a negative COVID-19 test result within the previous 14 days to be able to make their visit. In other words, visitors have to get tested continuously if they continue to visit these facilities. However, this requirement was not in line with expert advice. For example:

- The Testing Strategy Expert Panel did not support this requirement. According to its

presentation on July 5 to the Chief Medical Officer of Health, it strongly recommended the removal of the testing requirement for visitors to long-term-care and other congregate settings. Beyond burdening the laboratory system with more tests, this requirement provides limited assurance that a visitor does not have COVID-19: any visitor could still become infected with COVID-19 at any time following their test. As of September 30, this requirement was still in force.

- This same argument was reiterated by 25 (or about 90%) of the 28 the local Medical Officers of Health who responded to our survey: They told us that this requirement does not follow best practice and that visitors can develop COVID-19 at any time after receiving a negative test result. They also noted that visitors may have a false sense of security, believing on the basis of their test that they do not have COVID-19, resulting in them not following social distance guidelines as part of the visit.

Unlike Ontario, Alberta, British Columbia and Quebec have never had a requirement for most visitors to long-term-care and retirement homes to have a negative COVID-19 test result, although they do have comprehensive Family Support & Visitation of Patient & Resident guidelines to protect the safety of patients, residents and staff in acute care facilities and continuing care. This requirement in Ontario only increased the challenges of providing necessary supports and care for the residents of long-term-care homes and could make it harder for family members to be able to visit.

4.4.3 New Provincial COVID-19 Response Framework Loosens Public Health Restrictions against Public Health Ontario's Advice

On November 3, 2020, the province released the *COVID-19 Response Framework: Keeping Ontario Safe and Open* (COVID-19 Response Framework), which is a new colour-coded system for ranking public health units based on local situations, and determining measures for and restrictions on businesses in each region. The thresholds used in the COVID-19 Response Framework were much less restrictive than the thresholds recommended by Public Health Ontario, and loosened restrictions in regions where the number of COVID-19 cases was still trending upward, forcing some public health units to impose restrictions of their own.

On September 18, 2020, the Ministry requested Public Health Ontario to provide advice on possible epidemiological indicators for its draft COVID-19 Response Framework. Public Health Ontario's advice was based on the Ontario epidemiological context at the time and its review of documents in other jurisdictions, including the Centre for Disease and Control in the United States. On September 21, 2020, Public Health Ontario provided its advice, identifying six indicators that should be monitored in the four stages of response that were identified (vigilance, early warning, alert and high alert) (see **Figure 19**). These indicators were being used by the Public Health Measures sub-table when reviewing and providing advice on COVID-19 public health measures within each category.

On November 3, 2020, about a month and a half after receiving Public Health Ontario's advice, the province publicly released its COVID-19 Response Framework, which replaced the province's previous three-stage reopening plan (see **Appendix 15**). The new COVID-19 Response Framework assigns each public health region into one of the following five levels, with the last one being a measure of last and urgent resort.

- **Prevent (Green):** Standard public health measures would be expected (such as requiring tables at indoor dining establishments to be at least two metres apart).
- **Protect (Yellow):** Strengthened public health measures would be expected (such as limiting operating hours that alcohol can be served at indoor dining establishments from 9 a.m. to 11 p.m.).

Figure 19: COVID-19 Response: Framework Recommended by Public Health Ontario on September 21, 2020 (PHO) Compared to Framework Publicly Announced by Province on November 3, 2020 (ON)

Prepared by the Office of the Auditor General of Ontario

Indicators Recommended by Public Health Ontario for Moving between Colour-Coded Tiers	COVID-19 Response Framework							
	PHO Vigilance (Green)	ON Prevent (Green)	PHO Early Warning (Yellow)	ON Protect (Yellow)	PHO Alert (Orange)	ON Restrict (Orange)	PHO High Alert (Red)	ON Control (Red)
Case rate per 100,000 residences over 7 days	<5	<10	5–<10	10–39.9	10–<25	40–99.9	>25	≥100
% positivity of COVID-19 laboratory tests over 7 days	<0.5	<1	0.5 –<1.2	1–2.5	1.2–<2.5	2.5–9.9	>2.5	≥10
Doubling time in days[1]	≥30 (or decreasing)	–[1]	14–<30	–[1]	7–<14	–[1]	<7	–[1]
Reproductive number[2]	<1	<1	>1	Approx. 1	>1	1–1.2	>1	≥1.2
% of cases managed within 24 hours of the public health unit being informed of a positive test result	>90	–[3]	>90	-[3]	85–<90	–[4]	<85	–[5]
% of high-risk exposure contact tracing performed within 24 hours of the public health unit being informed of a positive test result	>90	–[3]	80–<90	–[3]	75–<80	–[4]	<75	–[5]

1. Ontario's COVID-19 Response Framework does not include this as an indicator.
2. Reproductive number (R) is a mathematical term that indicates how contagious an infectious disease is. It indicates the number of people who will contract a contagious disease from one person with that disease. Epidemiologists want this number to be as low as possible.
   - If R is less than 1, each existing infection causes less than one new infection. The disease will decline and eventually die out.
   - If R equals 1, each existing infection causes one new infection. The disease will stay alive and stable, but will not result in an outbreak.
   - If R is more than 1, each existing infection causes more than one new infection. The disease will be transmitted between people and may result in an outbreak.
3. Ontario's COVID-19 Response Framework does not specify a percentage for the Prevent (Green) or Protect (Yellow) tiers, stating only that case management and contact tracing within 24 hours of the public health unit being informed of a positive test result is adequate.
4. Ontario's COVID-19 Response Framework does not specify a percentage for the Restrict (Orange) tier, stating only that case management and contact tracing within 24 hours is adequate and that movement to Orange should happen if public health unit capacity for case management and contact tracing is at risk of becoming overwhelmed.
5. Ontario's COVID-19 Response Framework does not specify a percentage for the Control (Red) tier, stating only that movement to Red should happen if public health unit capacity for case management and contact tracing is at risk of becoming, or is, overwhelmed.

- **Restrict (Orange):** Intermediate public health measures would be expected (such as limiting capacity at indoor dining establishments to 50 people and no consumption of liquor between 10 p.m. and 9 a.m.).
- **Control (Red):** Stringent public health measures would be expected (such as limiting capacity at indoor dining establishments to 10 people).
- **Lockdown (Grey):** Wide-scale restrictions and measures would be expected (such as no indoor dining at establishments allowed).

Figure 19 compares the categories in the COVID-19 Response Framework and the thresholds recommended by Public Health Ontario on September 21 to the COVID-19 Response Framework publicly announced on November 3. Overall, the new thresholds are higher than that recommended by Public Health Ontario, meaning that the epidemic needs to be at a stage with higher cases and transmission prior to the implementation of public health measures. As discussed in **Section 4.5.5**, some indicators used in the province's framework are also not clear. As well, the thresholds at each stage under the province's framework did not align with those recommended by Public Health Ontario. For example, the threshold for triggering the most restrictive level under the province's framework is four times higher than that recommended by Public Health Ontario, as shown in these bullets:

- "Control (Red)" under the province's framework would be triggered only if there are over 100 COVID-19 cases per 100,000 residents over seven days.
- "High Alert (Red)" under the Public Health Ontario-recommended framework would be triggered even if there were only 25 COVID-19 cases per 100,000 residents over seven days.

Public Health Ontario and other public health stakeholders were not made aware of the indicators and thresholds selected by the government prior to their release and notified the Ministry of their concern that the thresholds were too high after the framework was released. For example, Public Health Ontario sent an email to the local Medical Officers of Health in each public health unit on November 5 suggesting that it learned about the new indicators only on November 3, the date when the government publicly announced the COVID-19 Response Framework.

As well, it appeared that not all public health units fully supported the province's COVID-19 Response Framework because it allowed for the loosening of restrictions in regions where the number of COVID-19 cases was still trending upward. As a result, some public health units imposed restrictions of their own. For example, on November 6, 2020, the province announced that effective November 7, Peel region would be moved from modified Stage 2 to "Control (Red)." Although "Control (Red)" has the strictest measures short of a full lockdown, it still allows more businesses to open than under modified Stage 2 (such as allowing indoor dining for up to 10 people). Given this, the local Medical Officer of Health in Peel region issued directives to the community that were much stricter than "Control (Red)" provisions, such as closing event spaces in banquet halls and banning wedding receptions and associated gatherings. On November 9, Toronto Public Health officials also expressed alarm, indicating that they were looking to follow Peel region and add an extra layer of local restrictions to the COVID-19 Response Framework. On November 10, the Toronto Medical Officer of Health announced those restrictions, which included not allowing indoor dining to resume.

Provincial direction that does not match local direction confuses the public and indicates that the province and public health units are basing their decisions on different information.

On November 13, the province announced that after consultation with the Chief Medical Officer of Health and the Public Health Measures Table, it had revised the COVID-19 Response Framework by lowering the threshold for each level. For example, "Control (Red)" would now be triggered if there are 40 or more COVID -19 cases per 100,000 residents

over seven days. However, this threshold is still at least 1.5 times higher than the threshold recommended by Public Health Ontario of 25 cases. Public Health Ontario informed us it was supportive of the new measures, particularly given the change in COVID-19 prevalence since its first recommendations were provided.

RECOMMENDATION 4

To better align policies and decisions made (including advice provided) with best practices and scientific and epidemiological evidence for the containment of COVID-19 in a cost-effective manner, we recommend that the Health Command Table, with the support of the Central Co-ordination Table:

- follow timely public health advice and recommendations from Public Health Ontario and the Testing Strategy Expert Panel going forward;
- consistent with the Testing Strategy Expert Panel's advice, approve the removal of the requirement for long-term-care and retirement home visitors who are asymptomatic and with no known COVID-19 exposure to be tested for COVID-19 within 14 days of a visit; and
- continue to review and provide advice for changes needed to the *COVID-19 Response Framework: Keeping Ontario Safe and Open* based on the advice of Public Health Ontario and feedback from the Public Health Measures table and public health units.

CONSOLIDATED RESPONSE FROM MINISTRY AND SECRETARY OF CABINET

Ontario's pandemic response has been based on evidence, assessment of risks and local context, and has benefitted greatly from public health advice and recommendations from Public Health Ontario, Ontario Health's Testing Strategy Expert Panel and other tables. Expert advice is an important input but is not the only factor in recommendations to government or in government decision-making.

Evidence and expert advice on the effectiveness of testing asymptomatic health-care workers continues to evolve, and the testing of visitors to and staff in long-term-care homes and retirement homes will contribute to the body of knowledge as the science evolves.

Testing of visitors to long-term-care homes and retirement homes was undertaken out of an abundance of caution, as a precautionary measure to protect Ontario's most vulnerable citizens. There is an ongoing need to protect long-term-care home residents and staff from the risk of COVID-19, particularly as long-term-care home residents are more susceptible to infection from COVID-19 than the general population due to their age and medical conditions.

The *COVID-19 Response Framework: Keeping Ontario Safe and Open* will continue to be informed by the advice of the Public Health Measures Table, Public Health Ontario and local Medical Officers of Health, as well as by the evolving evidence on the impact of the measures in the framework.

4.5 Communications Were Not Fully Effective within the Health Command Table, Not Provided to Impacted Stakeholders in a Timely Manner and Not Clear to the Public

As identified in **Section 4.1.1**, by the end of August 2020, the Health Command Table had grown to 90 participants in June 2020 and 83 participants as of August 31. Until July 2020, its meetings were held mainly via teleconference. Stakeholders, such as local public health units, were also concerned that the Health Command Table did not inform them early enough of its (or provincial) decisions: they sometimes learned of changes that directly impacted them only when those changes were publicly announced as part of a press conference.

4.5.1 Teleconference Meetings Were Not Fully Effective, and Their Discussions Were Not Documented in Detail

The Health Command Table and its various sub-tables began meeting on a regular basis (at least weekly) on February 28, 2020. However, the details of discussions during the meetings were not documented and records of decisions (such as advice to be provided to the Minister of Health, Premier and Cabinet) were not distributed to members. While summaries of the topics addressed by the Health Command Table and the resulting actions were posted online, no official minutes were taken or distributed for these meetings. The summaries identified only the topics and themes of each meeting but did not note who attended, what was said in discussions and the opinions of those present. As well, meetings were never held in person after mid-March 2020; the size of the Health Command Table likely contributed to this.

All meetings from late February 2020 to July 2020 were conducted via teleconference. Not until July 28, 2020, did the Health Command Table start meeting permanently through videoconference. This occurred after a trial videoconference on July 14, 2020, which resulted in several Health Command Table members commenting that they preferred videoconferencing to teleconferencing.

The effectiveness of teleconference meetings varies, depending on factors such as the size of the group, the extent to which group members are familiar with each other, and the complexity of issues being discussed. If the group is too large, as was the case for the Health Command Table, teleconference is an unproductive and ineffective medium for meetings. As noted in **Section 4.1.1**, membership of the Health Command Table expanded over time. Its original 21 members were added to by various Assistant Deputy Ministers from the Ministry of Health, the Ministry of Long-Term Care and other ministries; and professionals and consultants from across government and the health sector, who were added as "attendees." The Ministry identified 51 additional people as more common "attendees" at those teleconferences. At times, the Premier also attended these meetings. The teleconference participants informed us that they did not know the difference between "members" and "attendees," whether in terms of roles and responsibilities or their right to speak and provide advice at the meetings. Those whom the Ministry identified as attendees informed us that they thought they were members of the Health Command Table. In addition, like members, attendees at times had additional duties. For example, the Vice President of Public Health Ontario, who was classified as an attendee at the Health Command Table, is a co-chair of the Science Table (see **Appendix 9**).

Teleconferences with too many participants often become unfocused and can be dominated by a small number of participants. The rest of the participants can be overpowered and become passive as a result, just listening to the discussions without adding comments.

Our discussion with participants at the Health Command Table noted concerns, confirming that the teleconferences were not conducted effectively because of how many participants were involved. As well, the medium of teleconferencing and the size of the meetings hindered the provision of advice that would contribute to well-informed decisions based on scientific evidence and consideration of assessed risk. Here are some examples of the concerns:

- While participants received the agenda and documents and action items for discussion ahead of the meeting, and meeting summaries were posted online, official minutes were not taken or distributed. As a result, it is not possible to confirm who attended each teleconference and who said what on the calls and whether there were any dissenting opinions to the decisions (including on what advice to provide to Cabinet).
- Materials were often received the same morning as the Health Command Table meeting, which did not enable review prior to the meeting.

- Participants we spoke to noted that some participants may have felt intimidated to speak due to the personalities and seniority of the other participants on the call.
- Participants were not always clear on who was speaking or whether the speaker had expertise on the subject matter being discussed.
- Discussions were sometimes led by those participants with the loudest voice or strongest opinion on a subject, rather than by those with expertise.
- Decisions (such as about what advice to provide to Cabinet) were made via verbal consensus only, rather than by a vote at the end of the teleconference.

The use of videoconferencing could have eliminated some of these concerns, as participants could have seen whether the person speaking was an expert on the subject being discussed. Videoconferencing started only in July 2020, about five months after the beginning of the COVID-19 outbreak in Ontario. Although Ontario has a Provincial Emergency Operations Centre in Toronto with an 82-seat meeting room that was built and designed to be used during emergencies and would have enabled physical distancing of key Health Command Table members for in-person meetings, this facility was never used (see **Chapter 1 Emergency Management in Ontario—Pandemic Response**).

4.5.2 Decisions Made Were Not Communicated to Impacted Stakeholders on a Timely Basis

In some cases, provincial decisions were not communicated clearly enough to public health units or other impacted stakeholders in advance of them being publicly announced. This limited the ability of these stakeholders to prepare for the changes they needed to make for the decision to be implemented. Here are some examples:

- **The decision to change testing criteria:** On May 24, 2020, the province announced changes in testing criteria that allowed individuals with no COVID-19 symptoms to be tested at assessment centres if they believed that they could have the virus (see **Section 4.4.1**). This led to an immediate and significant increase in demand for tests. In the week that followed the announcement, the number of Ontarians visiting assessment centres more than doubled compared to the week before. While assessment centres had been notified on May 23, 2020 that an expansion in who could be tested for COVID-19 was coming in the next few days, they were not made aware of the specific date when the change would occur. This left the laboratory network and assessment centres unable to plan for and increase their testing capacity (such as increasing their hours of operation and the number of working staff) in time to meet the increased demand. In some cases, people were turned away because they could not all be accommodated.
- **The decision to reopen daycare centres:** On June 9, 2020, the province publicly announced that certain daycare centres could reopen on June 12 as long as they had appropriate measures in place to prevent the spread of COVID-19. Child-care-centre operators were required to follow strict health protocols to ensure the safety of child-care staff and children (such as requiring all child-care settings to keep children and staff in groups of 10 or less, have a COVID-19 response plan, keep daily records of all attendees, and clean thoroughly before operating and frequently after). The reopening guidance provided by the province informed daycare operators that they could speak with their local public health units if they had any questions. Forty-two percent of the local Medical Officers of Health we surveyed (12 out of 28) identified that they did not have enough time to respond to the reopening, given no specific prior notice from the province. The public

health units had to provide advice and guidance to daycare centres within a very short time frame and without a unified response. This included how to address children with flu or COVID-like symptoms. One public health unit could not meet the deadline and asked daycare centres to remain closed until it could provide them with training the week of June 14, 2020.

Similar communication shortfalls did not occur in Alberta during its response to the first wave of COVID-19. Senior management at the Alberta Health Service (the single provincial health authority in Alberta) informed us that its Chief Executive Officer, as well as the Senior Medical Officer of Health, were invited to a number of Emergency Management Cabinet Committee meetings, where they shared information and listened to discussions. This assisted them in strategically planning for changes in the COVID-19 response, as they were all aware of the discussions and decisions being considered by Cabinet before they were made.

4.5.3 Decisions and Recommendations Were Not Always Clearly Communicated to Ontarians

Communications by the Ministry and the province to the media and public were not always clear and consistent.

- **Inconsistent messages:** On September 30, 2020, the *Canadian Medical Association Journal* published an analysis of COVID-19 in long-term-care homes in Ontario and British Columbia, comparing the provinces' preparedness for and responses to the crisis. The study identified that in their daily briefings and media interviews, the Provincial Health Officer of British Columbia and elected leaders delivered consistent messages about the state of the pandemic and public health recommendations. In contrast, communication in Ontario was less co-ordinated, with elected leaders and the Chief Medical Officer of Health sometimes conveying conflicting messages in separate briefings. For example, as noted in **Section 4.3.3**, advice issued by other provinces and the federal government urged people to avoid non-essential travel. In contrast, the Ontario government encouraged citizens to travel on March 12, 2020; a memo dated that same day (and released the following evening) by the Chief Medical Officer of Health indicated that Ontarians should avoid all non-essential travel.
- **Confusion about who was the key spokesperson:** Local Medical Officers of Health who responded to our survey indicated they were confused by provincial officials delivering public health advice in place of the Chief Medical Officer of Health. During the first wave of the pandemic in the spring and summer of 2020, the Premier of Ontario was often the spokesperson on health recommendations, leading the daily press conferences, with the Chief Medical Officer of Health or Associate Chief Medical Officer of Health being called on to reiterate advice afterward. In contrast, the key spokespersons during the pandemic in other jurisdictions, particularly in Alberta, British Columbia and Manitoba, appeared to be their Chief Medical Officers of Health or equivalents.
- **No emergency communications plan or guide despite SARS recommendation:** The initial report by the Ontario Expert Panel on SARS and Infectious Disease Control recommended in 2003 that the Ministry develop a public health risk communications strategy. However, when the COVID-19 pandemic intensified in March 2020, the Ministry still did not have a plan or guide to emergency communications in a crisis. Existing emergency plans (discussed in **Section 4.7**) were silent on how the Ministry should communicate with the public in an emergency. For example:

- The Ministry of Health and Long-Term Care Emergency Response Plan, 2013, does not include guidance on communication. Section 6.2 is titled Crisis Emergency and Risk Communications Response Guide; however, the content in this section is noted as "under development."
- The 2013 Ontario Health Plan for an Influenza Pandemic contains a chapter on Health Sector Communications, but it does not cover communications with the media and the public at large. The chapter notes that although a media conference is included in the emergency information cycle, it is not described in this chapter as it is beyond the scope of health-sector communications. It was to be discussed in the Ontario Influenza Response Plan (OIRP) as a method to communicate with the public and other sectors. As noted in **Section 4.7.3**, the OIRP was never developed.

4.5.4 Reasons Why Public Health Measures Are Imposed or Relaxed Are Not Clearly Communicated or Shared with the Public

The Public Health Measures Table, a sub-table of the Health Command Table, provides regular reports to the Health Command Table and provides advice to the Chief Medical Officer of Health, who in turn reports to the Deputy Minister of Health and provides advice to the Premier and Cabinet, which then make final decisions regarding the public health measures and public education to be implemented at the provincial level. However, the Ontario government has not publicly shared all the information used to make these decisions.

On April 27, 2020, the province of Ontario published the document *A Framework for Reopening our Province* (Reopening Framework), which detailed the three stages of recovery that Ontario would go through to reopen businesses and loosen public health restrictions. The Reopening Framework stated that Ontario's Chief Medical Officer of Health would consider the following indicators to advise when the province could begin to ease public health measures:

- a consistent two-to-four week decrease in the number of new daily COVID-19 cases;
- a decrease in the rate of cases that cannot be traced to a source;
- a decrease in the number of new COVID-19 cases in hospitals;
- sufficient acute- and critical-care capacity, including access to ventilators, to effectively respond to potential surges;
- ongoing availability of personal protective equipment (PPE) based on provincial directives and guidelines;
- approximately 90% of new COVID-19 contacts being reached by local public health officials within one day, giving guidance and direction to contain community spread;
- ongoing testing of suspected COVID-19 cases, especially of vulnerable populations, to detect new outbreaks quickly; and
- a shift to new and other ways of testing and contact tracing to promote widespread tracking of cases.

Appendix 15 summarizes the changes in public health measures at each stage of reopening. As identified in **Appendix 1**, while the entire province entered Stage 1 on May 19, 2020, Stage 2 reopening was done on a regional basis between June 12 and July 7, 2020, and Stage 3 reopening occurred between July 17 and August 12, 2020. Additional changes to the stages regions have gone into or left have occurred since then.

The Health Command Table received and reviewed information on the above indicators approximately twice a week; however, not all of it was shared publicly. For example, Public Health Ontario publishes a daily summary that includes COVID-19 case counts and death counts by region and current outbreaks, but other information related to the indicators, such as acute- and critical-care hospital capacity, PPE inventory levels, or percentage of contacts being reached by public health units, is generally not shared with the public.

We also noted that decisions on imposing or relaxing public health measures did consider the above indicators. However, the Ministry did not specify what targets needed to be met in order to relax specific public health measures or what targets needed to be surpassed for additional public health measures to be imposed. For example, decisions on when to move the province or regions from Stage 1 to 2 or Stage 2 to 3 was not based on the achievement of specified metrics.

Proactively specifying and communicating these targets would have allowed the public to better understand why decisions were being made and may have prevented or reduced public fear and anxiety.

In contrast, some public health units are publicly reporting information on key indicators that are useful for making decisions regarding reopening. For example, Toronto Public Health publishes a COVID-19 dashboard that contains indicators similar to those identified in the Reopening Framework. The dashboard also includes a target for almost every indicator and organizes the indicators into four categories: virus spread and containment; laboratory testing; health-care system capacity; and public health. Based on the results of each indicator against the target, a status—green, yellow or red—is applied to each indicator and each category, as well as to the overall current status of COVID-19 in the region. This helps the public have a better understanding of how well the region is managing different aspects of its COVID-19 response and gives some insight into the likelihood that further restrictions or relaxing of public health measures will occur.

4.5.5 Criteria for Imposing or Relaxing Public Health Measures under New Provincial COVID-19 Response Framework Are Still Ambiguous and Create Confusion

As identified in **Section 4.4.3**, as we were finalizing this report, the Government of Ontario publicly released its *COVID-19 Response Framework: Keeping Ontario Safe and Open* (COVID-19 Response Framework) on November 3, 2020 (which was revised on November 13, 2020) to categorize and colour-code public health regions into five stages: Prevent (Green), Protect (Yellow), Restrict (Orange), Control (Red), and Lockdown (Grey). Depending on the stage, public health measures or restrictions would be imposed or relaxed. The COVID-19 Response Framework identified the following seven key indicators that would be considered for determining the stage of public health unit:

1. Weekly COVD-19 incidence rate per 100,000 residents;
2. Percentage of COVID-19 tests that came back positive for COVID-19;
3. Reproductive number (i.e., the estimated number of COVID-19 cases being transmitted by each existing COVID-19 case);
4. COVID-19 outbreak trends and settings;
5. Level of community transmission (where COVID-19 cases cannot be traced to a likely source of transmission);
6. Hospital and intensive care bed capacity; and
7. Case management and contact tracing capacity.

Beyond concerns that the thresholds for each stage do not align with expert advice (see **Section 4.4.3**), no clear targets are provided for four of the above seven key indicators to identify what level would trigger a public health unit to move from one stage to another. Specifically:

- COVID-19 outbreak trends and settings: Both "Restrict (Orange)" and "Control (Red)" stages identify that there would be repeated outbreaks in multiple sectors or settings and increasing number of large outbreaks. However, it does not define what is meant by repeated or large number of outbreaks.
- Level of community transmission: Both "Protect (Yellow)" and "Restrict (Orange)" stages identify that the level of community transmission is stable or increasing. However, it is not clear what percentage increasing would support a move between these stages.

- Hospital and intensive care bed capacity: "Restrict (Orange)" stage is applicable when hospital and intensive care bed capacity is adequate or occupancy is increasing whereas "Control (Red)" stage is reached when such capacity is at risk of being overwhelmed. However, there is no definition or specification on what level of capacity or occupancy is considered adequate or at risk of being overwhelmed.
- Case management and contact tracing capacity: "Restrict (Orange)" stage is applicable when case management and contact tracing capacity within 24 hours is adequate or at risk of being overwhelmed while "Control (Red)" stage is reached when such capacity is at risk of being overwhelmed. Again, no definition is given for what this entails. As noted in **Chapter 3 Laboratory Testing, Case Management and Contact Tracing**, while the province targets having 90% of case management (speaking to someone who tested positive for COVID-19) performed within 24 hours, between March and August, 2020 only about 80% of cases were contacted within 24 hours. It is not clear if this suggests that public health units are overwhelmed or if that performance is adequate.

RECOMMENDATION 5

To improve the effectiveness, timeliness and transparency of communication in the provincial response to COVID-19, we recommend that:

- all Health Command Table meetings be conducted through videoconferencing or in person (where appropriate physical distancing and public health measures can be followed) after its membership has been streamlined (see **Recommendation 1**);
- the Health Command Table prepare meeting minutes and document meeting attendees, key decisions made (such as on what advice to provide to the Minister of Health and Cabinet), timelines, deliverables and parties responsible for distribution and approval to support learning from past decisions and as a source of reference for future decisions;
- the Central Co-ordination Table develop a stakeholder communication strategy to reference who to inform prior to public announcements and provide sufficient time for stakeholders to immediately implement each decision announced;
- make the Chief Medical Officer of Health permanent member of the Central Co-ordination Table; and
- all advice to the Premier and Cabinet from the Chief Medical Officer of Health and the Public Health Measures Table on public health measures (such as advice on whether to impose or relax any public health measures in the province) be shared publicly.

CONSOLIDATED RESPONSE FROM MINISTRY AND SECRETARY OF CABINET

The Central Co-ordination Table facilitates a whole-of-government response to the pandemic that monitors progress, removes barriers, and drives inter-ministerial collaboration, including supporting ministries as they are actively engaged in timely communication with stakeholders to support implementation of government decisions.

The government also publishes via multiple channels and languages, including but not limited to Ontario.ca website, social media channels, and public press conferences to ensure stakeholders and the public are aware of government decisions in a timely manner.

The Ministries of Health and Long-Term Care agree with the need to have an efficient response structure and have made continuous adaptations as the COVID-19 pandemic has evolved. Over the course of the pandemic, the Ministry of Health has strengthened its secretariat support and project management of Health Co-ordination Table work streams.

Since February 2020, publicly accessible memorandums from the co-chairs of the Health Co-ordination Table to health system organizations and providers have been published following each meeting.

Cabinet receives advice, when needed, through direct briefings from the Chief Medical Officer of Health and other health experts from the public health and science tables.

Since the inception of the Central Co-ordination Table, the Chief Medical Officer of Health, the CEO of Ontario Health and senior staff of the Ministry of Health, Ontario Health and Public Health Ontario regularly attend these meetings for work streams that they are leading and/or where their knowledge and expertise would be of value to the discussion. The Central Co-ordination Table is a venue for integrated perspective across government.

The *COVID-19 Response Framework: Keeping Ontario Safe and Open* will continue to be informed by the advice of the Public Health Measures Table, Public Health Ontario and local Medical Officers of Health, as well as by the evolving evidence on the impact of the measures in the framework.

4.6 Analysis of Consequences and Risks Were Not Proactively and Sufficiently Performed as Part of Planning for Provincial Ongoing Response to COVID-19

The Ministry did not take a proactive approach to adequately analyze or consider potential consequences and risks when certain decisions were made or certain approaches were taken in the provincial response to COVID-19. For example:

- stopping almost all non-essential hospital services resulted in significant backlogs of elective surgeries (see **Section 4.6.1**); and
- not collecting race-based information resulted in populations with a higher risk of getting COVID-19 not benefiting from and receiving more focused prevention and containment measures (see **Section 4.6.2**).

4.6.1 Stopping Non-essential Hospital Services Resulted in Significant Backlogs of Elective Surgeries, Which Will Take Almost Two Years to Clear

A decision was made to stop almost all elective services, including surgeries, on the assumption that all hospital capacity would be fully needed for COVID-19 patients.

On March 12, 2020, Public Health Ontario gave a presentation to the Health Command Table suggesting that, based on the estimated spread and severity of COVID-19, intensive care hospital beds would reach full capacity across Ontario by the end of April. It was also expected that it would take an additional two weeks after that for all non-intensive care beds in hospitals to reach full capacity. Public Health Ontario estimated that postponing elective surgeries—defined as anything not needed urgently or on an emergency basis to sustain life—would delay when intensive care beds reached full capacity by one week and when all other hospital beds reached full capacity by two more weeks.

In response, on March 19, 2020, the Chief Medical Officer of Health, after consultation with others in the Ministry, issued a directive to hospitals and other health-care providers requiring that until further notice all non-essential and elective services cease or be reduced to minimal levels, subject to certain exceptions; for example, to prevent negative patient outcomes. The directive remained in place until May 26, 2020, when the Chief Medical Officer of Health amended it to allow for a gradual restart of these services.

Hospitals were also able to free up hospital beds by transferring more patients designated as alternate level of care (ALC) out of the hospital. These patients no longer require hospital care but can remain in hospital until a bed becomes available in another care setting such as a long-term-care home. For example, in March 2020, hospitals discharged

4,641 patients designated ALC, which was about 7% (or 309) more than the number of patients designated ALC (4,332) that on average were discharged each month in 2019.

The directive to stop non-essential services helped prevent certain hospitals from exceeding their bed capacity. An expected consequence of this was that numerous patients were unable to access routine or elective medical services for about 10 weeks, which created substantial backlogs in the health-care system. A study published in September 2020 in the *Canadian Medical Association Journal* estimated that between March 15 and June 13, Ontario accumulated a backlog of over 148,000 surgeries, which would take 84 weeks (almost 20 months, or close to two years) to clear. Any future reductions in elective surgeries, such as during subsequent waves of COVID-19, will further increase backlogs and lengthen wait times for elective surgeries, especially in regions where hospitals already have a high bed occupancy rate. Hospitals also now have a better understanding of COVID-19, allowing them to provide more effective and efficient care to those with COVID-19 while protecting other hospital patients from COVID-19 exposure.

We noted that regional variations in hospital bed capacity could be taken into consideration in the future to decide where and the extent to which non-essential medical services and elective surgeries need to be deferred. For example:

- **Figure 20** shows the regional differences in intensive-care-bed occupancy rates in hospitals from March 18 to May 15, which is the period when hospitals were directed to stop or reduce elective surgeries. The rate on May 15 ranged from about 61% in Ontario Health's North Region to about 80% in Toronto Region.
- **Figure 21** shows acute-care-bed occupancy between March 23 and May 15. The acute-care-bed occupancy rate was 81% on March 23, decreased during the month of April to 61% and rose again to 76% on May 15, just before the decision to stop non-essential services was reversed. Although it was precautionary to cancel elective procedures in March to create availability for COVID-19 patients, the occupancy was only 3% less when hospitals reopened. This also indicates that there could have been a faster reintroduction of elective procedures in certain regions of the province.

Figure 20: Intensive Care Unit Bed Occupancy Rates by Region, March 18–May 15, 2020 (%)

Source of data: Ministry of Health

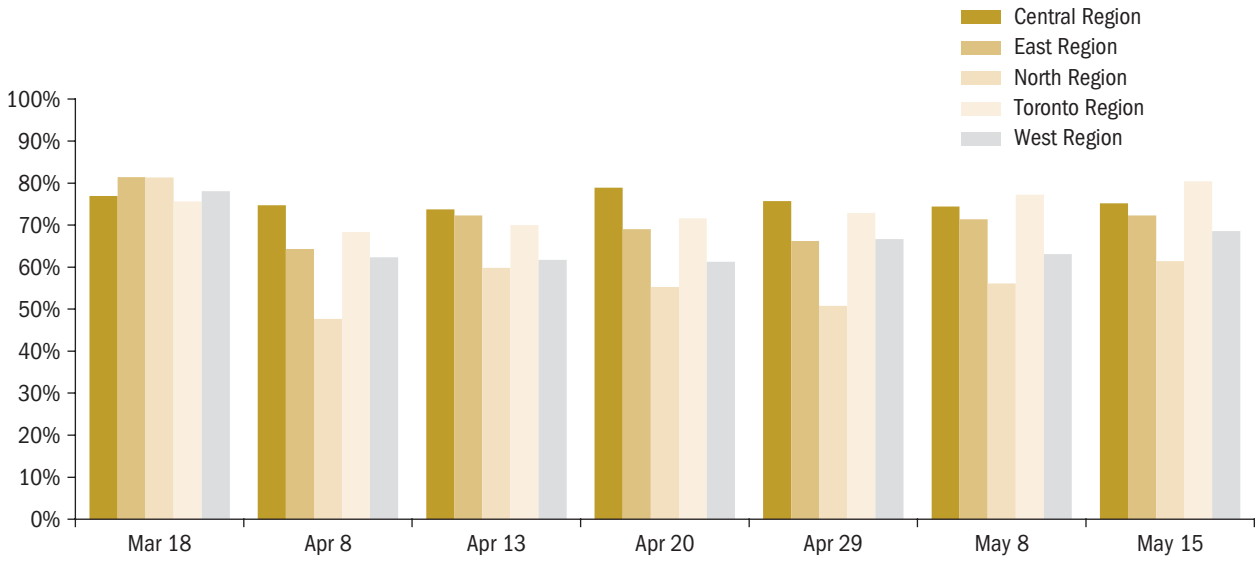
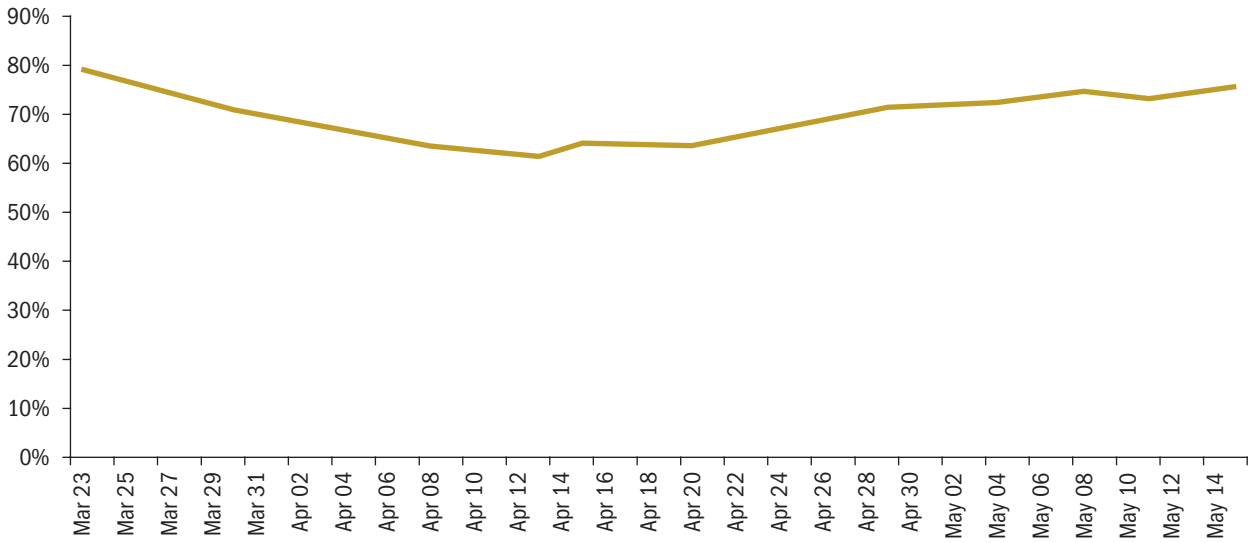


Figure 21: Acute-Care-Bed Occupancy Rates in Ontario, March 23–May 15, 2020 (%)
Source of data: Ministry of Health



4.6.2 Race-based Information Was Not Collected and Factored into Decision-Making to Give Special Attention to Populations with a Higher Risk of Contracting COVID-19

Immigrant populations in Ontario have been identified as having more cases of COVID-19 compared to other populations, as well as higher rates of hospitalization and death due to COVID-19. Despite health leaders recommending it in April, the Ministry of Health did not begin collecting provincial COVID-19 socio-demographic and race-based data until June 26, 2020.

On April 15, 2020, a letter was sent to the Minister of Health and the Chief Medical Officer of Health from a coalition of black health leaders. The letter identified that studies show differential access to health care due to race and socio-economic status, and that without collecting socio-demographic and race-based data, it cannot be understood who the pandemic disproportionately impacts. The letter identified a series of actions to be taken immediately, including:

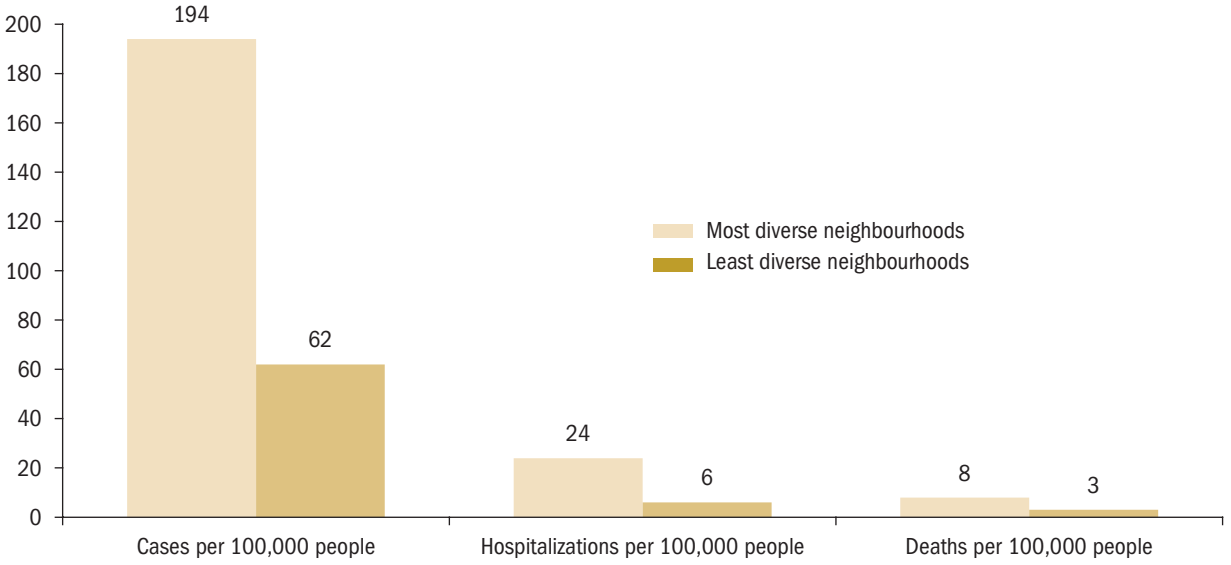
- Mandate the collection and use of socio-demographic and race-based data in health and social services now as it relates to COVID-19, and more expansively in future to inform overall health system planning and resource allocation.
- Start following the 2018 Ontario Health Equity Standards by mandating collecting race and socio-demographic data to "assess and report on the health of local populations describing the existence and impact of health inequities and identifying effective local strategies that decrease health inequities."
- Expand data collection and reporting requirements within the integrated Public Health Information System to include race.

Evidence has shown that immigrants and people living in regions with higher ethnic concentrations are at higher risk of contracting COVID-19. For example:

- A report published by Public Health Ontario on June 1, 2020 showed that ethno-culturally diverse neighbourhoods in Ontario were experiencing disproportionately higher rates of COVID-19, even after adjusting for the ages of people in the neighbourhoods. As shown in **Figure 22**, the most diverse neighbourhoods had rates of COVID-19 cases, hospitalizations and deaths that were between two and four times higher than that of the least diverse neighbourhoods.

Figure 22: Comparison of COVID-19 Cases, Hospitalizations and Deaths per 100,000 Residents between Most Diverse and Least Diverse Neighbourhoods

Source of data: Public Health Ontario



Note: The study used age-adjusted rates for neighbourhoods.

- A study published by the Institute for the Clinical Evaluation of Science on September 9, 2020 showed that although immigrants, refugees and other newcomers to Ontario make up just over 25% of the population, they accounted for almost 44% of all COVID-19 cases up to June 13, 2020. The study included immigrants and refugees who obtained permanent residency between January 1, 1985 and May 31, 2017 and those second-generation immigrant children under the age of 19 who were born in Ontario to mothers who had gained permanent residence in Ontario since 1985.

However, the Ministry did not begin collecting race-based information on individuals tested for COVID-19 until June 26, 2020. To that point, therefore, decisions on the best measures to contain the spread of COVID-19 did not have sufficient information to allow for measures to focus sooner on the populations at greatest risk of becoming infected.

We asked the Ministry why this action was not taken sooner. The Ministry informed us that it took time to complete consultations with partners inside and outside government, including the Anti-Racism Directorate, the Ministry of Indigenous Affairs, and other areas of the Ministry of Health and Public Health Ontario. Additional time was also needed to obtain approval from Cabinet to amend the regulation under the *Health Protection and Promotion Act*, and then publicly post the draft amendment for feedback, consistent with standard government processes.

RECOMMENDATION 6

To better prepare for subsequent waves of COVID-19 and protect the health of Ontarians in future, we recommend that the Ministry of Health and the Health Command Table:

- continually monitor and assess hospital bed capacity and wait times for elective surgeries across the province and by region to help identify ways of reducing the backlogs of those surgeries;
- assess the impacts of stopping or reducing elective surgeries to hospitals and patients and factor regional variations in hospital bed capacity and COVID-19 rates into future directives;

- regularly assess socio-economic data on COVID-19 cases to identify people with a higher risk of contracting COVID-19 and places with a higher risk of community transmission; and
- implement education, testing, contact tracing and other initiatives that address the needs of people with a higher risk of contracting COVID-19.

MINISTRY RESPONSE

The Ministries of Health and Long-Term Care agree with the need to monitor and assess health system capacity. These capacity measures, including hospital bed capacity and information about scheduled surgeries, have been reviewed at each Health Command Table meeting and have formed an important part of the COVID-19 response.

The decision to stop non-emergency scheduled surgeries and procedures was not made lightly. It was based on the modelling available at the time, which suggested that there was a high likelihood that COVID-19 patient needs would exceed hospital inpatient and intensive-care-unit capacity.

Guidance on the resumption of scheduled surgeries was released in May, beginning with Ontario Health's A Measured Approach to Planning Surgeries During the COVID-19 Pandemic on May 7, 2020, followed by the Ministry of Health's amendment to Directive #2 and accompanying guidance, COVID-19 Operational Requirements: Health Sector Restart on May 26, 2020.

The Health Co-ordination Table (formerly called the Health Command Table) is regularly assessing indicators and analyses to understand the impact of income and race on COVID-19 transmission. The Ministry of Health is working with Ontario Health and public health units to support higher-risk neighbourhoods in accessing the services they need to reduce the spread of the virus.

4.7 Health Emergency Response Plans Remain Outdated, Preventing Roles and Responsibilities from Being Clearly and Optimally Assigned in Advance of the Pandemic

4.7.1 Health Emergency Response Plans in Ontario Have Not Been Updated Since 2013

Before COVID-19, the Ministry of Health had responsibility for two response plans—the Ministry of Health and Long-term Care Emergency Response Plan (Health Response Plan) and the Ontario Health Plan for an Influenza Pandemic (Health Pandemic Plan) — that were intended to be used in the event of a pandemic. However, neither of these plans had been reviewed and updated since 2013. The Health Response Plan did not even revise its references to ministries when the Ministry of Long-Term Care was established as a separate ministry from the Ministry of Health in June 2019. This appears to be a contravention of the *Emergency Management and Civil Protection Act* except for a nuance that there needs to be an annual review of the Ministry's emergency management program and plan, with updates made only if necessary. While the 2019 Emergency Management Program Compliance Review conducted by the Ministry of the Solicitor General indicated that the Ministry of Health met all mandatory provincial emergency management program requirements, the compliance review identified areas for improvements, which included establishing governance mechanisms, and roles, responsibilities and accountabilities for health emergency management.

Since both response plans were outdated and were not attempted to be updated in January or February 2020, when the risk of a pandemic was increasing, roles and responsibilities were not clearly defined to respond in a timelier manner to COVID-19. The Ministry did not, and could not, fully follow these plans. Instead, it used them as guidance documents at the beginning of the pandemic. On February 28, 2020, it set up a new and

complex response structure involving numerous participants (see **Section 4.1**), which contributed to delays in Ontario's response and decision-making (see **Section 4.3**).

In contrast, British Columbia updated its influenza pandemic plan throughout the month of February 2020, shortly after the first case was confirmed in the province on January 27. It tailored this plan to the COVID-19 pandemic, clearly identifying roles and responsibilities as well as a clear chain of command. The updated pandemic plan was signed by the Deputy Minister of Health and the Deputy Minister of Emergency Management British Columbia on March 5, 2020 and released to the public on March 6, 2020.

Chapter 1 Emergency Management in Ontario—Pandemic Response addresses the issues surrounding the activation of Ontario's emergency response plans.

Health Response Plan

As mentioned, the Health Response Plan was last updated in 2013, with no annual updates since. The Health Response Plan is supposed to outline what the Ministry will do in the event of any emergency that affects the health-care system and the health of Ontarians, and it is intended to complement incident-specific plans such as the Ontario Health Plan for an Influenza Pandemic (Health Pandemic Plan).

The Ministry did not fully follow its Health Response Plan during the COVID-19 pandemic, using it as a guidance document at the beginning of the pandemic for setting up the Health Command Table (see **Section 4.3.1**). Our review noted that the response structure outlined in the Health Response Plan is very generic and broad. For example, it does not specify who should lead and participate and what their roles and responsibilities should be. Our review also noted that the content of the Health Response Plan is outdated. Specifically:

- As identified in **Appendix 2**, since October 2018, the Chief Medical Officer of Health has been assigned an additional title of Assistant Deputy Minister with responsibility for the Ministry's Public Health group. The Health Response Plan does not reflect this change.
- The Health Response Plan does not properly identify the key stakeholders to be involved in a health emergency response. It does not identify Ontario Health as one of these stakeholders. The Ontario Health agency was created in 2019 with the intent to have an integrated health-care system by co-ordinating and taking over the mandates of now-defunct provincial health agencies, including Cancer Care Ontario and eHealth Ontario, and the oversight of the 14 Local Health Integration Networks. The Health Response Plan also incorrectly identifies that there are 36 public health units (in 2018, public health units were reduced to 35, and were further reduced to 34 in 2020).
- The Health Response Plan states that meetings may be held face-to-face or, if circumstances do not allow, via teleconference. The effectiveness of teleconference meetings depends on various factors, such as the size of the group, the extent to which group members know each other and the complexity of issues being discussed. As identified in **Section 4.5.1**, teleconference meetings during COVID-19 were challenging because of the large number of participants, and by virtue of being seven years out of date, the Health Response Plan does not identify videoconferencing as a suitable option for meetings.

Health Pandemic Plan

The Ontario Health Plan for an Influenza Pandemic (Health Pandemic Plan) was introduced in 2004 (subsequent to SARS in 2003) and was also last updated in 2013. The Health Pandemic Plan describes the roles and responsibilities of provincial health-system partners in an influenza pandemic, and outlines a planning framework for response activities and continuity of operations based on the severity of the pandemic and other factors.

Since the Health Pandemic Plan was developed to deal with an influenza (commonly called a flu) pandemic, some aspects of it, such as guidance on anti-viral medication and vaccinations, were not initially relevant to the COVID-19 virus. The Ministry informed us that the Health Pandemic Plan was used only as a guidance document for developing documents and directives to respond to the COVID-19 pandemic.

As with the Health Response Plan, we noted that some parts of the Health Pandemic Plan are outdated. For example, the plan:

- does not mention the role and responsibilities of Ontario Health; and
- refers to the Ministry of Health and Long-Term Care, which in 2019 was separated into two ministries.

We also noted that the Health Pandemic Plan did not have, or had only limited, coverage of a number of areas that were critical for the COVID-19 response, including guidance on:

- increasing laboratory testing capacity, speed and reliability;
- contact-tracing capacity;
- range and efficacy of screening for the virus;
- how to balance and deal with competing priorities, such as preserving acute- and intensive-care capacity;
- the use of virtual care, which has become more common in recent years; and
- the use of modern communication tools such as videoconferencing.

4.7.2 Ministry Did Not Implement Our Recommendations from 13 Years Ago and from 2017 on Performing Regular Updates of its Emergency Response Plans

As part of our 2007 audit, Outbreak Preparedness and Management, we recommended that the Ministry:

- review both the Health Pandemic Plan and the Health Response Plan regularly to update them as necessary;
- periodically conduct simula¬tion exercises, which are interactive exercises that test the capability of an organization or other entity to respond to a simulated emergency, disaster or crisis, as recommended by the World Health Organization, to confirm that planned responses will work; and
- clarify the responsibilities of all parties involved in the response.

Our 2009 follow-up review of these recommendations found that the Ministry had taken actions to implement them; for example, it updated the Health Pandemic Plan and intended to update the Health Response Plan in fall 2009, it led and participated in a number of exercises to test the Health Pandemic Plan and other features of its pandemic preparedness, and it clarified and summarized roles and responsibilities as part of its review of the Health Pandemic Plan. However, the Ministry did not continue these actions. No updates have been done since 2013. Our audit in 2017 on Emergency Management in Ontario highlighted the need for the province's overall Emergency Plans to be regularly updated.

4.7.3 New Health Pandemic Plan Proposed Seven Years Ago Still Not Put in Place

The introduction to the 2013 Health Pandemic Plan ends with the following paragraph:

> This is the final iteration of the [Influenza Plan]. The Ontario Influenza Response Plan (OIRP) will eventually replace it. Through this new plan, the provincial health system's focus will shift from preparing for an influenza pandemic to creating and building effective seasonal influenza responses and escalating those measures during a pandemic. The OIRP will link to updated pandemic response plans from the WHO [World Health Organization] and PHAC [Public Health Agency of Canada], and it will also address the next steps documented in this version of the [Influenza Plan] and outstanding

lessons learned and best practices from H1N1. The OIRP will outline influenza responses for the entire health system, including government, primary health care, community care, hospitals and public health."

However, seven years after it was first proposed by the Ministry, the OIRP was still not in place when COVID-19 hit Ontario in 2020. The Ministry informed us that work on this plan was still pending. The 2013 Health Pandemic Plan provides only general guidance for health-care workers and primary-care providers, without specific guidelines for sub-sectors such as long-term care and hospitals. There is therefore a need for this new OIRP to provide more specific and timely guidance for health-care providers in different sectors.

RECOMMENDATION 7

To improve how quickly Ontario can effectively respond to future health emergencies and pandemics, we recommend that the Ministry of Health:

- review, improve and update the existing health emergency plans (the Ministry of Health and Long-Term Care Emergency Response Plan and the Ontario Health Pandemic Plan (or Ontario Influenza Response Plan, once implemented) on an annual basis; and
- implement the Ontario Influenza Response Plan and continually update information as lessons are learned from COVID-19, including specific guidance for health-care providers and sub-sectors such as long-term care and hospitals.

MINISTRY RESPONSE

The Ministry agrees with the need to apply lessons learned in emergency and pandemic planning. The Ministry is consistently in compliance with all mandatory emergency management program requirements under the *Emergency Management and Civil Protection Act*. This includes reviewing existing health response plans and providing updates where appropriate.

The Ministry will implement the Ontario Influenza Response Plan. The Ontario Influenza Response Plan will provide guidance on response mechanisms to address the influenza virus in both seasonal and pandemic situations. Influenza is a very specific virus that differs from other viruses that cause pandemics such as COVID-19 (a coronavirus). It is well understood from a scientific and technical perspective and has specific clinical and public health infrastructure to support responses.

With the emergence of COVID-19, the Ministry chose to adapt foundational planning documents for infectious diseases (i.e., Influenza, Middle East Coronavirus, Ebola Virus Disease) to this novel virus and leveraged the available public health and health system infrastructure, including the newly created Ontario Health, Ontario Family Health Teams.

The Ministry has issued over 50 response-focused guidance documents to direct the health system during the pandemic.

Lessons learned from many emergencies over the past 15 years, including the Ebola response, have highlighted the need for a shift in paradigm in emergency management. The recommended approach is to build ongoing readiness and resilience across the health system, opposed to planning hazard by hazard. Ontario has been implementing a system readiness approach from the outset of the COVID-19 pandemic.

4.8 Ontario's Public Health System Remains Fragmented and Not Well-Co-ordinated

4.8.1 Public Health Units Do Not Operate Uniformly, Resulting in Fragmentation and Inconsistencies

While Public Health Ontario and the Chief Medical Officer of Health are responsible for managing public health at the provincial level, public health

units have this responsibility at the regional level. **Appendix 3** identifies the responsibilities of these parties. Variations among the public health units and their silo operations have resulted in fragmentation and inconsistencies across Ontario.

Public Health Units Vary in Terms of Their Management and Operations

There are currently 34 public health units in Ontario. Each is governed by a Board of Health, which is a corporation with the responsibility for delivering local public health programs and services within its geographic borders. The public health units vary significantly in terms of their geographic coverage, organizational structures and governance. Specifically:

- The populations served by the public health units range from less than 34,000 to over 2,700,000.
- Each Board of Health appoints a Medical Officer of Health to lead its public health unit. Most, but not all, of the 34 Medical Officers of Health also have the role of Chief Executive Officer.
- The extent of autonomy varies from one Board of Health to another, depending on the governance model. There are currently five governance models among the Boards of Health (see **Appendix 16**).

We also noted that public health in other jurisdictions (such as British Columbia, Alberta and Quebec) is simpler, with less fragmentation and fewer inconsistencies than in Ontario. Specifically:

- At about one-third of Ontario's population, British Columbia delivers its public health through just five Regional Health Authorities, one Provincial Health Authority and one First Nations Health Authority, as compared with Ontario's 34.
- Alberta's Regional Health Authorities were dissolved in 2008, and Alberta Health Services was legally created on April 1, 2009. Public health programs and services are now managed centrally through Alberta Health Services, which is the single health authority in Alberta and which breaks down its operations into five geographical zones in the province.
- Public health in Quebec is delivered by only 18 Regional Public Health Authorities.

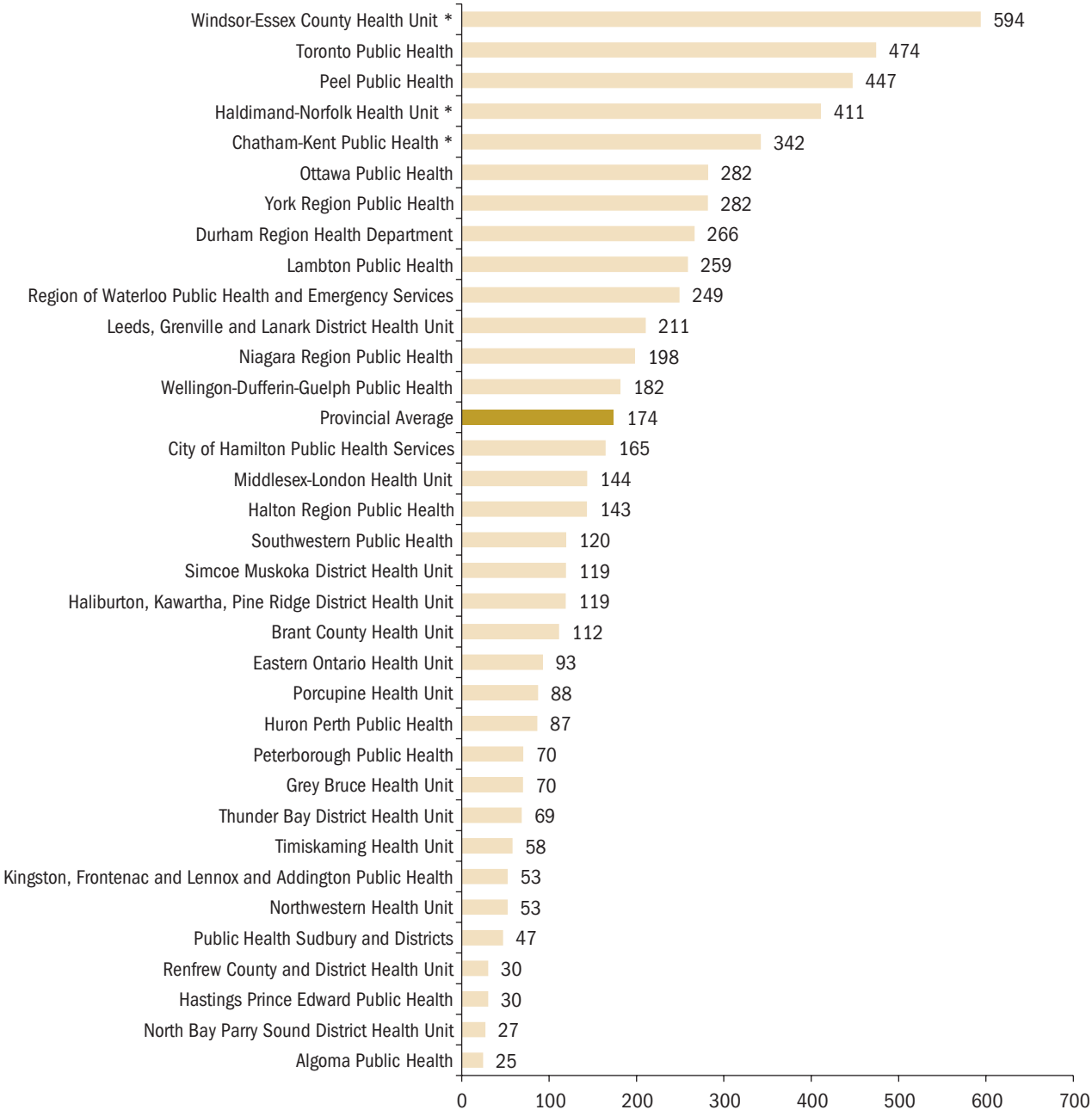
Public Health Units Did Not Respond to COVID-19 Consistently

The number of COVID-19 cases per capita in Ontario varied significantly by region. As of August 31, 2020, the rate of COVID-19 cases per 100,000 residents ranged from 25 in one public health unit to 594 in another (see **Figure 23**). These regional variations can be attributed to various factors, including population density, socio-demographics, the number and type of congregate settings, and proximity to other jurisdictions that were heavily impacted by COVID-19 cases, such as Quebec and the United States. Apart from these factors, the public health units' diverse responses to COVID-19 also contributed to regional variations in their performance and effectiveness in controlling COVID-19. As identified in **Section 4.2.2**, the Chief Medical Officer of Health did not issue province-wide directives to local Medical Officers of Health or Boards of Health or act on behalf of all Medical Officers of Health to issue identical orders throughout the province. Instead all directives were issued to health-care providers and health-care entities. As a result, the public health units developed their own recommendations and requirements. These guidelines and requirements differed from each other, especially with respect to the requirements for wearing masks and the precautions to be taken for temporary foreign farm workers (see **Section 4.2.2**).

Kingston, Frontenac, Lennox & Addington Public Health Unit (Kingston Public Health Unit) was one of the public health units that outperformed most other public health units in the following ways:

Figure 23: Number of COVID-19 Cases per 100,000 Residents by Public Health Unit, as of August 31, 2020

Source of data: Public Health Ontario



* This Public Health Units has a low population density but a high number of cases per capita because of farm outbreaks in its region.

- Despite the majority of its population living in urban regions, Kingston Public Health Unit had one of the lowest rates of COVID-19 cases in the province, at about 53 cases per 100,000 residents (or 112 total cases) as at August 31, 2020. It had no deaths due to COVID-19.
- The Kingston Public Health Unit has 11 long-term-care homes and 19 retirement homes in its region. As of August 31, 2020, only one staff member at a long-term-care home tested positive for COVID-19 (on April 1, 2020), and no residents contracted COVID-19.

The low rate of COVID-19 cases in the region can be at least partially attributed to Kingston Public Health Unit's early preparation. The unit began preparing the community before COVID-19 became a crisis in the province, and focused on infection and prevention control practices in long-term-care homes. For example, the Kingston Public Health Unit did the following:

- hosted its annual influenza preparedness workshop in August 2019 to bring together health-care partners from across the region to have an interactive discussion on how to prepare for a severe influenza season in the region;
- in early March 2020, began conducting compliance health audits at each long-term-care home to ensure that proper infection prevention and control procedures were in place and that staff were adequately trained to identify and manage a resident with suspected COVID-19; and
- prepared a manual for long-term-care homes to guide them in implementing necessary precautions during a viral outbreak. The manual contained information and resources to guide the homes in their response efforts, such as:
  - the criteria for when a home should declare an outbreak ;
  - a Respiratory Outbreak Control Measures Checklist that includes steps to take during an outbreak such as who to notify, which droplet and contact precautions to implement, environmental controls to implement such as cleaning measures, and restrictions and measures to put in place for the residents, staff and visitors; and
  - instructions on how to administer the collection of a specimen for COVID-19 testing, and how to store and deliver the specimen for COVID-19 laboratory testing.

The 34 local Medical Officers of Health and the Chief Medical Officer of Health participated in weekly calls beginning January 23, 2020, which have continued twice weekly since February 11, 2020, to share information about the ongoing pandemic response. Despite these opportunities for information-sharing, not all public health units followed the best practices or lessons learned from other public health units with better performance, like Kingston Public Health Unit. Public health units implement and share provincial policy and guidance, but as independent entities they are not required to put these into practice in a consistent fashion. This results in variations among public health units in their outbreak and emergency responses. For example, 71% or 20 of the 28 public health units that responded to our survey identified that they do not perform, and have not performed, an annual influenza pandemic preparedness session with local stakeholders.

4.8.2 Steps to Modernize Ontario's Public Health System Stalled Due To COVID-19; Recommendations for Changes Made Over 15 Years Ago

The steps the Ministry of Health had been taking to modernize Ontario's public health system were put on hold as a result of COVID-19. The need to reform Ontario's public health system had been identified and recommended in the following SARS reports (see **Appendix 2**):

- In December 2003, the *Initial Report* of the Ontario Expert Panel on SARS and Infectious Disease Control was released, in the aftermath of SARS. It recommended that the province should consider reinforcing and consolidating existing capacity to between 20 to 25 public health units. The Panel argued that the existing 37 public health units were too diffusely organized, which prevented them from having sufficient breadth of expertise at the local level in some parts of the province. The Panel also recognized that there needs to be a greater degree of alignment between public health units and other key health service areas.

- In April 2004, the *First Interim Report* of the SARS Commission recommended, "Local Medical Officers of Health and public health units, the backbone of Ontario public health, require in any reform process a strong focus of attention, support, consultation and resources. Reviews are necessary to determine if municipalities should have a significant role in public health protection, or whether accountability, authority and funding should be fully uploaded to the province. If local Boards of Health are retained, the province should streamline the processes of provincial leadership and direction to ensure that local Boards comply with the full programme requirements established by the province for infectious disease protection."

However, the Ministry has not addressed these recommendations to reform public health units. As well, our 2003 audit of Public Health Activity and 2007 audit of Outbreak Preparedness and Management also identified significant variations in funding and operations between public health units.

It was not until 2017 (14 years after the first recommendation) that the Ministry established an Expert Panel on Public Health that was asked to provide advice on changes to the structure, organization and governance of public health to address the lack of integration of public health with the broader health sector and to improve public health capacity and delivery. The panel identified a number of concerns with public health delivery in Ontario, including:

- a lack of surge capacity and challenges recruiting and retaining public health personnel, causing inequities in service delivery;
- a lack of capacity with smaller health units;
- a wide variety of governance models over public health units; and
- a lack of mechanisms to coordinate across public health units and work within the health sector.

The 2017 Expert Panel on Public Health made several recommendations to the Ministry, including establishing fewer regional public health entities and establishing autonomous boards of health that have a consistent, independent governance structure. However, these recommendations were not fully acted on.

In 2019, the Ministry introduced a proposal, called Public Health Modernization, to streamline the public health units' operations and address the SARS report's recommendations.

The proposal to modernize public health in Ontario was announced as part of the provincial government's budget on April 11, 2019. The following changes were proposed:

- reducing the number of public health units from 35 (now 34) to 10 by April 1, 2020;
- creating 10 new autonomous Boards of Health with regional and local representation; and
- revising the funding formula by increasing the municipal portion and decreasing the provincial portion, depending on the size of the population.

In August 2019, the government announced that a renewed consultation process would begin that would include the release of a discussion paper. In-person consultations began in November 2019 to solicit input from partners (including public health, emergency health and municipal stakeholders) on re-designing the public health system to be nimble, resilient, efficient and responsive to emerging issues. A number of regional sessions were held in various part of the province between November 2019 and March 2020, at which time consultations were paused due to COVID-19.

In November 2019, the Ministry issued a discussion paper on Public Health Modernization, highlighting several expected outcomes, which included "better consistency and equity of service delivery across the province" and "improved clarity and alignment of roles and responsibilities between the province, Public Health Ontario and local public health." The discussion paper also identified a number of critical challenges in the current public health system based on several reports over the past

20 years, including our Office's past audits. These challenges included:

- **Capacity issues contributing to inconsistent practices and varying services:** The capacity of public health units varies significantly across the province. Some public health units do not have sufficient human resources to deliver mandated programs and services—including infectious and communicable disease prevention and control, and immunization—and to monitor population health data and manage outbreaks. For example, our 2017 audit on Public Health: Chronic Disease Prevention reported that some public health units do not have the required time and/or staff expertise to review and analyze epidemiological data, and some were not evaluating or measuring the effectiveness of new programs. This difference in access to staff expertise could result in variations in public health units' ability to respond to public health threats and emergencies.
- **Misalignment of health, social and other services:** There are barriers to collaborating effectively among the public health, healthcare and social services sectors. The health of Ontarians depends on factors outside the health sector—housing, education, employment and the environment all play a role. In the current organization and structure of the public health sector, breaking down the silos across sectors by having public health professionals actively working with other members of the community on a variety of issues requires significant effort and resources.
- **Lack of effective co-ordination and duplication of effort:** There is duplication, unnecessary redundancies, inconsistencies and a lack of co-ordination within the public health system. Our 2017 audit on Public Health: Chronic Disease Prevention reported that "significant inefficiencies exist across the public health units because there are limited formal systems in place to co-ordinate their activities and share best practices." Research activities are being duplicated at multiple public health units when there are opportunities to leverage others in undertaking and sharing this work. As well, public health units tend to work individually to develop systems to collect data, and the type of data collected differs.
- **Inconsistent priority setting:** There are inconsistencies across the province in how priorities are set and decisions made regarding public health programs and services. The variation in governance models makes it hard for the sector to take collective action on public health issues that span the province. The variation in leadership models also means that decision-making and accountability within public health units are inconsistent, which presents challenges in how public health units collaborate among themselves.

On January 28, 2020, an in-person consultation session was held. An online survey was also available until February 10, 2020 to seek feedback from the public, public health agencies and any stakeholders. Some respondents felt that the number of public health units should be reduced, but not at the expense of local accessibility. They said that some public health units could easily amalgamate; a total of 20 to 25 units was identified as an appropriate number that would achieve the meeting of local needs, cost savings in the form of fewer executives, and better use and sharing of supportive resources like epidemiologists, communication specialists and IT infrastructure. This result is aligned with the recommendation from the December 2003 *Initial Report* of the Ontario Expert Panel on SARS and Infectious Disease Control. Despite all the work and consultations performed since October 2019, the Ministry subsequently paused changes to the public health system around March 15, 2020 in order to focus its efforts on responding to COVID-19. As a result, the existing Boards of Health will continue to operate beyond April 1, 2020 (for

an unknown duration), and the April 1, 2020 deadline for change is no longer applicable.

It is important that changes are made to improve the effectiveness and co-ordination of public health services provincially. As identified in **Section 4.1.4**, resource constraints also played a role in why some activities that would have been expected to be performed by the public health system were performed by other parties (such as Ontario Health). Considerations for changes could include more central oversight and consistency, with direction being provided by Public Health Ontario to public health units (such as during public health emergencies); a change in model where public health units report directly into Public Health Ontario versus autonomous boards of health, as well as structural alignment with Ontario Health's regional and sub-regional structure. Another reporting relationship would be for the Chief Medical Officer of Health reporting into Public Health Ontario, versus reporting as an Assistant Deputy Ministry to the Deputy Minister of Health. This reporting relationship may provide more independence to a Chief Medical Officer of Health when a pandemic emergency strikes. This would produce more public clarity in how public health decisions are made during a pandemic.

If the recommendations to reform Ontario's public health system from over 15 years ago had been responded to in a timely manner, the province could have addressed the long-standing public health challenges and achieved the expected outcomes of the Public Health Modernization proposal earlier, including "better consistency and equity of service delivery across the province" and "improved clarity and alignment of roles and responsibilities between the province, Public Health Ontario and local public health." These expected outcomes were critical to maximizing the effectiveness of Ontario's response to COVID-19.

RECOMMENDATION 8

To create a cohesive and more effective public health system, we recommend that the Ministry of Health:

- resume with its modernization of public health in a manner that does not undermine the ability of the public health system to respond to subsequent waves of COVID-19 or local public health needs, with consideration given to having a single point of public health leadership to allow for consistency across the public health and broader health systems, particularly during a public health emergency (such as through direction provided by Public Health Ontario and overall structural alignment with Ontario Health's regions and sub-regions) and the role and reporting structure of the Chief Medical Officer of Health to be able to independently provide advice as part of public health emergencies; and
- incorporate information gathered from consultations and surveys into its modernization of public health.

MINISTRY RESPONSE

The Ministry welcomes the observations and recommendations aimed at creating a cohesive and more effective public health system. Ontario's pandemic response has highlighted opportunities to enhance the responsiveness and consistency of public health actions across the province.

In November 2019, the Ministry of Health, in partnership with an advisor, initiated consultations on strengthening and modernizing public health and emergency health services.

To date, the Ministry has:

- received over 500 submissions from organizations and individuals in response to the emergency health services and public health modernization discussion papers; and

- met with over 300 participants in seven regional in-person consultations.

Consultations were put on hold in mid-March 2020 to allow public health to respond to the COVID-19 pandemic.

Once the COVID-19 pandemic is contained and risks to the public are mitigated, consultations will resume, and the Ministry will move forward with public health modernization.

Review recommendations will be provided to the Minister of Health and reviewed by Cabinet through regular decision-making processes.

4.9 Information on Travellers and Their Association with the Spread of COVID-19 in Ontario Is Incomplete, Delayed and Insufficient

4.9.1 Ontario Did Not Contact All Travellers Entering the Province Due to a Lack of Dedicated Resources and Its Failure to Receive Accurate, Complete and Timely Information

The federal government is responsible for deciding which visitors may enter Canada, which includes enforcing emergency orders issued by the federal Minister of Health, as well as for issuing and enforcing quarantine orders (see **Appendix 3**). In other words, Ontario relies on the federal government to control and monitor who is allowed to come into Canada. On March 25, 2020, the federal government announced an emergency order requiring any person (with or without COVID-19 symptoms) entering Canada by air, sea or land to self-isolate for 14 days. All individuals entering Canada are required to fill out the traveller contact information form and are screened by a border services officer or quarantine officer to assess symptoms. Foreign nationals (i.e., non-Canadian citizens) with symptoms of COVID-19 are not allowed to enter Canada. This information is provided to the Public Health Agency of Canada (PHAC) by the Canada Border Service Agency. PHAC then provides information on travellers with no COVID-19 symptoms at the time of entry into Canada to the provinces, which are then expected to follow up with these travellers to discuss isolation requirements and provide resources for support if the travellers begin to have symptoms.

However, we found that the Ministry of Health did not follow up with many of the travellers they received information on. On April 13, 2020, the Ministry began contacting all the travellers included in reports received up to that date to explain what self-isolation involves for the travellers, how they should monitor for COVID-19 symptoms, and how to access medical care, testing facilities and other support services, as needed. The Ministry informed us, however, that as of September 8, 2020, it had been able to reach out to only about 118,800 travellers (60,800 over the phone and 58,000 by email) out of the 233,300 international travellers included in the PHAC listings received from April 5 to August 31, 2020. Thus, almost 50% of (or 114,500) travellers could not be reached. The Ministry informed us that although the PHAC may have been contacting some travellers as well through automatic diallers and other means, they were not able to reach all travellers on their list due to travellers not responding to a phone message or email, errors in the traveller data provided and limited human resources at the Ministry to contact the travellers within their 14-day self-isolation period. The Ministry also identified that the information they receive is not always, timely or appears to be missing or incorrect. For example:

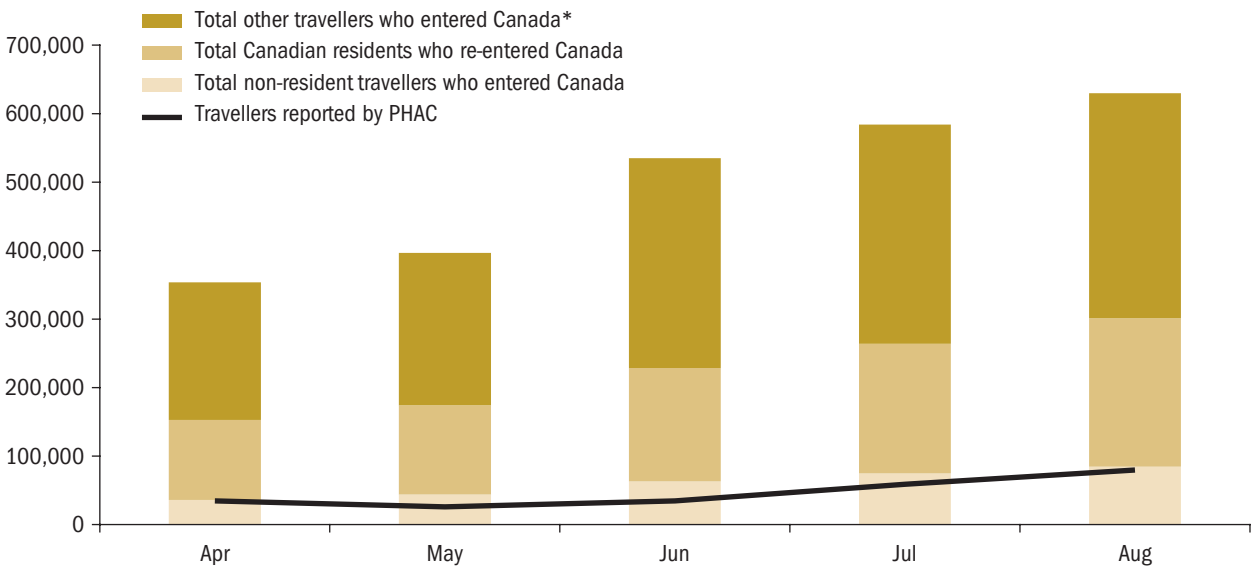
- The number of travellers appears inaccurate. The Ministry of Health began receiving lists of travellers to contact from PHAC on April 5, 2020. Statistics Canada identified that between April and August 2020 about 2.5 million international travellers entered Ontario. Of those travellers, 12% were non-residents of Canada, 33% were returning Canadian citizens, and 55% were other travellers consisting of foreign and resident crew

members, diplomats, military personnel, immigrants and former residents. The Statistics Canada information includes all travellers returning to Canada. However, the Ministry informed us that since some categories of travellers may have been purposely left out of the traveller lists provided by the PHAC, it was not able to follow up on all travellers. As well, since the Ministry removed children from these listings as soon as they were received, child travellers were not followed up on at all. **Figure 24** identifies the number of travellers, by type, entering Ontario during this time period. However, the Ministry only received information on fewer than 9%, or only about 233,300, of these travellers, indicating that such information was inaccurate and incomplete. The Ministry informed us that they had not determined if there was additional traveller information they should be receiving. For instance:

- The initial listing received by the Ministry on April 5, 2020 included some travellers who arrived in March; however, it reported an extremely small number of travellers returning to Ontario, such as just two on March 25 and 12 people on March 26. Given that 2.3 million travellers entered Ontario in the month of March 2020, a more realistic number for each of those days would have been closer to 74,000 new or returning travellers.
- The listing provided to the Ministry on June 15 included information on eight travellers said to have entered Canada on June 16, the day after the listing was provided.
- Traveller information was missing necessary details. Some traveller listings were missing information such as the traveller's contact details and whether the traveller had any COVID-19 symptoms. The PHAC no longer includes travellers who were exhibiting COVID-19 symptoms upon arrival in Canada. Arrival dates in Canada were at times either missing or incorrect. For example, 880 travellers had either arrived in Canada before the pandemic began and so before the PHAC began collecting their information or had no arrival date listed. The PHAC has instructed

Figure 24: Comparison of the Number of Travellers Who Entered Ontario and the Number of Travellers Reported by Public Health Agency of Canada (PHAC), April–August 2020

Prepared by the Office of the Auditor General of Ontario



* Other travellers consist of foreign and resident crew members, diplomats, military personnel, immigrants and former residents.

the Ministry that missing information should be interpreted as unknown.

- Information is not obtained by the Ministry in a timely manner. During the period between April 5 and August 31, 2020, 48% of the records were related to travellers who were more than halfway through their 14-day self-isolation period. In some instances, information was received by the Ministry after a traveller's 14-day self-isolation period had ended. This meant that the province was late in confirming whether these travellers had followed provincial isolation requirements; had any health concerns for which they could have been directed to the appropriate health-care resource for assessment or testing; and needed any additional support in self-isolating, such as help with getting groceries delivered. The Ministry informed us that it attempted on multiple occasions to rectify the situation with senior officials at the PHAC. Nevertheless, the problem of delayed reports was still ongoing at the time of our review.

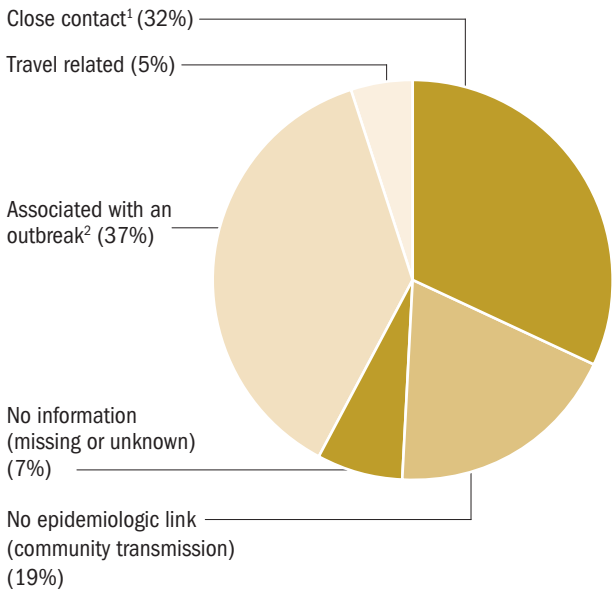
4.9.2 Ontario Does Not Collect Information on the Extent of Transmission by Travellers Who Had COVID-19

As identified in **Figure 25**, as of August 31, 2020, about 5% (or 2,049 of 42,421) confirmed COVID-19 cases in Ontario were known to have originated from travel outside of the province. While the individuals involved in these COVID-19 cases had likely also infected others, the full impact and extent of this is not clear to the Ministry or the public. For example, while almost 70% of COVID-19 cases were associated directly with close contact with individuals who had COVID-19 (including those who were part of an outbreak), there is no provincial reporting on which of these cases were directly associated with close contact to travellers who had COVID-19.

If the Ministry had directed public health units to specifically report on COVID-19 cases associated with close contact to travellers who had COVID-19, it would have helped the province and the public better assess the full impact of travellers who are bringing in and transmitting COVID-19 in Ontario.

Figure 25: Likely Sources of COVID-19 Transmission for Cases Identified in Ontario, January–August, 2020

Source of data: Public Health Ontario



Note: This figure covers 42,512 COVID-19 cases. Case information was provided by Public Health Ontario based on data entered by public health units as of August 31, 2020. The numbers may differ from what was publicly reported on August 31, 2020, because the public reporting is based on information extracted at various times for each public health unit on August 30, 2020.

1. More than 60% of these cases were likely transmitted by close contacts living in the same household.
2. 56% of these cases occurred in long-term-care homes, 10% occurred in retirement homes, 8% occurred on farms and 6% occurred in hospitals. Other sources of outbreaks include shelters, group homes and other workplaces.

RECOMMENDATION 9

To reduce the spread of COVID-19 by travellers to Ontario, we recommend that the Ministry of Health, with support from the Central Co-ordination Table:

- collaborate as necessary with other ministries or agencies to allocate the necessary resources to contact all travellers during their self-isolation period;
- elevate the issue to the Premier and the Minister of Health to communicate to the federal

government the importance of Ontario receiving accurate, complete and timely traveller information as soon as possible;

- enter into an agreement with the Public Health Agency of Canada to expeditiously clarify what information is needed on each traveller and how quickly the information will be provided to Ontario. The agreement could also cover federal responsibilities for communication, tracking and tracing when international travellers land at Ontario airports; and
- direct public health units to start reporting on the number of COVID-19 cases related to close contact with travellers with COVID-19, and publicly report this information as part of the daily and weekly COVID-19 summaries.

CONSOLIDATED RESPONSE FROM MINISTRY AND SECRETARY OF CABINET

Cabinet Office notes that the Central Coordination Table (CCT) is an internal coordinating committee that facilitates an integrated approach to supporting the government's COVID-19 response. CCT is not a decision-making body and does not have the authority to direct resources, enter into agreements or direct public health units. Ministers, supported by their Deputy Ministers and ministries, make recommendations directly to Cabinet for approval or endorsement. Funding decisions are made by Treasury Board (TB) based on submissions from ministries, and all TB decisions are confirmed by Cabinet.

Cabinet Office and the Ministries of Health and the Solicitor General agree with the importance of Ontario receiving accurate, complete and timely traveller information. The Ministry of Health continues to work the Ministry of the Solicitor General, the Public Health Agency of Canada, the Canadian Border Services Agency and other federal partners to strengthen the follow-up for travellers returning to Ontario.

The province has raised concerns about the federal management of borders through correspondence and meetings with relevant federal counterparts. There has been correspondence by provincial Ministers to federal Ministers highlighting requests to require everyone entering Canada to provide contact information; to clarify roles and responsibilities between federal and provincial monitoring activities (public health and enforcement) and develop a segmented and risk-based approach for returning travellers; and ensure that the proper protections, federal resources and personnel are in place to minimize risk.

The province will continue to advocate for changes to make Ontario's international borders safer.

Since the summer, there has been progress, including the requirement from PHAC on November 20, 2020 for travellers arriving by air to provide their information electronically. This will support improved and faster data-sharing.

The Ministry reports confirmed cases by COVID-19 by likely acquisition, including travel, in two daily measures and two weekly measures developed by Public Health Ontario and on the government's **Ontario.ca** website. This data shows that travel is a decreasing driver of disease in Ontario, and has considerably reduced as a source of infection from mid-April and is currently a likely source of infection for less than 1% of daily cases.

Appendix 1: Summary of the Key Events in the COVID-19 Pandemic around the World and in Ontario, as of August 31, 2020

Prepared by the Office of the Auditor General of Ontario

Date	Event
Dec 31, 2019	China reports a cluster of cases of pneumonia in Wuhan, Hubei Province to the World Health Organization (WHO).
Jan 3, 2020	The Office of the Chief Medical Officer of Health in Ontario first communicates to local Medical Officers of Health the cluster of undiagnosed viral pneumonia in Wuhan, China.
Jan 12, 2020	China publicly shares the genetic sequence of the source of the outbreak, a novel coronavirus.
Jan 13, 2020	Officials confirm the first recorded case outside China, in Thailand.
Jan 24, 2020	The first meeting of Canadian Health Ministers on COVID-19 is held.
Jan 25, 2020	Officials confirm the first presumptive case of the novel coronavirus in Canada, in a traveler returning from Wuhan, China to Toronto, Ontario.
Jan 27, 2020	The Ministry of Health Emergency Operations Center is changed to activation status in response to the novel coronavirus.
Jan 28, 2020	The first meeting of the Federal–Provincial–Territorial Special Advisory Committee on the novel coronavirus is held.
Feb 11, 2020	WHO announces the virus is now called "COVID-19."
Feb 28, 2020	The first meeting of the Health Command Table is held.
Mar 8, 2020	The first COVID-19–related death in Canada occurs at Lynn Valley Care Center in British Columbia.
Mar 11, 2020	WHO declares COVID-19 to be a pandemic.
Mar 11, 2020	The first COVID-19–related death in Ontario occurs at Royal Ontario Hospital in Barrie, Ontario.
Mar 12, 2020	The Minister of Education issues a Ministerial Order to close all publicly funded schools in Ontario.
Mar 14, 2020	Canadians abroad are strongly urged by the federal government to return to Canada as soon as possible.
Mar 18, 2020	The government of Ontario declares an emergency under s. 7.0.1 (1) of the *Emergency Management and Civil Protection Act*.
Mar 21, 2020	The Canada–US border is closed to all discretionary travel.
Mar 24, 2020	The Ontario government orders closure of all non-essential businesses across the province.
Apr 11, 2020	The first meeting of the Central Co-ordination Table is held.
May 8, 2020	Select businesses are allowed to re-open, including garden centres and nurseries.
May 19, 2020	Ontario enters Stage 1 of re-opening.
Jun 12, 2020	24 public health units begin entering Stage 2 of re-opening.*
Jun 19, 2020	All remaining public health units (with the exception of Peel Public Health, Toronto Public Health and Windsor-Essex) move to Stage 2 of re-opening.
Jun 24 and 25, 2020	Peel Public Health, Toronto Public Health and Windsor-Essex (except for Leamington and Kingsville) enter Stage 2 of re-opening.
Jul 7, 2020	Leamington and Kingsville enter Stage 2 of re-opening.
Jul 17, 2020	24 public health unit regions begin entering Stage 3 of re-opening.*
Jul 24, 2020	All remaining public health units (with the exception of Peel Public Health, Toronto Public Health and Windsor-Essex) move to Stage 3 of re-opening.
Jul 31, 2020	Peel Public Health and Toronto Public Health enter Stage 3 of re-opening.
Aug 12, 2020	Windsor-Essex region enters Stage 3; all regions are now in Stage 3.

Ontario-related event

Note: Dates and details in this figure are based on our review of public information and various documents provided by the Ministry of Health, including but not limited to email communication to public health units, the terms of reference for the Health Command Table and information presented to the Central Co-ordination Table.

* 10 public health units (Durham Region Health Department, Haldimand-Norfolk Health Unit, Halton Region Public Health, Hamilton Public Health Services, Lambton Public Health, Niagara Region Public Health, Peel Public Health, Toronto Public Health, Windsor-Essex County Health Unit and York Region Public Health) did not move into the next stage as early as the other 24 public health units.

Appendix 2: Summary of Relevant Recommendations from Key SARS Reports

Prepared by the Office of the Auditor General of Ontario

Area	Recommendations	Implemented?	Report Section Where Discussed
First Interim Report by the SARS Commission[1] (April 2004)			
Independence and accountability	• 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.	Yes • The Chief Medical Officer of Health is an Assistant Deputy Ministry leading the Public Health Branch of the Ministry of Health.	4.2.1
	• The Chief Medical Officer of Health should have operational independence from government in respect of public health decisions during an infectious disease outbreak.	Yes • The Chief Medical Officer of Health has the power to investigate health risks and act to prevent, eliminate or decrease those risks (a role previously assigned to the Minister of Health).	4.2.2
	• Such independence supported by a transparent system requiring that any Ministerial recommendations be in writing and publicly available.	No • Ministerial recommendations are not always publicly available.	4.2.1
Public health system	• Local Medical Officers of Health and public health units, the backbone of Ontario public health, require in any reform process a strong focus of attention, support, consultation and resources.	No • Action on this was not taken until 2019. This work was put on hold due to COVID-19. Public health units still operate independently.	4.8.2
	• Reviews are necessary to determine if municipalities should have a significant role in public health protection, or whether accountability, authority and funding should be fully uploaded to the province.		
	• If local Boards of Health are retained, the province should streamline the processes of provincial leadership and direction to ensure that local Boards comply with the full programme requirements established by the province for infectious disease protection.		

Area	Recommendations	Implemented?	Report Section Where Discussed
Second Interim Report by the SARS Commission [1] (April 2005)			
Medical independence and leadership	• Complete the work of making the Chief Medical Officer of Health independent of political considerations in respect of medical decisions and direct public health management. This requires the transfer of operational authority from the Minister to the Chief Medical Officer of Health in respect of public health labs, assessors, inspectors and enforcement.	**Partially** • The Chief Medical Officer of Health sits on the Strategic Planning Committee and may direct Public Health Ontario to provide scientific and technical advice and operational support to any person or entity in an emergency or outbreak situation that has health implications. However, he does not have operational authority over public health labs, assessors, inspectors or enforcement.	4.8.2
	• Amend the *Health Protection and Promotion Act* so that the powers now assigned by law to the local medical officers of health are assigned concurrently to the Chief Medical Officer of Health. These powers shall be exercised by the medical officer of health in the local region, subject to the direction of the Chief Medical Officer of Health.	**Yes** • The Chief Medical Officer of Health may exercise the powers of a Board of Health or Medical Officer of Health if there is a risk to health. • The Chief Medical Officer of Health may direct Boards of Health to require the adoption or implementation of policies or measures concerning infectious diseases, health hazards and public health emergency preparedness. • The Chief Medical Officer of Health may issue directives to health-care providers and health-care entities respecting precautions and procedures to be followed to protect the health of persons anywhere in Ontario.	4.2.2
	• Provide a greater measure of central provincial medical leadership and control in respect of infectious disease protection and management, over the 36 semi-autonomous health units throughout the province.	**No** • There has not been a change to increase provincial medical leadership and control over the public health units.	4.2.2 4.1.3
	• Put provincial public health emergency planning under the authority of the Chief Medical Officer of Health and local public health emergency planning under the authority of local medical officers of health.	**Partially** • This was the case until August 31, 2020, when provincial public health emergency planning was moved to be under the Assistant Deputy Minister of Pandemic Response and Public Health Modernization (see **Figure 10**).	4.1.3

Area	Recommendations	Implemented?	Report Section Where Discussed
Final Report of the SARS Commission[1] (December 2006)			
Precautionary principle	• The precautionary principle, which states that action to reduce risk need not await scientific certainty, should be expressly adopted as a guiding principle throughout Ontario's health, public health and worker safety systems by way of policy statement, by explicit reference in all relevant operational standards and directions, and by way of inclusion, through preamble, statement of principle, or otherwise, in the *Occupational Health and Safety Act*, the *Health Protection and Promotion Act* and all relevant health statutes and regulations. • In any future infectious disease crisis, the precautionary principle guide the development, implementation and monitoring of procedures, guidelines, processes and systems for the early detection and treatment of possible cases. • In any future infectious disease crisis, the precautionary principle guide the development, implementation and monitoring of worker safety procedures, guidelines, processes and systems.	**Partially** • Five directives were issued by the Chief Medical Officer of Health (see **Figure 11**). Though legislated to use the precautionary principle when issuing directives to health-care providers and entities, the Chief Medical Officer of Health did not fully apply the precautionary principle as a guiding principle in taking timely action to limit the impact of COVID-19 on Ontarians.	4.3

Public health system	• The government complete the process of fixing the public health system, including:
	  • establishing the Ontario Health Protection and Promotion Agency;
	  • revitalizing the Central Public Health Laboratory; and
	  • providing sufficient and sustained funding for public health.
		Partially
		• Public Health Ontario (then called the Ontario Health Protection and Promotion Agency) was established in 2008. While dedicated funding for operations, including laboratory testing, has been provided, there has been no funding increase for base operations since 2013/14.
			4.1.4

Initial Report by Ontario Expert Panel on SARS and Infectious Disease Control[2] (December 2003)			

Chief Medical Officer of Health independence	• The Ministry should immediately amend the *Health Protection and Promotion Act* to:
	  • provide clear authorization to the Chief Medical Officer of Health to report to the Legislature; and
	  • issue public comment on matters of significant public health importance independently of the Minister of Health and Long-Term Care.
		Yes
		• The Chief Medical Officer of Health has the ability to report to the Legislature and the public.
			4.2.1

Area	Recommendations	Implemented?	Report Section Where Discussed
Public health system	• The Ministry should review, in conjunction with the Medical Officers of Health, the Association of Local Public Health Units and the Association of Municipalities of Ontario, the existing number of public health agencies in the province. Within two years, the Ministry should act on the results of the review to consolidate the number of Public Health Units to between 20 and 25 units, retaining local presence through satellite offices.	No • The Ministry did not complete a review of the existing number of public health agencies and reduce the number of units to between 20 and 25 within two years.	4.8.2
Final Report by Ontario Expert Panel on SARS and Infectious Disease Control[2] (April 2004)			
Communications	• As part of the review of the Mandatory Health Programs and Services Guidelines for public health, it is recommended that consideration be given to the inclusion of public health risk communications as one of the program standards.	No • The Ministry of Health and Long-Term Care Emergency Response Plan, 2013, does not include guidance on communications.	4.5.3
Public health system	• Proceed with the development and phased implementation of an Ontario Health Protection and Promotion Agency. The proposed Agency should be equipped with appropriate legislated authority, an expert board, and appropriate mechanisms to promote accountability and transparency. They also propose that strong organizational and operational linkages with the Canadian Public Health Agency be established in the overall design.	Yes • Public Health Ontario was established.	4.1.4

Chief Medical Officer of Health independence	• The *Health Protection and Promotion Act* should be amended to provide the Chief Medical Officer of Health with the following protections:
	  • The authority for the Chief Medical Officer of Health to issue public comment, including comment to the Legislature where required, without prior authorization by the Minister but where in the opinion of the Chief Medical Officer of Health, public health urgency requires action.
	  • The authority for the Chief Medical Officer of Health to issue such research or reports, which in the opinion of the Chief Medical Officer of Health are pertinent to promoting awareness of issues pertaining to ongoing or emergent threats to the health of Ontarians and/or the capacity of the province to respond to such threats. Outside of cases of health urgency, the Minister shall be provided by the Chief Medical Officer of Health with a review period of not more than thirty days of such material prior to public release.
		Yes
		• The *Health Protection and Promotion Act* was amended to provide the Chief Medical Officer of Health with the ability to report publicly to the Legislature and the public.
			4.2.1

1. The SARS Commission, chaired by Justice Archie Campbell, was established by the government of Ontario in 2003.
2. The Ontario Expert Panel on SARS and Infectious Disease Control, chaired by Dr. David Walker, was established by the Ministry of Health and Long-Term Care in 2003.

Appendix 3: Key Parties involved in Ontario's COVID-19 Response

Prepared by the Office of the Auditor General of Ontario

Level	Organization	Description
Federal	Public Health Agency of Canada	• Distributes information received from the World Health Organization to the provinces. • Collects COVID-19 information from provinces, such as case and death information, for consolidation and provision to the World Health Organization.
	Canada Border Services Agency	• Facilitates the flow of international travellers into Canada, including their compliance with the travel restrictions imposed by the federal government on who may enter the country. • Collects information on international travellers to share with the Public Health Agency of Canada for ensuring compliance and enforcement of the 14-day quarantine or isolation requirement established by the government of Canada.
Provincial (Health)	Ministry of Health	• Leads Ontario's health-care response to COVID-19. • Chairs (Deputy Minister of Health) the Health Command Table.
	Ministry of Long-Term Care	• Supports the Ministry of Health's response by participating in the Health Command Table and sub-tables related to long-term-care and retirement homes • Develops and implements policy for long-term-care and retirement homes

	Chief Medical Officer of Health	• Takes on the role of an Assistant Deputy Minister, reporting to the Deputy Minister, Ministry of Health, with responsibility over the Ministry of Health's Public Health group.
		• Issues a directive:
		  ◦ to any health-care provider or health-care entity identifying precautions and procedures to be followed when they are of the opinion that there exists or there may exist an immediate risk to the health of persons anywhere in Ontario; and
		  ◦ to any or all Boards of Health or local Medical Officers of Health requiring the adoption or implementation of policies or measures when there exists or is an immediate risk of a provincial, national or international public health event, a pandemic or an emergency with health impacts anywhere in Ontario, where the policies or measures are necessary to support a co-ordinated response to the situation.
		• Co-chairs the Health Command Table.*

	Ontario Health	• Leads five regional steering committees. • CEO co-chairs the Health Command Table.*
	Public Health Ontario	• Conducts surveillance of reportable disease and provides scientific and technical advice to the public health and health-care systems. • Operates 11 public health laboratories, which perform testing of infectious diseases (including seven laboratories that perform COVID-19 testing).
	Health-care providers	• Hospitals and primary care providers assist with assessing and treating individuals with COVID-19. • 33 hospital and three community laboratories perform COVID-19 testing. • About 150 assessment centres (primarily operated by hospitals) collect specimens from individuals seeking a COVID-19 laboratory test.

Level	Organization	Description
Province (Non-health)	Solicitor General	• Administers the *Emergency Management and Civil Protection Act*, which was used on March 18 to require a number of public and private businesses to remain closed.
	Emergency Management Ontario	• Reports to the Solicitor General, with responsibility for overseeing and co-ordinating the province's emergency management program as well as overseeing the emergency management programs of the various ministries and municipalities in Ontario.
Municipal	Public health units	• Administer health promotion and disease prevention programs as well as communicable disease control, including performing case-management and contact-tracing activities associated with COVID-19.

* Not formalized in the Health Command Table's terms of reference as of August 31, 2020 (see **Section 4.1.3**).

Appendix 4: Ways of Imposing Public Health Measures and Restrictions During a Pandemic

Prepared by the Office of the Auditor General of Ontario

Instrument	Issued By	Issued To	Legislation	Purpose	Example
Emergency Orders	Lieutenant Governor in Council (on behalf of the Premier and Cabinet)	Any Ontarian or organization	Mar 18–Jul 21, 2020: *Emergency Measures and Civil Protection Act*[1] Since Jul 21, 2020: *Reopening Ontario (A Flexible Response to COVID-19) Act*[2]	• Implement widespread measures across the province. • Impose fines in cases of non-compliance.	• Closure of bars and restaurant (indoor dining), theatres, cinemas, concert venues and other facilities. • Limit indoor gatherings to 10 people.
Minister's regulations	Minister of Health	Health-care providers and health-care entities (groups that oversee health-care providers)	*Health Protection and Promotion Act*	• Designate diseases as communicable diseases, diseases of public health significance and virulent diseases, which must be reported to local public health officials. • Require health-care providers and health-care entities to provide information if there is an immediate risk to health.	• Require that novel coronaviruses, including Severe Acute Respiratory Syndrome (SARS), Middle East Respiratory Syndrome (MERS-CoV) and 2019nCoV (COVID-19), be reported.
Directives	Chief Medical Officer of Health	• Health-care providers and health-care entities (groups that oversee health-care providers) • Boards of Health and local Medical Officers of Health • Public Health Ontario	*Health Protection and Promotion Act* *Ontario Agency for Health Protection and Promotion Act*	• Require health-care providers and health-care entities to take preventative measures. • Require Boards of Health to follow policies to provide a consistent response to an emergency. • Require Public Health Ontario to provide scientific and technical advice and operational support to any person or entity in an emergency or outbreak situation that has health implications.	• Stop all non-essential and elective medical procedures.

Instrument	Issued By	Issued To	Legislation	Purpose	Example
Orders issued through *Health Protection and Promotion Act*	Local Medical Officers of Health	Businesses, residents and visitors to the local region	*Health Protection and Promotion Act*	• Require any person to take or refrain from taking any action in regard to a communicable disease.	• Require all individuals to wear masks in public indoor settings.[3]
Municipal bylaw	City Council (or equivalent)	Businesses, residents and visitors to the local region	Municipal bylaw	• Require any person to take or refrain from taking any action in regard to a communicable disease.	• Require all individuals to wear masks in public indoor settings.[3]
Guidance and advice	Various groups (including the government of Ontario, the Chief Medical Officer of Health, the Ministry of Health, Public Health Ontario, Local public health units)	Any Ontarian or organization	None	• Provide written or verbal direction on recommended practices regarding infection prevention and control or public health measures to assist people in making choices that appropriately balance health risks.[4]	• Advise against all non-essential travel. • Advise on the size of social bubbles.

1. After a province-wide emergency is declared under the *Emergency Measures and Civil Protection Act*, additional regulations can be made to implement widespread measures across the province.
2. When the Reopening Ontario (A Flexible Response to COVID-19) Act came into effect, it assumed the regulations under the *Emergency Measures and Civil Protection Act* and all other provincial orders that had been in place. As the province recovers, regulations are removed or revised as needed.
3. See **Figure 12** for details on masking orders by public health units.
4. While it is generally not mandatory to follow guidance or advice, if the guidance or the advice is referred to in an Emergency Order, Directive or an Order issued through the Health Protection and Promotion Act, 1990, it must be followed.

Appendix 5: COVID-19 Cases and Deaths by Province and Territory, as of August 31, 2020

Prepare by the Office of the Auditor General of Ontario

Province/ Territory	Population	Total Cases	Total Deaths	Cases per 100,000 Residents	Deaths per 100,000 Residents*
ON	14,723,497	42,421	2,812	288	19
QC	8,572,054	62,492	5,760	729	67
BC	5,142,404	5,790	208	113	4
AB	4,417,006	13,902	239	315	5
MB	1,378,818	1,214	14	88	1
SK	1,179,618	1,619	24	137	2
NS	977,043	1,085	65	111	7
NB	781,024	191	2	24	0
NL	522,994	269	3	51	1
PE	159,249	44	0	28	0
NT	45,201	5	0	11	0
YT	41,980	15	0	36	0
NU	38,966	0	0	0	0

* Numbers are rounded to the nearest whole number. As a result, some provinces and territories identified as having zero deaths per 100,000 residents did have COVID-19 deaths.

Appendix 6: Audit Criteria

Prepared by the Office of the Auditor General of Ontario

1.	Pandemic and health emergency response plans were prepared in compliance with legislation and appropriate standards and were regularly tested and updated.
2.	Pandemic and health emergency response plans were acted on in a timely manner to respond to COVID-19 in Ontario.
3.	Roles and responsibilities of stakeholders involved in pandemic response were clearly defined and were followed.
4.	Preparation for the risks associated with COVID-19 began sufficiently ahead of the first incidence of COVID-19 in Ontario.
5.	Relevant, accurate and timely information was regularly collected and assessed to enable the intended outcomes of Ontario's COVID-19 response to be achieved and to make any changes where necessary in a timely manner.
6.	Expert advice and lessons learned from previous pandemics, including Severe Acute Respiratory Syndrome (SARS) pandemic, were used in Ontario's COVID-19 response.

Appendix 7: Key Parties Interviewed as Part of Audit

Prepared by the Office of the Auditor General of Ontario

	Key Parties
Public health units*	1. Haldimand-Norfolk 2. Hamilton Niagara Haldimand Brant 3. Kingston, Frontenac and Lennox and Addington 4. Middlesex-London 5. Ottawa 6. Peel 7. Thunder Bay 8. Toronto 9. York Region 10. Windsor-Essex County
Other jurisdictions	• Dr. Bonnie Henry, Provincial Health Officer for British Columbia • Senior management at British Columbia's Ministry of Health • Senior management at Alberta Health Services
Stakeholder groups	• Ontario Hospital Association • Ontario Medical Association • Registered Nurses' Association of Ontario

* These 10 public health units accounted for over 75% of COVID-19 cases in Ontario, as of August 31, 2020.

Appendix 8: Members of Health Command Table, as of August 31, 2020

Prepared by the Office of the Auditor General of Ontario

Position	Date Joined in 2020
1 Chair	
Deputy Minister, Minister of Health[1]	Feb 28
42 Members	
Chief Medical Officer of Health[1]	Feb 28
President and CEO of Ontario Health[1]	Feb 28
Assistant Deputy Minister, Health Services, Ministry of Health[1]	Feb 28
Executive Lead, Ontario Health Teams, Ministry of Health[1]	Feb 28
Assistant Deputy Minister, Hospitals and Capital, Ministry of Health[1]	Feb 28
Assistant Deputy Minister, Capacity Planning and Analytics, Ministry of Health[1]	Feb 28
Chief Information Officer, Health Services Information and Information Technology Cluster, Ministry of Health[1]	Feb 28
Assistant Deputy Minister, Health Transformation, Ministry of Health[1]	Feb 28
Assistant Deputy Minister, Digital Health, Ministry of Health[1]	Feb 28
Assistant Deputy Minister and Chief Administrative Officer, Corporate Services Division, Ministry of Health[1]	Feb 28
Assistant Deputy Minister and Executive Officer, Drugs and Devices Division, Ministry of Health[1]	Feb 28
Deputy Minister, Ministry of Long-Term Care[1]	Feb 28
Director, University of Toronto Joint Centre for Bioethics, Sun Life Financial Chair in Bioethics[1]	Feb 28
Assistant Deputy Minister, Mental Health and Addictions, Ministry of Health[1]	Feb 28
Assistant Deputy Minister, Emergency Health Services Division, Ministry of Health[2]	Mar 5
Vice President, Health System Performance, Ontario Health	Mar 5
Business Unit Lead (Shared Services), Ontario Health	Mar 5
Associate Chief Medical Officer of Health (A), Office of the Chief Medical Officer of Health	Mar 5
Chief Health Protection Officer, Public Health Ontario	Mar 8
Assistant Deputy Minister, Operations, Ministry of Long-Term Care	Mar 12
President and CEO, St. Joseph's Health System and Niagara Health	Mar 16
Assistant Deputy Minister, Ministry of Economic Development, Job Creation and Trade	Mar 25
Chief Coroner of Ontario, Officer of the Chief Coroner (Solicitor General)	Mar 25
Chief Microbiologist, Public Health Ontario	Mar 25
Assistant Deputy Minister, Policy Division, Ministry of Long-Term Care	Mar 26
Associate Chief Medical Officer of Health	Apr 5
President and CEO, University Health Network	Apr 19
Assistant Deputy Minister, Population Health Initiatives, Ministry of Health	Apr 19
Executive Lead, Office of Women's Issues, Ontario Health	Apr 19
Special Advisor, Ministry of Health	Apr 19
Professor and Chair, David Braley Health Sciences Centre, McMaster University	May 31

Note: Details in this table are based on a membership listing provided by the Ministry of Health. This list does not contain the 51 additional attendees to the meetings (see Section 4.5.1). For example, in addition to Public Health Ontario having two members on the Health Command Table, it also had two participants on the Table as attendees (President and Chief Executive Officer (acting); and Chief, Strategy and Stakeholder Relations, Research, Information and Knowledge and Vice President).

1. One of the 21 members of the original Health Command Table that was set up on February 28, 2020.
2. On August 31, 2020, the role was updated to Assistant Deputy Minister, Pandemic Response and Public Health Modernization, Ministry of Health.

Appendix 9: Listing of Sub-tables under the Health Command Table, as of August 31, 2020

Prepared by the Office of the Auditor General of Ontario

Table Category	Table Name	Description	# of Members	Date Formed (in 2020)
Strategic/ Implementation Tables	1. Collaboration Table	Provides strategic advice to the Command Table based on engagement with key health-sector organizations.	32	Mar 14
	2. Labour Table	Provides strategic advice to the Command Table on issues related to labour unions and agreements.	40	Mar 27
	3. Control Table	Co-ordinates oversight, access and distribution of Personal Protective Equipement (PPE) to health and non-health organizations, maintains a line of sight into the availability of PPE, and optimizes the distribution of PPE to health-service providers and the broader public service.	19	Apr 5
	4. Incident Management System Committee	Creates and implements an Incident Management System approach to long-term-care homes in critical need to ensure they have the health human resources, Infection Protection and Control (IPAC) supports and PPE they need to stabilize.	20	Apr 21
	5. Health System Response Oversight Table	Leads the operational management and co-ordination response to the COVID-19 pandemic, discusses and identifies actions to address issues or challenges encountered by the Regional Steering Committees and/or the provincial tables.	41	Mar 8
	6. Retirement Home/ Long-Term-Care Operations COVID Action Table (formerly Long-Term-Care Table)	Provides advice and support in addressing issues related to long-term care, including effective testing and outbreak containment.	63	Mar 14
	7. Mental Health and Addictions Table	Addresses issues related to supporting service continuity in mental health and addictions services, including supports for health- care workers.	56	Mar 14
	8. Provincial Primary Care Advisory Table	Provides advice to the Ministry on key issues affecting primary care providers by linking frontline primary care providers and decision-makers at the regional and provincial levels to streamline critical information, guidance and supports.	21	Apr 16
	9. Public Health Measures Table	Provides advice to the Chief Medical Officer of Health on public health measures (i.e., implementation, assessing effectiveness, scaling back) to prevent or slow the transmission of COVID-19.	15	Apr 11
	10. Rapid Response Table	Ensures all parts of Ontario's public health response are leveraging available data to rapidly identify and respond to emerging provincial and local issues and trends relating to COVID-19 spread.	42	Apr 30

Table Category	Table Name	Description	# of Members	Date Formed (in 2020)
	11. Ontario Health/ Ministry of Health Home Care Table	Provides a forum for home and community care providers to raise issues and work with Ontario Health and the Ministry to address issues.	37	Mar
	12. Deceased Management Cross Functional Table	Leads the planning and implementation of end-to-end deceased management.	2	Apr 11
	13. Lab Capacity and Testing Strategy Forum	Co-ordinates lab capacity and testing strategy elements with a focus on key priorities and population groups across sectors, while ensuring timely and sufficient lab capacity.	10	Apr 11
	14. Recovery and Planning Table Long-Term Care Sector Stabilization	Maintains gains achieved in protecting residents and staff and managing the COVID-19 public health emergency.	23	Aug 18
Technical Advisory Tables	15. Provincial Critical Care Table	Supports local and regional critical care planning by producing provincial guidance, processes and solutions for in-scope issues; connects and collaborates with other provincial tables/activities on connected issues; disseminates communications for in-scope and connected issues.	27	Mar 23
	16. Lab Leadership Committee	Supports capacity development and resource management in the lab sector, and connects with lab testing facilities to identify and address operational issues pertaining to COVID-19.	25	Mar 25
	17. Ontario Critical Care COVID Command Centre	Reports into the Provincial Critical Care Table (see 15) and manages critical-care capacity and equipment, responding to surges in real time.	25	Mar 14
	18. Testing Strategy Panel	Reports to the Lab Leadership Committee (see 16) and is responsible for developing an evidence-based province-wide testing strategy for COVID-19—updating testing guidance and documents, and identifying and providing guidance around testing prioritized population—and considers alternative testing approaches and develops demand estimates.	15	Apr 5
	19. Data Modelling Table	Provides technical advice and updates on the development and use of epidemiological modelling to respond to the pandemic.	34	Mar 26
	20. Bioethics Table	Provides ethical guidance and representation at both provincial and regional tables to support decision-making throughout the response.	22	Mar 14
	21. COVID-19 Evidence Synthesis Table	Provides high-quality, relevant and timely synthesized research evidence about COVID-19 to inform policy makers, health-care practitioners, administrators and citizens as the pandemic continues.	26	Apr 11
	22. Science Table	Works with leading scientific experts in key COVID-19 fields to provide a weekly summary of important scientific evidence.	35	Jun 15

Table Category	Table Name	Description	# of Members	Date Formed (in 2020)
	23. Surveillance Strategy Working Group	Develops and oversees a COVID-19 epidemiologic surveillance strategy and a related implementation plan, to improve Ontario's understanding of the presence, distribution and impact of the disease in Ontario throughout the pandemic phases.	17	Jun 27
Communications Tables	24. COVID-19 Central Communications Table	Ensures aligned, effective and consistent public and stakeholder communications on COVID-19 across the province at both provincial and regional levels.	10	Mar 14
	25. Provincial Stakeholders Communication Table	Provide a forum for stakeholders to identify and address stakeholder and public communications needs based on their work on COVID-19.	23	Apr 11
Inactive Tables	26. Long Term Care Action Plan*	Identifies and organizes work streams to implement the Long-Term Care Action Plan, which was released by the government on April 15.	30	Apr 6

Note: Individuals may sit on one or more tables.

* This sub-table is inactive. It was made up of the Assistant Deputy Ministers from the Ministry of Health and the Ministry of Long-Term Care, was short term (approximately 2–3 weeks).

Appendix 10: Members of the Central Co-ordination Table, as of August 31, 2020

Source: Ministry of Health

Position	Role in Government
2 Co-chairs	Secretary of Cabinet
	Chief of Staff to the Premier
4 Command Table Leads	Deputy Minister of Health
	Chief COVID-19 Procurement Advisor
	Deputy Solicitor General, Community Safety
	Deputy Minister, Treasury Board Secretariat
6 Members	Deputy Minister, Finance
	Deputy Minister (Policy), Cabinet Office
	Deputy Minister (Digital and Data), Cabinet Office
	Deputy Minister, Government and Consumer Services
	Deputy Minister, Intergovernmental Affairs
	Deputy Minister (Communications), Cabinet Office
8 Regular Attendees	Deputy Chief of Staff (Policy), Premier's Office
	Principal Secretary, Premier's Office
	Deputy Chief of Staff (Strategic Communications), Premier's Office
	Deputy Chief of Staff (Issues Management, Media Relations and Legislative Affairs), Premier's Office
	Chief of Staff, Minister's Office, Ministry of Health
	Senior Director and General Counsel, Cabinet Office
	Director and Executive Assistant, Cabinet Office
	Assistant Deputy Minister, Central Co-ordination Table Secretariat

Appendix 11: Relevant Sections from the *Health Protection and Promotion Act* Related to the Powers of the Chief Medical Officer of Health, the Minister of Health and Local Medical Officers of Health

Prepared by the Office of the Auditor General of Ontario

Section	Ontario's Chief Medical Officer of Health	Minister of Health	Local Medical Officers of Health
Section 77.7 Directives to health care providers			
77.7 (1)	Where the Chief Medical Officer of Health is of the opinion that there exists or there may exist an immediate risk to the health of persons anywhere in Ontario, he or she may issue a directive to any health care provider or health care entity respecting precautions and procedures to be followed to protect the health of persons anywhere in Ontario.		
77.7.1 (1)		Where the Minister is of the opinion that there exists or there may exist an immediate risk to the health of persons in Ontario from a new or emerging disease, the Minister may issue an order directing any health care provider or health care entity or any other prescribed person to supply the Minister or his or her delegate with any information provided for in the order.	

Section	Ontario's Chief Medical Officer of Health	Minister of Health	Local Medical Officers of Health
Section 77.9 Directives to boards and medical officers			
77.9 (1)	The Chief Medical Officer of Health may issue a directive to any or all boards of health or medical officers of health requiring the adoption or implementation of policies or measures concerning the matters set out in subsection (2) if the Chief Medical Officer of Health is of the opinion, a) that there exists, or there is an immediate risk of, a provincial, national or international public health event, a pandemic or an emergency with health impacts anywhere in Ontario; and b) that the policies or measures are necessary to support a co-ordinated response to the situations referred to in clause (a) or to otherwise protect the health of persons.		
77.9 (2)	The Chief Medical Officer of Health may only make a directive under this section with respect to measures or policies concerning, a) infectious diseases; b) health hazards; c) public health emergency preparedness; or d) a matter prescribed in regulations made by the Minister.		

Section	Ontario's Chief Medical Officer of Health	Minister of Health	Local Medical Officers of Health
Section 22 Order by M.O.H. re communicable disease			
22 (1)			A medical officer of health, in the circumstances mentioned in subsection (2), by a 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.
22 (2)			A medical officer of health may make an order under this section where he or she is of the opinion, upon reasonable and probable grounds, a) that a communicable disease exists or may exist or that there is an immediate risk of an outbreak of a communicable disease in the health unit served by the medical officer of health; b) that the communicable disease presents a risk to the health of persons in the health unit served by the medical officer of health; and c) that the requirements specified in the order are necessary in order to decrease or eliminate the risk to health presented by the communicable disease

Appendix 12: Dates of First Confirmed COVID-19 Case, by Country, January and February 2020

Prepared by the Office of the Auditor General of Ontario

Date of First Case	Country
Jan 13	Thailand
Jan 16	Japan
Jan 20	South Korea
Jan 21	Taiwan
	United States
Jan 23	Singapore
Jan 24	France
	Malaysia
	Nepal
	Vietnam
Jan 25	Australia
	Canada
Jan 29	Finland
	United Arab Emirates
Jan 30	India
	The Philippines
Jan 31	Italy
	Russia
	United Kingdom
Feb 4	Belgium
Feb 14	Egypt
Feb 19	Iran
Feb 21	Israel
	Lebanon
Feb 24	Afghanistan
	Bahrain
	Iraq
	Kuwait
	Oman
Feb 25	Algeria
	Austria
	Croatia
	Switzerland
Feb 26	Brazil
	Georgia
	Greece
	North Macedonia
	Norway
	Pakistan
	Romania
Feb 27	Denmark
	Estonia
	Nigeria
	San Marino
	The Netherlands
Feb 28	Azerbaijan
	Belarus
	Iceland
	Lithuania
	Mexico
	Monaco
	New Zealand
Total	**52**

Note: COVID-19 was first identified in China in December 2019.

Appendix 13: February 16, 2020 Email from the Ministry of Health Emergency Operations Centre to Hospitals

Source: Ontario Hospital Association

From: EOC Operations (MOHLTC)
Subject: Clarification: Provincial Case Definition COVID-19
Date: Sunday, February 16, 2020 10:45:54 AM

Good morning,

The Ministry of Health has become aware of a number of hospitals in Ontario who are intending to use a case definition other than the current federal and provincial COVID-2019 case definition for the purposes of PUI identification. In particular, there has been suggestion that several hospitals would like to expand the affected area component of the case definition to include Hong Kong, Japan, Macau, Malaysia, Republic of Korea, Singapore, Taiwan and Thailand.

The ministry's latest case definition (released on February 7th, 2020) identifies mainland China as the affected area. This misalignment with the provincial and federal case definitions could lead to inconsistencies and possible confusion in the health care system due to variations in process and practices adopted from hospital to hospital.

In addition, this misalignment will also create difficulties in laboratory testing. Public Health Ontario Laboratory is conducting testing for 2019-nCoV testing from individuals meeting criteria for a person under investigation (PUI) or probable case for 2019-nCoV as outlined by the ministry. At this time, the case definition considers travel to mainland China only and therefore samples with other travel history would NOT generally be eligible for testing.
There continue to be federal/provincial discussions regarding the evolution of the national case definition. However, until such time when it changes, all health system providers should use the current Ontario case definition on the ministry website as part of the ongoing efforts to safeguard the health and safety of all Ontarians we work to address the evolving COVID-19 situation.

EOC Operations
Ministry of Health Emergency Operations Centre
Eocoperations.moh@ontario.ca
Health Care Provider Hotline: 1-866-212-2272

Appendix 14: COVID-19 Cases and Deaths related to Long-Term-Care and Retirement Homes, by Province and Territory, as of September 30, 2020

Source of data: National Institute on Ageing, Ryerson University

Province/ Territory	# of Cases in Long-Term-Care and Retirement Homes	# of Deaths in Long-Term-Care and Retirement Homes	# of Long-Term-Care and Retirement Homes Affected	% of Total Homes Affected	% of Total Cases	% of Total Deaths
QC	16,972	4,682	618	28	23	80
ON	**10,818**	**2,153**	**524**	**38**	**20**	**75**
AB	1,328	167	100	29	7	63
BC	624	129	62	16	7	55
NS	392	57	13	10	36	88
MB	46	6	14	5	2	30
NB	26	2	2	0	13	100
SK	8	2	4	1	0	8
PE	1	0	1	3	2	0
NL	1	0	1	1	0	0
NT	0	0	0	0	0	0
NU	0	0	0	0	0	0
YT	0	0	0	0	0	0
Canada	**30,216**	**7,198**	**1,339**	**23**	**19**	**77**

Note: Percentages have been rounded to the nearest whole number.

Appendix 15: Summary of Ontario's Framework for Reopening Businesses, Services and Public Spaces

Prepared by the Office of the Auditor General of Ontario

Phase	Purpose	Date	Restrictions
Phase 1—Protect and Support	The government's primary focus is on protecting the health and well-being of individuals and families; supporting frontline health-care workers, essential workers and businesses; and providing immediate support to protect people and jobs.	Mar 18, 2020	Emergency orders put in place include the closure of non-essential workplaces, outdoor amenities in parks, recreational areas and public places, and bars and restaurants; restrictions on social gatherings; and limiting staff from working in more than one retirement home, long-term-care home or congregate-care setting.
Phase 2—Restart	The government will reopen Ontario businesses and public spaces gradually. This will be based on the advice of the Chief Medical Officer of Health, including the criteria and thresholds for moving from one stage to another. Each stage will last for an approximately two-to-four-week period to allow for close monitoring of any impacts or potential resurgence of cases.	Stage 1—May 19, 2020	Select workplaces that are well-positioned to follow public health advice to maintain physical distancing and implement workplace safety guidance can be opened, such as construction sites, retail, media industries, outdoor recreational amenities and sports (without spectators), professional services related to research and development, animal and veterinarian services, household services, and short-term rentals.
		Stage 2—Jun 12, 2020 (most regions)*	More workplaces and outdoor spaces can be opened, such as some personal-care services; restaurants and bars; shopping malls and centres; photography, film and TV, tour and guide services; some recreational outdoor and water facilities; campgrounds; libraries; child-care services and summer day camps; and places of worship.
		Stage 3—July 17, 2020 (most regions)*	Nearly all businesses and public spaces can remain open, with public health and workplace safety restrictions in place, while some high-risk venues and activities will remain closed until they can safely resume operations.
		Modified Stage 2—Oct 10, 2020 (Ottawa, Peel and Toronto regions), Oct 19, 2020 (York region)	Some businesses and public spaces are to be closed, including indoor food and drink services, indoor gyms and fitness centres, casinos and gaming establishments, cinemas, performing arts, personal-care services where face coverings must be removed, team sports except for training sessions (no games or scrimmage), and conference and convention centres (other than courts).
Phase 3—Recover	Ensuring the health and safety of the public and workers will continue to be a top priority as Ontario transitions to a "new normal." The government will partner with businesses and other sectors to lead Ontario's economic recovery. The focus will be on creating jobs and opportunity across the province, while working to restore long term prosperity for the benefit of every individual and family in Ontario.	Ontario has not yet reached this stage.	All restrictions will be lifted.

* See **Appendix 1** for the dates each region entered the stage.

Appendix 16: Governance Models for Boards of Health in Ontario

Source: Ministry of Health

Model *	Established By	Description
1. Autonomous Integrated (2)	*Health Protection and Promotion Act*	• Operates within a municipal structure • Members are appointed by the municipality and by the Lieutenant Governor in Council (for provincial representatives) • Board approves budget • Employees are employees of the Board
2. Regional (6)	Region-specific Acts	• Council of regional government acts as the Board • Employees are employees of the region • Board approves budget
3. Single-Tier (2)	City-specific Acts	• Council of single-tier municipality acts as the Board • No citizen or provincial employees • Employees are municipal employees • Board approves budget
4. Single-Tier: Semi-autonomous (2)	City-specific Acts	• Single-tier Council appoints members to a separate Board • Employees are municipal employees • Council approves budget
5. Autonomous (22)	*Health Protection and Promotion Act*	• Separate from any municipal organization but with multiple municipal representatives • Members are appointed by the municipality and by the Lieutenant Governor in Council (for provincial representatives) • Board approves budget • Employees are employees of the Board

* The number in parentheses after each model type represents the number of public health units following that model.

Office of the Auditor General of Ontario

20 Dundas Street West, Suite 1530
Toronto, Ontario
M5G 2C2

www.auditor.on.ca

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