Legislative Assembly of Ontario

Assemblée législative de l'Ontario

Official Report of Debates (Hansard)

P-28

Standing Committee on Public Accounts

Special Report, Auditor General: COVID-19 Preparedness and Management

1st Session
42nd Parliament

Wednesday 10 March 2021

Chair: Taras Natyshak
Clerk: Christopher Tyrell

Journal des débats (Hansard)

P-28

Comité permanent des comptes publics

Rapport spécial, vérificatrice générale : Préparation et gestion en lien avec la COVID-19

1re session
42e législature

Mercredi 10 mars 2021

Président : Taras Natyshak
Greffier : Christopher Tyrell

Hansard on the Internet

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. The address is:

Le Journal des débats sur Internet

L'adresse pour faire paraître sur votre ordinateur personnel le Journal et d'autres documents de l'Assemblée législative en quelques heures seulement après la séance est :

https://www.ola.org/

Index inquiries

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7400.

Renseignements sur l'index

Adressez vos questions portant sur des numéros précédents du Journal des débats au personnel de l'index, qui vous fourniront des références aux pages dans l'index cumulatif, en composant le 416-325-7400.

House Publications and Language Services
Room 500, West Wing, Legislative Building
111 Wellesley Street West, Queen's Park
Toronto ON M7A 1A2
Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario

Service linguistique et des publications parlementaires
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

ISSN 1180-4327

CONTENTS

Wednesday 10 March 2021

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON PUBLIC ACCOUNTS

COMITÉ PERMANENT DES COMPTES PUBLICS

Wednesday 10 March 2021

Mercredi 10 mars 2021

The committee met at 1230 in room 151 and by video conference, following a closed session.

SPECIAL REPORT, AUDITOR GENERAL: COVID-19 PREPAREDNESS AND MANAGEMENT

MINISTRY OF HEALTH

ONTARIO HEALTH

PUBLIC HEALTH ONTARIO

MR. STEVEN DAVIDSON

The Chair (Mr. Taras Natyshak): We'll call the meeting of the Standing Committee on Public Accounts to order. We're here to begin consideration of chapter 2, Outbreak Planning and Decision-Making, of COVID-19 Preparedness and Management, a 2020 special report of the Office of the Auditor General.

Joining us today are officials from the Ministry of Health, Ontario Health and Public Health Ontario, as well as the secretary of cabinet.

You have 20 minutes, collectively, for an opening presentation to the committee. We'll then move to the question-and-answer portion of the meeting, when we will rotate back and forth between the government and official opposition caucuses in 20-minute intervals, with some time for questioning for the independent member. I would invite each person to introduce yourself for Hansard before you begin speaking.

You may begin when you're ready.

Mr. Steven Davidson: Good afternoon, Chair, and committee members. My name is Steven Davidson. I'm the secretary of the cabinet, head of the Ontario public service and clerk of the executive council. I'm joined today by Helen Angus, Deputy Minister of Health; Dr. David Williams, Chief Medical Officer of Health for Ontario; Matthew Anderson, president and chief executive officer of Ontario Health; Colleen Geiger, president and chief executive officer of Public Health Ontario; and Alison Blair, associate deputy minister, pandemic response and recovery, at the Ministry of Health. Also on the line are a number of additional government officials.

Thank you for the opportunity to be here today to speak to the provincial response to the COVID-19 Outbreak Planning and Decision-Making report released by the Office of the Auditor General of Ontario in November 2020. As you know, the report is one of a series of special reports released by the Office of the Auditor General on COVID-19 preparedness and management in Ontario. The context for this report is unique from other audit reports, because it provides recommendations on the government's response to the pandemic, which continues to be ongoing.

I would like to first thank the Auditor General and her team for the work on this report and the other COVID-19 response reports. We appreciate this work, which will continue to inform our response to the evolving COVID-19 pandemic. The reports will also inform our ongoing emergency and pandemic preparedness activities.

From the report that is before us today, we've collectively submitted a status update on this report's recommendations. We've also submitted an overview slide deck on Ontario's COVID-19 response structure as context for our discussions today. We won't go through this material in detail, but I will speak to a few highlights of our status update and slide deck that address some of the points and recommendations in the report, including key principles of Ontario's response and how our response has evolved over the course of the pandemic and continues to do so. I'll then turn it over to Deputy Minister Helen Angus to speak to the specific health components of our response structure.

The COVID-19 pandemic is a health crisis, as you'll know, which has had and continues to have significant impacts not just on the health of Ontarians, but on all aspects of our society and our economy. Like jurisdictions across Canada and around the world, the global scale of the pandemic and the unprecedented scope of its impacts has challenged us to think differently about how we mobilize as government and as a society.

As the disease progressed, new and evolving science, evidence and data emerged, and the health, social and economic implications continued to broaden. This has required a whole-of-government approach, drawing on all ministries in an integrated and coordinated way. It has required co-operation and coordination amongst all levels of government, and it has required strengthened and, in some cases, new partnerships between government and service delivery partners not just in the health sector but across multiple sectors.

In early 2020, the province engaged in early proactive work to review our existing plans, frameworks and structures in the context of the critical, unprecedented circumstances created by COVID-19. Early actions focused on leveraging existing structures to organize the province's health response, driven by public health advice

from the Chief Medical Officer of Health in coordination with other health partners and experts; reviewing and activating our emergency plans across ministries and sectors; and working with a range of partners, including the federal government, to share information, coordinate actions and update Ontarians regularly with the latest information available.

We also began regular cross-government meetings to plan for and consider the impacts of COVID-19 on Ontario's sectors, institutions and ministries, and to identify and implement appropriate actions and measures.

As the head of the Ontario public service, I was also focused on addressing the impact on the public service and machinery of government, and reviewing and implementing our plans to ensure continuity of operations throughout the pandemic.

Our planning and response structure has been guided by several key principles. First, it is important to be clear that since the onset of this pandemic, the health, safety and well-being of Ontarians has remained the government's priority. It is the government's responsibility to take into account broad indicators of health and well-being, including mental health, social isolation, food security and critical supply chains, and employment and overall livelihood of the people of Ontario, and these considerations have been at the forefront for the province throughout the pandemic. Recognizing the multi-dimensional impacts of COVID-19, our response structure has consistently been guided by a whole-of-government approach to respond to the health and associated social and economic challenges of the pandemic.

Second, our structure did not create new decision-making bodies. It's focused on how we organize and coordinate public service resources in an efficient, integrated manner to support ministerial responsibility and cabinet decision-making.

Third, our response structure has continued to be iterative as the disease and impacts have evolved, and has been informed by changing data, evidence and trends.

Fourth, our response structure is designed to be action-oriented, efficient and effective. It currently supports and coordinates three cross-sectoral work streams; specifically, health, supply chain and public safety.

Building on these principles, our structure has evolved over the course of the pandemic, based on the changing needs of the situation.

While this has been a health crisis, it has also had significant, complex social and economic impacts for the province. The pandemic has taken a personal toll on the lives of Ontarians—including the tragic loss of lives.

Over the course of the year, case trends have changed and evolved with different regional and population impacts, and the government has had to act accordingly.

And, as you know, the pandemic is not over. We're currently facing new challenges with emerging variants of concern.

Front and centre of Ontario's response throughout the pandemic has been the end-to-end health response guided by public health advice from the Chief Medical Officer of Health, in consultation with Public Health Ontario, local medical officers of health and other health system leaders and experts. Deputy Minister Helen Angus will speak more about the critical health-focused response and how that was structured to enlist participation of partners from across the public health and health care system.

We knew we needed to think more broadly about how our response structure could address the full spectrum of implications of the pandemic in a rapid response manner. That's why we sought external advice to draw on emerging best practices from jurisdictions around the world. Informed by this advice, and building on our existing structures, we established the Central Coordination Table in April of last year. The Central Coordination Table is an internal coordinating forum which I co-chair with the Premier's chief of staff. The Central Coordination Table oversees and coordinates three, and formerly four, cross-sectoral work streams, each led by a coordination subtable chaired or co-chaired by a deputy minister and supported by a small number of cross-functional or cross-ministry teams. These work streams are health, supply chain, public safety and, formerly, critical personnel.

The Central Coordination Table is not a decision-making body. Ministers, supported by their deputy ministers and ministries, continue to make recommendations to cabinet for approval or endorsement. Funding decisions are made by Treasury Board based on submissions from ministries, and all Treasury Board decisions are confirmed by cabinet. This has not changed throughout the pandemic.

1240

The Central Coordination Table structure has supported rapid, timely, integrated and coordinated discussions across government on key issues facing the province to support government decision-making by cabinet. The Central Coordination Table has allowed us to move quickly and be responsive to the changing nature of the disease in a flexible, integrated way that draws on all parts of government. It also provides a forum to review data and trends, to provide a challenge function and address emerging issues or barriers.

Given the pace of discussions and decisions required, this approach has been critical to organize ourselves as a public service on a regular basis in a structured way to discuss key issues, actions and data to provide advice to government decision-makers and ensure a coordinated execution of government decisions.

The Chief Medical Officer of Health, Associate Chief Medical Officer of Health and other officials and experts from Public Health Ontario and Ontario Health are regular attendees and contributors at the Central Coordination Table.

We've made adjustments to the structure and work streams over the course of the pandemic, based on evolving needs and focus. This includes adding new areas of focus as required and winding down streams of work or folding them back into line ministries and central agencies.

Our discussions have been informed by the pandemic's trajectory and have focused at times on the immediate emergency response, health system capacity, outbreak

management, reopening, preparedness for future waves, as well as sector- and population-specific discussions.

Cross-functional teams have worked together across government on priority areas of response; for example:

—securing and distributing critical supplies, such as personal protective equipment;

—addressing the needs of priority, high-risk populations and settings;

—personnel and facility needs; and

—compliance and enforcement of public health measures.

This structure continues to provide an efficient means to leverage and coordinate the efforts and the expertise of multiple ministries, agencies and sector partners, and we will continue to refine it as the pandemic continues to evolve.

I'll now turn it over to Deputy Minister Helen Angus [*inaudible*].

Interruption.

Mr. Steven Davidson: We'll use my mike, so we can keep her on mute. We're sharing a common mike.

I will turn it over to Deputy Minister Helen Angus to speak about the specific health components of our structure and actions in response to the Office of the Auditor General's report, but before I do, I do want to acknowledge the work of the entire public service and our partners throughout the ongoing pandemic. The challenge is not over. I'm tremendously proud and thankful for the hard work, dedication and resilience of our public service in continuing to respond to the ongoing pandemic and protect the health and safety of Ontarians. As we continue to move forward, the work of the Auditor General and her team will continue to inform our response as well as support our future preparedness activities.

Thank you again for the opportunity to speak directly with you today about Ontario's COVID-19 response.

Helen?

Ms. Helen Angus: Thanks very much for the opportunity to speak with you today. My name is Helen Angus. I'm the Deputy Minister of Health. It's a pleasure, as always, to return to the Standing Committee on Public Accounts to talk about the Auditor General's report.

First, [*inaudible*] thank the Auditor General and her team for the work on the audit. As always, we recognize the important work of her office and appreciate the collaborative relationship between the Office of the Auditor General and the Ministry of Health.

We do appreciate the value of this report as a point-in-time snapshot of the province's pandemic response, and we acknowledge the opportunities that the report provides to guide our work moving forward. The audit was a little bit different than many, in that it was not reviewing an event of the past or evaluating value for money in a particular program, but it was evaluating the government's response to a pandemic that was unfolding and—it has already been noted—continues to unfold in real time.

I'm going to take the next few minutes to talk about the foundational context within which the Ministry of Health is operating, the health coordination structure, the role of the Chief Medical Officer of Health and public health advice and, if we have time, some of the accomplishments throughout the pandemic.

First, I'd like to talk about the context to situate the Auditor General's findings and recommendation. The secretary just spoke to the broader challenges and complexities faced by COVID-19 and how this informed a whole-of-government response.

I think everybody understands how complex Ontario's health care system is—144 hospitals, 34 public health units, over 600 long-term-care homes, and a very active home care system that delivers more than 40 million visits per year. With a health care system that's large and intricate in an unprecedented global pandemic, the decision-making structure used by the province was really designed to reflect the breadth and scope of the task ahead. We intentionally built a large tent to bring together as many experts and sectors as we thought needed to provide strategic and evidence-based advice to inform and shape a province-wide approach.

At the earliest stage, the ministry acted quickly, in January 2020, and we used our existing management system processes that had been put into place over a number of years. On January 6, we had an alert to the electronic Canadian Triage and Acuity Scale—CTAS—to support the identification of persons under investigation presenting in hospitals. On January 10, 2020, information was shared with local medical officers of health to raise awareness of the emerging issue and to initiate planning. On January 22, 2020, the novel coronavirus was designated as a disease reportable under the Health Protection and Promotion Act, allowing the reporting of case information and enabling public health response authorities. And on January 26, 2020, the ministry introduced its first guidance document to the health care system, outlining prevention and response strategies specific to the sector.

As the secretary mentioned, Ontario's response to COVID-19 has been guided from the outset by the key principles. The health and safety of the population of Ontario has remained our priority throughout the pandemic. In order to meet these principles, in February 2020, we enlisted a broad base of partners with expertise across the breadth of public health and the health care system to create the health command table, which was later renamed the Health Coordination Table to really reflect, I think, its function.

While the Minister of Health and cabinet remained decision-makers on pandemic response, policy, programs and funding, the Health Coordination Table served—and serves, on an ongoing basis—as a venue for system and government leaders to consolidate strategic advice for government decision-making. Our coordination structure brought together representatives from hospitals, primary care, academia and others with officials from across government, including long-term care, seniors and accessibility and labour.

By mid-March, we had developed technical advisory tables and sub-tables on a range of topics, including primary care, surveillance, public health measures, testing,

bioethics and mental health and addictions. These groups came together to review, strengthen and implement provincial and regional plans to respond to the pandemic.

It has been stated that Ontario's COVID-19 response structure was large and unwieldy. However, the province's governance structure was intentionally designed to provide a coordinated response with input and leadership from experts in many fields and to quickly mobilize in a provincial pandemic response.

On the role of public health and the Chief Medical Officer of Health: Public health, including the CMOH and Public Health Ontario, have been critical drivers of the response planning and implementation. The Chief Medical Officer of Health has guided the public health response to the pandemic, providing advice and expertise to government in consideration of the advice of Public Health Ontario, the Public Health Measures Table and local medical officers of health.

The chief medical officer and I meet daily to discuss the numbers, trends and any potential new areas of concern, to be both nimble and responsive to the emerging situation—

The Chair (Mr. Taras Natyshak): Ms. Angus, you have about a minute and a half.

1250

Ms. Helen Angus: Thank you very much.

As co-chair of the Health Coordination Table, the Chief Medical Officer of Health provides critical support in setting priorities and determining areas of focus for the table. In addition, public health leaders from Public Health Ontario have key leadership roles at various tables, including the science advisory table, the data modelling table, the Public Health Measures Table and the surveillance strategy working group, and I thank them for their efforts. These tables report into the Health Coordination Table, where they provide updates on emerging research trends, modelling and advice.

I would just note that the last 12 months have been extremely challenging for all of us, and all Ontarians. Our daily lives today are really, largely, what you couldn't even imagine a year ago, and Ontarians have adapted and adjusted in a way that is laudable. Again, I thank them for their efforts: for the masking, for the social distancing, for the time they spend away from their families—and of course, the front-line workers, working on the front line of this pandemic response.

I think none of this would have been possible without our partners on the ground. Again, I think about the essential workers in the health care system, and the people who work to maintain our food supply and the supply chain. They've been working around the clock to respond to this pandemic, and I thank all of them.

Perhaps with that—

The Chair (Mr. Taras Natyshak): Perfect timing. Thank you very much, Ms. Angus and Mr. Davidson.

We'll move to the question portion of this afternoon, and it starts with the official opposition. Madame Gélinas.

M^me^ France Gélinas: Thank you all for being here this afternoon, and thank you, Mr. Davidson and Deputy Angus, for your presentation.

My first question will start—for those who know me, I tend to start at the 40,000-foot level, then 10,000, then I drill down. So I'm at the 40,000-foot level. We are looking at Outbreak Planning and Decision-Making, which is chapter 2 of the Auditor General's work.

I'll start with you, Deputy. How ready, robust and complete was our outbreak planning in Ontario in January 2020?

Ms. Helen Angus: I'm happy to answer your question. Thank you for your question. I'll ask Dr. Williams to join in the discussion, as well.

I think that we had a number of experiences in Ontario, going back, obviously, to SARS and the outcomes from that. We had the Ontario Health influenza plan. We certainly used those plans to guide the response to the pandemic in terms of the work of the emergency management branch and the experience that they have had over a period of years, preparing and practising emergency response.

I would say that while we had plans that reflected what would happen with an influenza outbreak across the province, we had to work quickly in order to respond to a global pandemic. I think the scope and scale and shape of a global pandemic required that we were fleet of foot in order to put together some of the things—

M^me^ France Gélinas: You're drilling down too early, Deputy. I will go into those questions later. Just tell me, on a scale of 0 to 10—0, we're not ready at all; 10, everything had been figured out—where Ontario was in January 2020 when it comes to outbreak planning.

Ms. Helen Angus: On outbreak planning? I don't know that I can give you a specific number. We weren't perfectly prepared, because I don't think that's possible, but I think we were well prepared.

M^me^ France Gélinas: We'll give it an 8?

Ms. Helen Angus: I'll take that—a pass.

M^me^ France Gélinas: Dr. Williams, what's your assessment as to how ready Ontario was for this pandemic in January 2020?

Dr. David Williams: My name is Dr. David Williams. I'm the Chief Medical Officer of Health for the province of Ontario.

Thank you, Madame Gélinas, for that question. It's one we always ask ourselves, every time when we come into an outbreak—how prepared are we for this one, in particular? We have many ones that we go through.

Your scale is an interesting one; we're never 0. We would never be presumptive to say we're 10, because that would be, I think, a risky thing to say. You always have to be ready to be prepared to adjust and to respond. That was part of our thinking back in late 2018-19, following our response to Ebola, about being ready and resilient. One has to be nimble and one has to be willing to change and prepared to quickly adjust, because one cannot predict totally how the pandemic, in this case, would go, or how other outbreaks will go at the outset, since you're dealing with these issues impacting us in Ontario, from a global

perspective—many things starting offshore, in areas that you don't know all the details about, that you have little control over, but will impact you nevertheless in our global environment.

M^me^ France Gélinas: So give it a 6?

Dr. David Williams: I would like to gauge it at definitely an 8, but I would like to say somewhere between 6 and 8, certainly above passing grade. One of our things is to always be ready, and I would never presume—as I said before—to be 9 or 10, because then I would not be looking to be nimble and responsive.

M^me^ France Gélinas: Mr. Davidson has his hand up, but Mr. Schwartz, I'm coming to you soon, if you want to start to think about the same scale.

Mr. Davidson, go ahead.

Mr. Steven Davidson: Thanks. I will be brief, but I did want to interject and just add that I think our existing government decision-making structures and processes showed themselves to be nimble and flexible and adaptable. As I had spoken about at the beginning—and we may have an opportunity to speak later just about the breadth of impact and how critical it was that all parts of government were able to mobilize—actions taken by government were rarely without impact somewhere else, and so the interconnectedness of our response to the pandemic was really, really important for us to be vigilant on.

So I would say—and keeping it at 40,000 feet; I won't go deep. But we can come to later how we pulled up and adapted an existing central coordinating table so that we could harness from across and canvass all the potential implications of single actions as they would relate to other actions and other sectors and other parts of Ontario's community.

Thank you for just letting me add that.

M^me^ France Gélinas: No problem. So you would also be in the 7-to-8 range, Mr. Davidson?

Mr. Steven Davidson: Well, I would leave the numeric to you, respectfully. I do think the pace of the advancement of the pandemic was just something beyond what any of us could have imagined. I think that our pandemic preparedness and emergency preparedness systems were strong and well-poised. We had to go so much beyond that, and I think that what they showed to me, as the leader of the public service, is that we were able to adapt and move in an agile, rapid, responsive way. So I won't presume a numeric score, but I think we were well-poised to do the work that we needed to do.

M^me^ France Gélinas: Fair enough. Mr. Schwartz?

Dr. Brian Schwartz: My name is Brian Schwartz. I'm vice-president of Public Health Ontario.

Thank you for the question.

I would agree with, and maybe add to, the deputy's remarks about the preparedness that I observed from the government and participated in in my roles at Public Health Ontario. I think going beyond the planning for an influenza pandemic, the province prepared for the Pan Am Games in 2015 and continued, after the Ebola outbreaks in 2014-15, to prepare the health care system.

We were prepared for an influenza pandemic, as everybody else was. I think we were less prepared for a coronavirus pandemic, which was unlike our previous experiences with coronaviruses; for example, SARS—and even preparing for Middle East respiratory syndrome. So I would probably cut the difference and say maybe we were a 7. I don't think that it was really feasible to prepare completely, as the secretary has noted, for a unique coronavirus pandemic, as evolved in January last year.

1300

M^me^ France Gélinas: Thank you. I don't know if anybody else is dying to give me a number. Otherwise, I will start to drill down a bit.

Mr. Anderson, I saw your smile there. Did you want to take a 40,000-foot-level look as to our preparedness for outbreak planning and decision-making?

Mr. Matthew Anderson: I don't have anything to add from a numbers perspective. The best that I can add to that conversation is that it's not just the government who was prepared; I think that many of our health care providers—I was still on the provider side of this when everything got started. Getting ready at our hospitals and our other provider agencies was critical, as well, to the response.

I would probably echo the comments, particularly, that Dr. Schwartz just mentioned around the real shift from an influenza outbreak to a coronavirus outbreak. It certainly taxed us—but again, building on the readiness that was there in the system.

M^me^ France Gélinas: Thank you. Drilling down a bit, we're looking at outbreak planning and decision-making. The two models that stand out are really the command-and-control model—which was adopted by many other jurisdictions, including other provinces in Canada; the decision-making; the command; you can hold the people making the decisions accountable—versus the coordination and collaborative model that the deputy has explained to us.

Deputy, I will start with you again, but I am forewarning the others on the call that the same question will be asked of you. Why did Ontario select to go that way?

Ms. Helen Angus: The short answer, from my perspective, is that when we looked to the documents and the structures that we had prepared for, this is what we had prepared for. It was exactly a command or coordination table that involved the executive of the Ministry of Health. We obviously engaged quickly—and that, of course, was Dr. Williams, Ontario Health and Public Health Ontario as our core partners in the response. It is what we prepared for. It proved to be nimble.

I can say that the decision-making of government was completely at our avail throughout the pandemic. We were able to get decisions quickly from the government, and I know the secretary may want to comment on that. But maintaining ministerial accountability of the Westminster model throughout the pandemic response felt like it was an asset for us, rather than the reverse. It allowed for a broader discussion of impact beyond solely the health impact, which is appropriate for a provincial government. We were very pleased to work within that structure.

M^me^ France Gélinas: At the time you called it the "health command"; now I understand that the name has changed. It really gives the impression that Ontario had a command table. It had the name of it, but not the functions of it.

Ms. Helen Angus: Yes, I think the "command table" name was probably embedded in the documents that we had and is language that's often used in emergency responses at an organizational level in Parliament. It was a poor choice of words from the outset. I really think "Health Coordination Table" better reflects the function.

But I can say that the terms of reference for what was then the command, now the coordination, table were clear to all participants in terms of how we would come together, look at the data, devise strategies for implementation and respond to emerging concerns, and obviously brief and prepare materials for decision-making, as is the ministry's responsibility.

M^me^ France Gélinas: Dr. Williams, can I hear your perspective on this, as to having a command structure rather than what Ontario had?

Dr. David Williams: It's an interesting question, because they do overlap. I think the command-and-control is somewhat of a linear structure in that way. If it is more of a single-response entity, it makes sense to have that in that place.

Part of our IMS structure, incident management system—I know that Dr. Schwartz will want to comment on that when he gets a turn—it's what we founded the whole structure on.

Basically, when you're having a coordinating structure, you have people who have command functionality in there as well, so that when you start off, you have one level, and then part of our plan is, when the response starts to impact a larger sector, such as the whole Ministry of Health—and the planning process, I include the long-term-care help—you involve leadership in that, and the leadership is either in the Minister of Health or the designate which, of course, is the deputy minister, and works at that table there with the executive of the Ministry of Health, whether it's collaboration, there are clear lines for giving direction and response for command purposes, as built into the existing structures of the government. And then, later, when we had the CCT, the central coordinating committee, because we had already alerted the secretary of cabinet, saying if it gets larger into a state of emergency, then it gets to an all-of-government response. Then you have that kind of coordination. But there's no doubt at that table, with the secretary of cabinet, of his role, leadership, and of course that of the other deputy ministers—that has a command-type structure that needs to take place if and when necessary. So while we use the term "coordinating," there's no doubt embedded in those are command and ordered structures that can make decisions that are pertinent, and of course have to be done in a very timely manner, at all levels of government, whether it's in the Ministry of Health, whether it's government-wide or feeding up into the cabinet, for all those decisions. As it gets larger and larger, you have to be able to embed all those in different levels, but you bring in a lot of expertise to those tables to inform your command structure on what they need to do in a timely fashion, as expeditiously as possible.

M^me^ France Gélinas: Dr. Schwartz, what do you think? From a public health point of view, how do you best manage a pandemic—with a control-and-command or with a collaborative?

Dr. Brian Schwartz: I think the science has evolved and is continuing to evolve in terms of disaster response in general. Command-and-control is very effective in a one-site, less-than-complex emergency. If you have a number of places where you're responding, like in a hospital or in a different kind of disaster, in a firefighting situation, then it works pretty well, and IMS works very, very well.

In a complex system with a complex emergency that continues to evolve, I think command-and-control is not as effective, as the government recognizes, at least in terms of its nomenclature. Perhaps originally—I couldn't speak to this—the system was always coordination. But I think a combination of clarity on roles and responsibilities through an incident management system, for specific tasks—but a coordinated and somewhat distributed approach across different jurisdictions in a complex emergency needs to be integrated. I think the science is still evolving on this, as we go through the most complex emergency we've ever experienced globally.

M^me^ France Gélinas: But the clarity of roles and responsibilities remains a key success factor in your—

Dr. Brian Schwartz: And communicating across what those responsibilities are, so different people know what their role is, but also, very importantly, how they integrate with the roles of others.

M^me^ France Gélinas: All right.

Mr. Davidson, I saw that you had your hand up. You've seen the topic that I'm trying to get information on. At the end of the day, you ended up being co-chair of the decision-making during a health pandemic, with no health background. How did you feel about all that?

1310

The Chair (Mr. Taras Natyshak): Mr. Davidson, you've got about a minute and a half left on the clock.

Mr. Steven Davidson: Okay.

Well, first, just to say—and I did say this in my opening remarks—that the Central Coordination Table is not a decision-making table; it's a coordinating table, and it supports the provision of advice to the government, which makes decisions.

I did want to mention the Emergency Management and Civil Protection Act, under which the province declared a state of emergency in mid-March, because that gave the government statutory powers, through order-making by the Lieutenant Governor in Council, to do a range of things which, under the health table, would not have been possible. The health response machine simply does not have the authority; the Health Protection and Promotion Act does not provide authority, as Dr. Williams said.

As the scale and scope of the impact of the pandemic grew to touch all parts of the province and all parts of government, the declaration of a state of emergency was a turning point, and that very formally required cabinet decision-making, because cabinet had new authority in

areas of closing or regulating places, including businesses and schools; procuring needed goods and services; authorizing persons to render services in an extraordinary way; and regulating travel or movement within areas. These were all decisions that were vested in cabinet through its authority—

The Chair (Mr. Taras Natyshak): Thank you very much, Mr. Davidson. Sorry; I've got to cut you off. I'm going to stick to the clock.

We are going to move to the government members for 20 minutes. Mr. Crawford.

Mr. Stephen Crawford: First, I want to start out by thanking all the presenters for being here today. We appreciate you taking the time. I certainly want to thank everyone in the public service for all their great work.

Ontario, I think, at the end of the day, has come out of this—well, we're still in the midst of it; we're hopefully at the back end. But we are, I think, in a better position than most jurisdictions in North America. If you look at the case count per capita, I think Ontario ranks very well in terms of being amongst the lowest, so I think that's a good place to be.

Having said that, obviously no government anywhere in the world has gotten this 100% correct. This is a new global pandemic we've had to deal with, so there are areas we can improve on, obviously, and things that we can do better, and we need to get to the bottom of how we can do that.

My first question is for the secretary of cabinet, and it relates to the Central Coordination Table. Why was the Central Coordination Table set up, and did this add another layer of complexity to the response capacity of the government?

Mr. Steven Davidson: Thank you very much for the question. This is actually a very nice segue from the previous question, so I appreciate the opportunity to speak more about the genesis and the purpose of the Central Coordination Table and its four work streams—now three.

Two points to set the stage for this—one is just to reinforce the point—Dr. Williams made it just now—that this pandemic really was without precedent, certainly in our lifetimes, in terms of its impact. It touched every individual, every business, every community, every aspect of government service delivery and, essentially, every part of our lives. As I mentioned, too, interventions and initiatives to manage the pandemic were never isolated. One move impacted on other areas, and so the interconnectedness and the complexity of the response when we were managing a pandemic of that scale was really significant. As I said in my opening remarks, it really required an all-of-government approach. My job as the secretary, in normal times, is to ensure that the public service mobilizes and assembles to ensure that decisions presented to elected decision-makers are well-defined and that options are supported by evidence and data and trends analysis, and that cross-cutting impacts are identified and assessed, that risks are identified and assessed, that all the related considerations—operational, labour relations, constitutional: There's a wide, wide range of considerations that need to be assessed in bringing forward advice to government. It's my job to ensure that the public service is mobilized to do that in the most efficient and effective way possible. That's number one.

Number two is the pace of all of this. Back in February and March, the disease itself was advancing rapidly. The data and the evidence and the scientific data were evolving rapidly. I do not have a health background and I'm not a clinician—so very, very much accessing the expert research science, epidemiology, public health expertise that was mobilized and had been mobilized under the Health Coordination Table, formerly the "Health Command Table." I think Helen put it right that that was the nomenclature of a more contained emergency management world. As this work extended across all of government, that term became less appropriate. We adjusted accordingly, and the more appropriate coordination term was applied. Things were moving very, very fast. We did have the health table structure in place. We also had, under the Ministry of the Solicitor General, the emergency management office, under the chief of emergency management, which was scaling up and working very well in a coordinated way with—each ministry has its own Emergency Operations Centre, so health has its own. This was a health emergency in the first instance, so the PEOC, the Provincial Emergency Operations Centre, was working very well with the Ministry of Health emergency operations system.

And then to speak a moment about a central coordinating table that already existed, which the Premier's chief of staff and I regularly chaired—in normal times, it met twice weekly. That would be a place for—really complex, critical items that were making their way to cabinet for decision-making would come to us. We very quickly had adjusted that to focus pretty much exclusively on COVID-19-response-related items in this period of March.

The rapid pace of change, the unprecedented scale of the challenge—I brought in expert external advice to do a really quick diagnostic of what we had in place right now. I did select a firm that was doing similar work for other jurisdictions in Asia, Europe and some states in the US and asked them to take a look at what we had. They confirmed, in many respects, the utility of what we were doing. But really critically for me and of immense value, in really short order, they were able to give us very clear and specific advice on gaps and ways that we could organize ourselves in a way that was more efficient and supplemental to our existing structures.

In terms of complexity, the government of Ontario's 24 ministries—which in normal times work very collaboratively, horizontally, to bring forward cross-ministry, cross-sectoral files—have access to existing structures, policy, committees. There's a forum that Cabinet Office and the Premier's office set up to bring multiple ministries in to help reconcile where there may be quite legitimate different perspectives on an issue. But those all take time. Those are managed in a quite decentralized way. We didn't have time for that, and I needed to pull in the best talents and resources and mobilize the OPS to support this pandemic in real time.

1320

Cabinet, as the decision-making body, in those early weeks and months, was meeting five days a week, sometimes six days a week, sometimes seven days a week. So, as Deputy Angus said, we had access to decision-makers. We needed to mobilize as a public service so that we could support real-time decision-making. The world was unfolding around us. Other jurisdictions that were, in some respects, ahead of us with respect to the pace of the pandemic had undertaken measures, and so we had, to some extent, the benefit of observing the impact of those that informed our work. But fundamentally, what we needed to deliver as a public service was a nimble and responsive mobilization of resources.

Each of the four work streams that fell under the Central Coordination Table was very well and distinctly defined, with the advice of McKinsey. The health table remained the health table. We didn't disrupt that; we simply supplemented it with three other tables. I'll just describe them for a minute, because I hope this creates a picture of the cross-sectoral and cross-ministry work that we brought to bear to support the response and government's decision-making.

Supply chain and domestic production strategy was one table. We had health system supply chains, personal protective equipment. There were existing supply chains and distribution channels in the health sector, but all of a sudden, PPE—personal protective equipment—was needed by other, non-health sectors. So we had a cross-sectoral work stream, including education, corrections and other ministries, who needed to tap into that stock and develop brand new relationships and partnerships and access distribution channels, contribute to inventory management data gathering that they had never done before. So it was a massive amount of concerted work that happened through that cross-sectoral working group. And then the third on that was domestic production strategy. I think we all would have heard the Premier talk about his determination that Ontario would be self-reliant in this regard in the future. As committee members would know, one of the results of that work was to secure a plant in Brockville for 3M to domestically produce N95 masks.

That's an example of one of the four streams of work.

Other critical personnel: We needed to look at Ontario public service, broader public service deployment. We had a table that looked at mental health and what supports people are going to need.

Deployment of provincial services: I would use the example of digitally enabled virtual courts in the justice sector. What, in other times, would have been multi-year transformation projects were expedited in a way that I think surprised all of us. So there's focused work done under there.

And then public safety, which really leveraged the emergency management infrastructure in the system but also had a concerted focus on vulnerable populations, congregate care settings for adults—really ensuring that we were vigilant to what the emerging data and evidence was showing us about disproportionate impact of the pandemic on certain population groups.

What I did was appoint a deputy to chair each of these. Deputy Angus was already co-chair, with Dr. Williams, of the health table; Deputy Di Tommaso was co-chair of public safety—and Deputy French, of critical personnel. Supply chain actually had, first, a former deputy leading it, Kevin Costante, and then we brought in an external sourcing and supply expert, Allan MacDonald, to lead that work for a term. That was really productive, and we learned a lot from the private sector expertise that he brought to bear.

When you think of it, really—one central coordination table, four defined work streams, drawing out of the 24 ministries and the multiple agencies and really pulling in from all parts of the public sector, so I could look to each of those four deputy leads as accountable for delivery against those defined priority work streams. And they evolved over time, as the pandemic has continued to evolve.

I would just add that—and this was also what we benefited from McKinsey's advice, the external consultants we worked with on the governance model—we set up a secretariat, a small one, and we didn't build or replicate resources that existed elsewhere, but having common access to information and data from the health tables and from some of the sectoral tables so that, as a government and as leaders of the four tables and as leaders of the working groups, we would all have a common set of information that was keeping pace, as best we could, in real time with the evolution of the pandemic.

We had Jill Vienneau, who is with us today, in from one of the ministries, as the ADM to lead this secretariat. We drew on Ontario Digital Service to help us digitally enable our data-gathering. It really was, is and continues to be an all-of-government effort. In my view, had we not had that in place in order to support the central table, which, as I said, the Premier's chief of staff and I do co-chair even in normal times, because it's a very effective way of bringing in the most complex, multi-faceted, multi-ministry files for a central kicking-of-the-tires, to use a colloquial expression—we couldn't have done what we have done relying on our existing ministry structures. Ministries are very motivated and very—

The Chair (Mr. Taras Natyshak): Sorry, Mr. Davidson. Mr. Barrett would like to interject.

Mr. Toby Barrett: I'm sorry, Chair. I just want to mention that I do know some of my colleagues are also really eager to ask some questions.

The Chair (Mr. Taras Natyshak): Any of your colleagues who wish to interject at any time can raise another question.

Mr. Toby Barrett: Ms. Hogarth?

The Chair (Mr. Taras Natyshak): Ms. Hogarth? Yes, go ahead.

Ms. Christine Hogarth: Thank you. How much time do I have, Chair?

The Chair (Mr. Taras Natyshak): You have four minutes and 45 seconds.

Ms. Christine Hogarth: Maybe you can give me a quick answer, because this is really important.

First of all, I want to thank everybody for the work you are doing and echo my thanks to the front-line health care workers.

Something I hear quite often is that decisions are based on scientific evidence and scientific advice. We hear that over and over and over again. What I want to ask you is, where does this advice come from and what actually is the scientific evidence that guides these important and often life-changing decisions? I would like to ask this on behalf of my community and our business owners. Can you explain a little bit about how you obtain this advice and the scientific evidence, and subsequently, how does the government utilize this information to make these important decisions?

The Chair (Mr. Taras Natyshak): Who to, Ms. Hogarth?

Ms. Helen Angus: Perhaps I can answer that. I might ask Assistant Deputy Minister Michael Hillmer, who is the ADM for capacity planning and analytics, to elaborate on that.

We certainly wanted to have the detailed data on the spread, sources and locations of COVID-19 put into the public domain, because we know that the public wanted to understand and have assurances that the government was taking every step to ensure that the decisions and policies and programs are available on data and evidence—and so very much what we saw, what the government saw and what was put out in the public were all the same.

You've obviously met Dr. Schwartz, but there are terrific scientists at Public Health Ontario and beyond, and we make great use of them in terms of providing advice, and set up tables for scientists to meet and to provide advice; specifically, on matters related to things like treatment options and promising treatments; to the modelling of where the pandemic was shifting towards, what the growth or decline patterns might be, the patterns within specific populations—a wide variety of questions. The Ministry of Health also maintains a research branch within the strategic policy division, and they produced over 40 evidence summaries which also have been used to guide our response. Much of that work has been made public.

1330

I think one of the things that might be an enduring part of the health care system and an asset for Ontario going forward is a data platform that has been created in order to provide the data, to allow for world-class expertise, scientific inquiry and evidence all to come together and to really advance our understanding of the science of COVID-19. I would say it has been a journey; the science has improved and been revealed to us in real time as we've been proceeding to respond to the pandemic.

As a leader in the Ministry of Health, I would say I'm very grateful to the scientists for having stepped up and provided us with their best advice—

The Chair (Mr. Taras Natyshak): Just one minute left, Ms. Angus.

Ms. Helen Angus: —and to public policy-makers for making it understandable, being available to us, and in the case of Dr. Steini Brown, Dr. Schwartz and others, also being visible to the public and making their scientific analyses available to the public and, in fact, posted on dedicated websites where the public can access those scientific briefs—and, of course, the media for covering that in great detail.

I don't know whether, Michael, you have a moment just to hit some high points or can talk a little bit later about the depth of collaboration with the researchers in Ontario, and how we've also looked beyond our borders to look at what the global—

Ms. Christine Hogarth: I just want to—

The Chair (Mr. Taras Natyshak): Unfortunately, that's all the time that we have for this round.

We are going to move to the independent members who may be on the call. Mr. Blais.

Mr. Stephen Blais: I have a question for Mr. Davidson.

Thank you, everyone, for being here today.

In her report—I believe it's on page 7—the Auditor General outlines that in May, despite there being no evidence about the value of asymptomatic testing in long-term care, the government chose to make that decision anyway. I was wondering if you could tell us how that happened. We've just heard about how evidence informs decisions, and you've spoken, Mr. Davidson, about your table being responsible for filtering advice up to cabinet for decision-making. If there was no advice to inform cabinet of that decision, how did that all come about?

Mr. Steven Davidson: Thank you very much for the question.

First, neither I nor the Central Coordination Table provide advice directly to government. And I would not characterize the role that the table plays as "filtering" by any means; I would call it much more a coordination table that ensures that all aspects of an issue have been fully revealed, considered and analyzed. To the extent that the table provides direction, it's direction back to ministries.

The delivery of advice to cabinet, as I said in my opening remarks, continues to be directly by ministers responsible to cabinet and, as Deputy Angus just mentioned, a really strong, active role on the part of the public health advisers. Dr. Steini Brown, co-chair of the science advisory committee, Dr. Williams and Dr. Yaffe all present directly to cabinet and provide cabinet with the benefit of their advice and analysis—so that is very much the case.

The Chair (Mr. Taras Natyshak): One minute left.

Mr. Steven Davidson: I think, with respect to the specifics on asymptomatic testing, I would turn to my colleague Deputy Angus in a moment.

But first, just speaking more generally about cabinet's approach to decision-making and its use of the scientific evidence, I would say that—and I outlined the first principle of our response being ensuring the health and safety of Ontarians, and that has been through on the public service and on the government side with respect to their decision-making. In doing that, exercising an abundance of caution has also been a guiding principle. So there have been, certainly, and there are and continue to be discussions around a single intervention and what

unintended consequences that might create for the system. And so—

The Chair (Mr. Taras Natyshak): Thank you very much, Mr. Davidson. I'm sorry to cut you off again. That ends the first round of questions.

We're going to move to the second round, but I just want to offer some suggestions to members of the committee as well as those who are on the call with us today to provide us with insight and information. If we could keep the answers concise and pointed, then we can get through more questions.

Of course, to the members of the committee—if you can get through as many of the questions, don't feel as though you're being rude cutting off those who are answering. They have a lot of information, and I'm sure they could talk ad nauseam about this. But we need to keep them on focus and on point, so it is your responsibility as members to, unfortunately, cut them off when you want to roll onto another question.

With that, I will move to Ms. Bell for the second round.

Ms. Jessica Bell: Thank you very much for coming to this committee today.

I do want to emphasize the Chair's comments: There are a lot of questions that we have. If I do interrupt you, it's not that I'm trying to be rude; it's just that I have so many other questions to ask, as do my colleagues.

I read the Auditor General's report very carefully, and one thing that really stuck out to me was the lesson from the SARS pandemic and the need to emphasize that that precautionary principle is very important when responding to a pandemic.

Just to clarify, the precautionary principle is, if there's reasonable evidence of an impending threat to public harm, responsible efforts to reduce risk shouldn't wait for scientific proof.

What I noticed in reading the report is that there were some examples where the precautionary principle wasn't used as diligently as it could be. The examples that were given include:

—there was an assessment that the risk of COVID-19 to Ontario in March was low, even though COVID-19 was spreading elsewhere;

—there was a delay in acknowledging community spread, even though it was clear that it was;

—there was a decision to discourage COVID-19 testing at airports, even though COVID-19 was in other countries; and

—there was a decision to not require long-term-care-home staff to wear PPE and be restricted from moving from multiple facilities.

That's pretty concerning to read.

This is a question to Dr. Williams: What is your plan around applying the precautionary principle moving forward? How is it going to differ from how it has been applied before?

Dr. David Williams: Thank you for the question.

In looking at the concepts around the "precautionary principle"—it's one that I have been involved with for nearly 20 years, since the Campbell commission. Justice Campbell used the term and had that type of definition. Through a number of other cases and outbreaks, we have utilized the precautionary principle on a regular basis. One aspect in there is, of course, it's not refined in its definition. It leaves it open, saying that you would not wait for scientific proof. That means you don't wait until all the case control studies and the published literature is out and all that, because, as those of us in science have experienced, that does take time to come forward, and in the midst of an outbreak or a pandemic, those processes are not readily available. So one then takes advice, goes forward on forming committees. I know Dr. Schwartz would have some comment to make on this, as well.

When one has a scientific advisory table, while they do review existing literature and evidence in regard to any questions that may arise—when you do that, whether it's various analysis, meta-analysis etc., one may find a paucity of a direct evidence link to a question. Then one brings in a number of consultants or experts in the area, and they review the material as well, and then you ask them for their expert opinion based on the best evidence they have at the time, even if it is not there, readily available, because you need an answer. Then you try to have a consent of agreement around the table of all the experts—to say, "What is your best advice at this time?" You need an answer, you need to move ahead on it, but you want it based on as much quality information as possible, even if the hard written literature is not there at that time. That was what was of concern to Justice Campbell on that matter there—that, of course, it was not readily available—but you would still use your expert opinions.

1340

Ms. Jessica Bell: Dr. Williams, just to clarify, I did ask specifically around how you're looking at using the precautionary principle moving forward.

Dr. David Williams: I was going to say that my method would be the same as I had in the past: I will continue to use my scientific advisory table. I will continue to be advised by both our provincial ones, Public Health Ontario, groups like Dr. Steini Brown, Dr. Schwartz co-chairing. I use our federal-provincial-territorial committees, and they have multiple scientific committees as well. They network with international groups and experts. So it's a compilation of expert review and opinions on that matter. This has been our practice. It has done us well and continues to serve us well on that. They not only raise their consent and opinions on matters; they raise concerns and issues, bringing that forward at a time that even supersedes the precautionary principle. So I value that, I welcome that and I'll continue to do so on a forward basis—because that is how we would like to look at how we do it.

Ms. Jessica Bell: I'm going to move on to my next question. My next question is also to Dr. Williams. It's around the power of the Chief Medical Officer of Health.

My question to you is: What health directives or recommendations did you make to the government that

they chose not to take action on or delayed taking action on?

Dr. David Williams: I'm thinking of all of the different ones, and as the deputy and secretary of cabinet have stated—being invited to many tables to make recommendations and directions forward, I found nearly all the ones were followed and taken action on. Some where we would like to take action were under federal authority, and we would raise that up to our federal-provincial-territorial level and see if they would take action and decision-making on that. Those, of course, were not under my direct control, and you've alluded to some already on those. So we would work with that, as well.

I found that pretty well I was not only asked or listened to on my recommendations; I was invited to make recommendations and to give advice on a regular basis to there. So I don't have any ones that I can remember were outright refused. They were brought into the venue of timing, and to go through the processes quickly to try to get—because they would have implications, as the secretary of cabinet said, and the deputy also. They would have system-wide implications, would require development of policy—financial implications, moving as quickly as possible and as rapidly as possible in there.

Ms. Jessica Bell: Dr. Williams, I'm going to get specific: Did you assess the risk of COVID-19 as low back in March?

Dr. David Williams: At the beginning of March, and working with our federal-provincial-territorial partners—because we were doing this in a coordinated manner, so we kept asking and checking to see: Is Canada, at large, at risk? In the early days of March, we didn't have hardly any cases in Ontario or in Canada, for that matter. We didn't see the rise until later in the second week, and those were still travel cases coming in. So the risk for the public at large—and the same as was voiced by our federal counterparts—remained low for Ontarians, except we warned them not to travel and warned them for contact of people who had been travelling. But the general issue was still low at the outset of March.

Ms. Jessica Bell: You're saying that it was low back in March. Okay.

Have you recommended that workplace outbreaks in Ontario be published?

Dr. David Williams: We have, in outbreaks in workplaces, which gets down to the local public health level—

Ms. Jessica Bell: But have you specifically recommended that workplace outbreaks in the province be published? I know Toronto is publishing them, but I am asking if you have recommended that for the province.

Dr. David Williams: I've asked the local health units and the medical officers of health to say, "If you're carrying out an outbreak investigation in a workplace, you will publish it, as we have always done." This is our standard protocol. If it's just within the workplace and it only affects the workers, working with the proper other parts of the ministry and working with the management and coordination to ensure the safety and health of all the employees—you can work that within the construct of just keeping it with the business.

If the public is affected at large, or if you can't be sure that the public is not affected at large, then you have the requirement to go and make it public to notify them if they have been in contact with that business or have been exposed potentially through products, materials or through existing protocols with that organization.

You can make it public when it's necessary to inform and keep the safety of the public in mind, but that's a decision that a medical officer and their team have to make because they're investigating the outbreak and they know the extent of the information, or lack thereof.

Ms. Jessica Bell: Have you personally recommended the province introduce a provincial paid sick day plan either at the health coordinating table or the central command table?

Dr. David Williams: My overall position on that matter is that, combined with other aspects related to helping some individuals who have had difficulty when dealing with the quarantine policies during the period of time, whether it's because of their living situation or because of their work situation, where they may have felt pressured because of a lack of financial resources to be able to adhere to the quarantine principles—we would seek some method to assist in that matter. We found high-risk community groups and we initiated the whole aspect of at-risk communities—and looking at strategies and protocols, not just sick leave and paid leave, but other ones that are necessary to go beyond that to try to assist in those high-risk populations.

Ms. Jessica Bell: I'm not sure if that is a yes or a no.

I have a specific question: Did you recommend that public health restrictions on November 3 be loosened even though, from what we're hearing, Public Health Ontario did not recommend it?

Dr. David Williams: On November 23, 2020?

Ms. Jessica Bell: I have November 3.

Dr. David Williams: November 3, 2020?

Interjection.

Dr. David Williams: Correct; thank you. At that stage, then, we were going through the process that—they had already moved down to stage 3 and opened at the level during the summer, August and September. In that time in November, we were starting to introduce the concepts of stepping back up—to say, "Should we go back up and reverse the order and go into stages 3, 2 and 1?"

As you know, at that time, we had already implemented the stage 2 option for certain of our health units, and we started to introduce the concept of the framework and a tiered structure to reimpose limitations in the province area by area, because the impact and the changes were not consistent and homogeneous throughout the province. At the time, we looked at the 34 public health units and their respective jurisdictions and their data.

Ms. Jessica Bell: One thing that came up in the Auditor General's report was the lack of clarity around how decisions were being made with the coordinating table and

then also the central command table. One of the recommendations that they had was that there is a clearer record of decisions and meeting minutes recorded during those meetings, and that relevant ones are published.

Can you commit to moving forward on the Auditor General's recommendations? This is a question to Steven Davidson.

Mr. Steven Davidson: Thank you for the question.

There are records of the meeting, certainly of the central coordination table, that record action items. Those are distributed after every meeting. We do keep a record of action items coming out of a meeting, as I've said before. It's not a decision-making table, so there is not a relevant record of decisions, per se.

Maybe, if you would like, I would refer to Deputy Angus to talk about the record of decisions at the Health Coordination Table.

Ms. Helen Angus: We do take detailed notes. In fact, that was one of the overall project management functions to support the Health Coordination Table that was enhanced over the summer—and the establishment of the dedicated office.

1350

From the outset, we have been reporting out summaries of the meetings and posting them publicly. For stakeholders, we have weekly or biweekly—depending on the season—meetings of our collaboration table, which includes over 30, I think, provincial associations, and we generally review the state of the pandemic and drill into specific topics and actions and engage in a dialogue around those, many of which are the subject of the Health Coordination Table deliberations that week.

So I think that we have been doing pretty good record-keeping from the beginning—but also the reporting-out—and that continues to this day.

I don't know whether Associate Deputy Minister Alison Blair would like to comment further, since that has been in her purview, supporting the work of the Health Coordination Table.

The Chair (Mr. Taras Natyshak): We're just going to get Auditor General Lysyk on the record here first. Bonnie?

Ms. Bonnie Lysyk: At the time that we did the review, we looked at a period from January to the end of August, and during that period we looked at what was being published and the content of what was being published. And so we do have in our report a differentiation between what is being published and what the intent is of the recommendation. The intent of the recommendation is to allow people to understand what views were expressed and what information was discussed at the committee meetings, rather than the ultimate decisions.

We did hear back from the stakeholders to the initial meetings in that period of time. I can't comment on what changed subsequent to the end of August, but during that period of time, members who participated in the committee did wish they had more information to understand what decisions were actually taken, and what the response was to comments that were provided to negate the reasons why some of those decisions weren't taken.

So we were looking for more fulsome information. Having said that, there is information published on the website, but the report details what we were looking at in terms of that recommendation, what we thought the public and the participants would appreciate.

The Chair (Mr. Taras Natyshak): Ms. Bell.

Ms. Jessica Bell: That was also my assessment from reading the Auditor General's report—that there was a discrepancy between what information the government was sharing and what information the public would deem as reasonable in terms of meeting minutes.

I want to talk a little bit more around the role and powers of the Chief Medical Officer of Health. When I read the Auditor General's report, it showed that the Chief Medical Officer of Health didn't lead Ontario's COVID-19 response and should have. When I look at the list of names in the command table, I don't see the Chief Medical Officer of Health's name there. And when I read the Auditor General's report, it did say that in the interviews that were taken and in the review of documents that was made, it was not clear that the Chief Medical Officer of Health was acting, in all practical terms, as the co-chair of the Health Coordinating Table. I would appreciate your response on that.

What is your assessment of the auditor's assessment of the Chief Medical Officer of Health's role, and what is your plan to give the Chief Medical Officer of Health more of a leadership role moving forward?

Interjections.

Ms. Jessica Bell: Yes, I think you probably have a better understanding of who would be best to answer that question.

Ms. Helen Angus: I will start, and then maybe Dr. Williams can join in.

This has obviously taken up a fair bit of airspace, and I think it was a function of the translation of the whole senior management committee of the Ministry of Health being part of the then command table. Of course, Dr. Williams was part of it—so my mistake, perhaps, for not drawing out his role specifically in that documentation.

I can tell you that Dr. Williams has been and continues to be the subject matter expert, the leader of the public health response throughout the pandemic. The fact that I happen to functionally chair the meetings is mostly so that Dr. Williams can make his highest and best contribution in terms of the subject matter of public health. It is on Dr. Williams that I, as the deputy, and the command table—

The Chair (Mr. Taras Natyshak): One minute remaining.

Ms. Helen Angus: —have relied upon his expertise from the beginning. I meet with him and Matt Anderson and a few others every morning at 7 o'clock, and we discuss the state of play. We work together on the agenda planning for every coordination table meeting. I support him in his role in terms of preparation of materials and advice to cabinet.

His role has been, I think, central and essential to the pandemic response that we have mounted in Ontario. I just want to thank him for his tireless effort and his leadership. As an expert in public health, he has brought—

Mr. Taras Natyshak: Thank you very much, Ms. Angus. I'm sorry to cut you off.

We are going to move to the government side for another 20-minute rotation of questions, led by Mr. Cuzzetto.

Mr. Cuzzetto, go ahead.

Mr. Rudy Cuzzetto: Thank you all for being here today.

I have watched and listened to a number of technical briefings throughout this pandemic, and I could see firsthand that Public Health Ontario has played and continues to play a big role in assisting the government in its decision-making process.

I would like to ask Dr. Williams and Colleen Geiger to speak a bit about the background of PHO and to take us through the important role they have played in assisting the province to respond to COVID-19 and protect the people of Ontario.

Dr. David Williams: Thank you for that question, because it's a critical one, and one that is very important to me throughout this process.

One thing that's key when you're dealing with such a huge issue like this, and having watched and been part of the team supporting previous Chief Medical Officers of Health in dealing with SARS and dealing with other responses—the presence of a scientific advisory group was found critical.

When I was called down to work with SARS and assist Dr. Sheela Basrur at that time, working with the SARS scientific table in parallel demonstrated how critical that was and how much more we need it. As a result, when we did go through the process of carrying out Operation Health Protection—which had two parts to it. One was the formation of an agency. We didn't have an agency in Ontario. At that time, BC did and Quebec did; Ontario didn't. We worked hard to create the agency, and I was part of those initial days of putting it together, with a vision and ideas that we had in mind of how such an agency would be structured, how it would take place. Even as the first chair and then co-chair of the Provincial Infectious Diseases Advisory Committee—we knew that one day we would have a number of things in there, housed in the Public Health Ontario agency. It was called the Ontario Agency for Health Protection and Promotion in those days—and that's what the act is called.

So we worked hard to get that institution put together—the early days of temporary structures, and then how to form and get the staffing, the different resources in place. And then, through its evolution, under its initial director, Dr. Vivek Goel, and working through that period of time with the board in different areas, seeing that the agency would have a different relationship with the Office of the Chief Medical Officer of Health and how that would be a special adviser to the Chief Medical Officer of Health in there—such that, compared to some agencies, where Chief Medical Officer of Health and his or her staff have various roles and functions in connecting and coordinating at different levels with the agency, this was seen as a different one than a typical arm's-length agency that one didn't have that much contact with, except through memos and documents. So as a result, we always have had a good working relationship, respecting the autonomy and the arm's-length distance of the agency.

1400

Later, of course, where I was the acting chief medical officer of health back then, we incorporated the public health laboratory system into the agency—that was a tremendous dynamic—and then later, when I was in my acting role, benefited from the role of not only the agency, with the expertise being in many areas, not just in epidemiology but in infectious disease outbreak management, IMS structures, infection prevention and control and many other components that were there, but with the laboratory, with the expertise of newly recruited people such as Dr. Vanessa Allen, as the chief medical microbiologist at that time. Having that level of expertise in Ontario was a huge step forward in preparing us for many outbreaks to come and many issues related to public health.

As a result, then, the role of PHO in the pandemic—right from the get-go, they were our scientific advisory group, and they were critical in some of the early phases. That's why, when we started off this one in January, we were talking with them in the second week of January, when we saw some of the HPOC notices from the federal government about this new entity—what does it mean? What does it consist of? As compared to SARS, right away, we had genomic sequencing coming through, before we even knew what the signs and symptoms definitely were—and all those discussions. They were instrumental, one of the first provinces to develop a laboratory test—in Ontario, the polymerase chain reaction. Doing all that quality testing and how it was set up moved us well ahead on our testing protocols etc.

It has been a very intense time—heavy work for the agency coming on a formal basis, an informal basis, getting on the end of the phone, sending emails over, asking for answers to many questions at different times. So there's a formal process, and there's very much an informal process, where they can get on the phone and some of the VPs would call me up and say—or the director then, working with Dr. Donnelly, very much on a phone call, quick basis: "You need to know this. You need to be aware of that. I think you should think about this." It was invaluable to have that information coming—and their involvement sometimes at the FPT level, as well, that made Ontario one of the leads in bringing scientific evidence and information and critiquing that information at all levels of tables and coming to the so-called command table, the Health Coordination Table. Dr. Donnelly was one of the initial members at the table—as well as with our first press conference announcing our first case in Ontario. Dr. Donnelly from PHO was at the table and has been many times in the past, at different conferences.

So they have been instrumental, they have been a team partner on that all the way through, and we have depended,

are depending and continue to depend on them in many ways, let alone the daily publishing of data and analytics, which some provinces haven't got to the same level, and the extent and the sophistication of that kind of data reporting.

I'm going to hand it over and hear what Colleen Geiger would like to say about how she sees Public Health Ontario—and she may ask some others to comment on how that is involved with us and the intense work in working collaboratively with them throughout this process. If that is okay, Chair, I would ask Colleen Geiger to make some comments accordingly, and if others want to make comments—

The Chair (Mr. Taras Natyshak): Actually, I'm going to interject and give the floor to MPP Anand, who has another question.

Mr. Deepak Anand: Chair, I'd like to echo what my colleagues have said: that we've gone through and we're actually still going through a tough time. As we all do, I would like to thank everyone on this panel for your service. Definitely, it wasn't an easy task.

I'm a member from Peel, and Peel is the home of high-risk communities. The data shows that cases per 100,000 are around three times compared to less diverse neighbourhoods.

On behalf of my communities, I'd like to ask the panel, what was your advice to the cabinet on how to support these hard-hit communities—that's question number one—and what targeted supports should be provided to them so that they can be out of it quickly?

The Chair (Mr. Taras Natyshak): Who was your question directed to?

Mr. Deepak Anand: Anyone on the panel can do it.

I see a hand raised. So, Rhonda, do you want to go?

Ms. Rhonda McMichael: I'm happy to address that question.

I'm Rhonda McMichael. I'm assistant deputy minister of population health initiatives at the Ministry of Health.

We know from the data that COVID-19 doesn't affect all populations and neighbourhoods equally. Evidence shows that racially diverse, newcomer and lower-income populations, who often live and work in challenging settings and may face language and cultural barriers, are particularly hard-hit. Unfortunately, it's in these communities where we see COVID-19 continue to spread. Containing the virus requires tailored, community-based responses to address systemic barriers and the issues of these communities.

That's why the ministry mobilized the High Priority Communities Strategy, providing $12.5 million to support lead community agencies and community partners—very much a community-led strategy, in 15 priority neighbourhoods in Durham, Peel, Toronto, York and Ottawa, such as Bramalea, parts of Mississauga, Rexdale, Scarborough, western and eastern York, Durham west and central Ottawa. These jurisdictions were selected due to their high COVID-19 prevalence, low testing rates and sociodemographic barriers to testing and self-isolation, and the ministry has started to collect that very important sociodemographic data, which has helped us to target this community very specifically.

As part of the strategy, local lead agencies work with Ontario Health, public health units, municipalities and community partners to deliver key interventions for the hardest-hit neighbourhoods. The interventions are focused on three key pillars: community outreach and engagement, increased access to testing, and wraparound supports that use a case management approach. These interventions are designed to support self-isolation for those who test positive, have been in close contact with COVID-19 patients or are awaiting results, and to mitigate the disproportionate negative impact of COVID-19 on these vulnerable and marginalized communities by connecting individuals with wraparound financial and essential supports.

I'll detail some of the initiatives and actions under way as part of the strategy.

The first pillar is tailored community outreach and engagement, just to ensure that people are aware of the services and supports that are available. This is very much a building-by-building strategy, a boots-on-the-ground strategy to provide intensive outreach efforts so that individuals are aware of what is available to help them get through this crisis. Lead agencies have developed communications materials that are culturally and linguistically appropriate and sensitive, including flyers in a number of languages, social media strategies and engagement with key community leaders and faith leaders to ensure messages are delivered effectively from trusted sources. That means using community newspapers, faith group news bulletins, mail-outs, WhatsApp—where people are really getting their information. By the beginning of this month, 526 partner organizations like food banks, social services and health services are supporting the strategy's 15 lead agencies. More than a thousand community ambassadors have been engaged to deliver this outreach and to reach out to members of the community. Lead agencies and their ambassadors have contacted almost 60,000 people directly and distributed over 36,000 PPE kits, so thousands of people in these hard-hit communities are now better informed, supported and empowered to protect themselves and their family members.

The second pillar is increased testing, so that has undergone for a number of months—this means mobile testing; new community testing sites at pharmacies and in the community; pop-up sites; expanding site hours, so that people are able to get there; partnerships with paramedic services to increase the capacity and the resources; providing transportation, so people can get to and from testing sites; participating in the rapid screening program, so that we can use the latest technology; and working to see about the efficacy of saliva testing, to make it more accessible. We see in South Asian communities in Peel and York, and the Chinese and Tamil communities in Markham, that pop-up testing and access to testing have been increased significantly. At the beginning of the month, there were 30 community testing sites—that represents 25% of all of the community testing sites in the province. So while many of

these communities have struggled with lower testing rates, we are seeing improvements in Mississauga, Peel and Durham.

Finally, perhaps the most important pillar of the strategy is around wraparound supports. I know MPP Bell was asking about sick leave and those types of benefits. This strategy really focuses on providing those types of supports directly to individuals—whether they need grocery deliveries or emergency financial assistance so they can self-isolate safely at a hotel or at a designated isolation facility or in their own home. Emergency financial assistance is being provided, through federal sick leave benefits, up to $500 a month. The province is providing $733 in additional provincial emergency assistance funding to help with short-term financial obligations. If you are a family or if you have children, that amount does increase. More than 3,600 people have received this support in the last two months alone—and that's just the case management support. Other people have been able to avail themselves of other services. In addition, the province has invested $42 million to create 1,500 spaces in 11 isolation centres in those communities—Toronto, Peel, York and Durham. The voluntary centres also provide wraparound supports, including meals, security, transportation and links to health and social services, all free of charge. Hundreds of people are using these facilities every week.

1410

So far, the results of the strategy have been very strong, and we measure that by outcomes; in particular, decreased COVID-19 positivity. While we see rates across the province are lowering in general, many of the communities are overperforming. Weekly per cent positivity in priority communities has been reduced to 4.3%, which is higher than the general population still, but as of March—

The Chair (Mr. Taras Natyshak): Excuse me, Ms. McMichael. Mr. Anand would like to ask another question.

Mr. Deepak Anand: I really appreciate the work you have done; again, my request is to please continue doing it. We still see the numbers not coming down, so that targeted approach is still required.

I thank the government—we actually got $10.7 million this morning. I will pass the baton to my other colleagues if they want to ask—but again, thank you so much for that.

The Chair (Mr. Taras Natyshak): Are there any other questions from the government members?

Mr. Parsa, you've joined us just halfway through, so I need you to just tell us who you are and where you're at.

Mr. Michael Parsa: No, Chair, I was here from the beginning—but I will tell you, I'm Michael Parsa, and I am at Queen's Park. I'm in Toronto, Ontario. I have been here.

The Chair (Mr. Taras Natyshak): Sorry, Mr. Parsa. You weren't here this morning when we did the roll call. For the record, we need—

Mr. Michael Parsa: I apologize. I am here in Toronto, Ontario, Chair.

Can you tell me, please, how much time we have left? I just want to know which—

The Chair (Mr. Taras Natyshak): You've got four minutes left on the clock.

Mr. Michael Parsa: Thanks very much, Chair.

I want to start off by thanking each and every one of you, not just for being here, but for all the work you have done in the last year or so. In particular, I want to thank Dr. Williams for everything you have done, and Deputy Minister Angus. Thank you so much, on behalf of all my constituents. It hasn't been easy, we all know.

As always, I also want to thank the Auditor General and her office for all the great work that they have done.

Before I ask a question, I just want you to know that my role on this committee is not to be critical. I want to ask questions that are objective, because I want to learn from lessons in the past, good or bad, as we move forward.

The area that I'm going to be asking about, and you briefly touched on this, is testing. I want to ask more about rapid testing. This will not be a secret—it's top of mind for everyone. It was a hot topic for everybody throughout this pandemic, and I think it's going to be, as well. If you think about rapid testing, testing in schools or in workplaces when more and more people return, and places like long-term-care homes, for example—testing has been and it's going to be a critical component of this pandemic, and in particular, for us to be able to slow the spread of the virus.

I was wondering if you can take me through some of the work that has been done to improve testing capacity over the course of the pandemic up until now and the plan as to how we're going to be—because as critical and as important as inoculation and vaccinating people is, I still think testing is important. I'm sure you'd all agree how important testing is going to be. If you don't mind, specifically touch on, as much as you can, rapid testing, please.

The Chair (Mr. Taras Natyshak): Who is your question directed to?

Ms. Angus, I saw you raise your hand.

Ms. Helen Angus: I'll start, and then I'll ask Fredrika Scarth, who has done an awful lot of work on rapid testing, to jump in.

I just want to say that Ontario is actually a leader in the country in the deployment of rapid tests. We're pretty excited about their utility in helping us manage the pandemic. We've been deploying rapid tests to a whole lot of different environments, some being in long-term care, workplaces, schools.

There are two kinds of rapid test. One is the rapid diagnostic test, and one is a rapid screening test. Both are finding great purpose in our pandemic response. In fact, I think our team has been invited to go and talk to other jurisdictions so that we can be encouraging of their rapid testing efforts, because our experience and use of rapid tests is the deepest and most widespread and diverse in the country.

Fredrika, can you say a few words about that and answer MPP Parsa's question?

The Chair (Mr. Taras Natyshak): You've got one minute left, Ms. Scarth.

Ms. Fredrika Scarth: Thank you.

As the deputy noted, we've been working to expand and make accessible rapid testing across a range of settings since the tests were first approved by Health Canada in the late fall of last year and became available to us in the province in mid-November of last year.

The deputy noted that there are two kinds of rapid—or point-of-care—tests that we have available in Ontario. One is rapid diagnostic, and that is particularly helpful and useful for us as an adjunct to our overall pandemic response in communities that are remote, rural, Indigenous, where the testing turnaround times can be lengthy simply because of remoteness and the length of time it takes to move a sample specimen to our lab system. And so we have—

The Chair (Mr. Taras Natyshak): Thank you very much, Ms. Scarth. I'm sorry to cut you off.

I appreciate the efforts of committee members on the second round.

We've got three minutes allocated to the independent members. Mr. Blais.

Mr. Stephen Blais: Dr. Williams, this is for you.

The Auditor General has pointed out that the SARS commission recommended that, during an infectious disease outbreak, your position should have operational independence from the ministry. Further, the Health Protection and Promotion Act provides the power for you to be able to provide directives to public health care providers and medical officers of health. But she has also indicated that you chose not to take that action under your authority and that you would consult always with the ministry—or consult with the ministry or others. So I'm wondering if that's true and why you chose not to exercise those authorities.

Dr. David Williams: Thank you for the question.

I would start by saying that I have powers and authorities, same as a local medical officer of health; one chooses to use them when one needs to use one. One uses their influence as far as direction. If one achieves the result through education, awareness and knowledge, one doesn't have to use directives unless they're necessary to carry out certain legal requirements. That permits people to take action where they would need to be empowered or for legal constraints that have to be overcome in that matter.

I found throughout this whole process here the main aspect is, one, having a good, collegial working relationship with all LHINs—especially all my medical officers of health in the field, where they'll feel free to call me up, we talk to each other, we give direction, advice and all that. They may say they need some assistance or they don't, they need an order or they don't need an order.

A directive is something that, when we did SARS—

Mr. Stephen Blais: Mr. Chair?

Excuse me, Dr. Williams—

The Chair (Mr. Taras Natyshak): Mr. Blais, go ahead.

Mr. Stephen Blais: Dr. Williams, let me cut to the chase: Who at the ministry did you consult with before providing these directions? The recommendation from the commission is for you to act independently of the ministry.

Dr. David Williams: If you're asking about the actual writing of directives per se, as a final legal tool to take action, there was extensive consultation with our legal counsel, looking at the needs, with our scientific advisory table—from PHO, from my fellow staff in my office, of my associates and others who looked at it very carefully.

In the SARS one, our experience was that when one wrote out directives ad nauseam, the field complained bitterly saying, "This is confusing. They're not what you're talking about—they're piled up, and we can't follow the process. If you do this again, don't write them like that. Write a few, write them well, write them carefully and make sure they deal with all the points and matters that are in there; and please consult with us if you're going to do one, because we can give you valuable advice." That came from wider sector stakeholder consultations. Why? Because it's a tool that enables many people to do the right thing the right way, and by having their input on it, we start off with a lot of compliance right from the get-go. But it's a legal tool that is empowering, not limiting that matter, so—

The Chair (Mr. Taras Natyshak): Thank you very much, Dr. Williams.

1420

We've got time on the clock for a third round. It will be truncated, in that the government—it will be nine, nine and three, so with that, we will begin back to the opposition.

I just want to remind committee members that it is our obligation to try to stay close to the report provided to us by the Auditor General, because we're going to have to write a final report and so the information, the questions that we're asking, should be relevant and relative to the report. I know you can do whatever you want, should you choose, but when you ask broad questions, you're going to get broad answers. That doesn't serve this committee well, nor does it serve the public well, when we are faced with the task of presenting a comprehensive report. Please stay focused on the job at hand. Make your questions concise.

And for those who are attending from ministries, please try to keep your answers concise and pointed, as well.

With that, Madame Gélinas, the floor is yours.

M^me^ France Gélinas: My first question will be to Dr. Schwartz.

Public Health Ontario leads surveillance. Do you think that the scientific and technical advice that you have made during the pandemic should have been made public?

Dr. Brian Schwartz: With MPP Gélinas's permission—could I turn this over to Ms. Geiger, who is the president and CEO?

M^me^ France Gélinas: Sure.

Ms. Colleen Geiger: I'm Colleen Geiger. I'm the acting president and CEO at Public Health Ontario.

Just to clarify—the question was to do with whether we should make our advice public? Is that correct?

M^me^ France Gélinas: Correct.

You do public surveillance through your work at Public Health Ontario.

Ms. Colleen Geiger: Yes.

Mme France Gélinas: Do you think that the recommendations you make, the advice that you make should be made public?

Ms. Colleen Geiger: With respect to surveillance, we publish epidemiological reports. In fact, we've published over 450 reports since the beginning of the pandemic.

Mme France Gélinas: During the pandemic, do you figure that as you were giving advice to the different tables that this advice should have been made public?

Ms. Colleen Geiger: I would say it depended on the construct of the table. We have made our information—and certainly our epi reports are published. They are available on our website. If information is requested of us in confidence, we have delivered that in confidence.

With respect to our general release of knowledge products, we do go through, as is required by our memorandum of understanding with government, a notification process—

Mme France Gélinas: How much of the advice that was requested of you was requested in confidence?

Ms. Colleen Geiger: I'm not sure that I could answer that question—

Mme France Gélinas: Has any of it been required in confidence?

Ms. Colleen Geiger: Yes, we have been asked to provide information in confidence.

Mme France Gélinas: Were you asked to sign a confidentiality agreement at any point?

Ms. Colleen Geiger: I have not personally been asked to sign a confidentiality—

Mme France Gélinas: Has anybody else you know been asked?

Ms. Colleen Geiger: I am only aware in the context of participation at the Public Health Measures Table that there was a protocol with respect to that, for which members of Public Health Ontario who were on that table did sign non-disclosure agreements, as was expected of other table members. That's the only example I can think of that I could give you directly—

Mme France Gélinas: How many people were asked to sign those non-disclosure agreements?

Ms. Colleen Geiger: I'll see if I can find a specific number, but that would be a very small number; somewhere probably between one and three.

Mme France Gélinas: But not you?

Ms. Colleen Geiger: Not me. I'm not a member of that table, no.

Mme France Gélinas: Okay. Maybe I'll stay with you.

Moving on to the precautionary principle: Not a week went by that I didn't have a nurse reaching out to me—she works in a hospital; she cannot access N95s—not a day went by that I didn't have a PSW working in a long-term-care home who could not access basic PPE.

We are at the point right now where the ONA—Ontario Nurses' Association—is taking the government to court over the availability of N95s.

What were Public Health Ontario's recommendations, and what was your advice regarding PPE? Let's start with N95s.

Ms. Colleen Geiger: The Public Health Ontario advice with respect to N95s came through PIDAC, or the Provincial Infectious Diseases Advisory Committee, which is comprised of experts in infection prevention control as well as public health. This includes representatives from both the health care and public health side of the health system. The advice of that committee with respect to N95s is published on our website and mandates it only in very specific circumstance. That information was considered and, I believe, was reflected in guidance that was provided by Dr. Williams and the Office of the Chief Medical Officer of Health.

Mme France Gélinas: Do you believe that the guidance and memos that came from the table respected the precautionary principle?

Ms. Colleen Geiger: Yes, I do. Our information was based on science. I'm comfortable with the information, and I accepted the recommendation from PIDAC.

Mme France Gélinas: Deputy, I'll go to you.

How did we end up in a place where ONA is taking the government to court because nurses on the front line cannot gain access to N95s?

Ms. Helen Angus: I'm happy to answer the question. I think that Dr. Williams may want to join in, as well, because directive number 5, that comes from Dr. Williams, makes it clear that risk assessment at the point of care would require the provisioning of appropriate PPE, including N95s.

We have written to the health sector, as recently as a couple of weeks ago, reminding them that we have ample quantities of PPE, including N95s.

I think the secretary talked earlier about the domestic production strategy and—

Mme France Gélinas: So how come they cannot gain access, Deputy? Why are they calling me?

Ms. Helen Angus: I don't know. I think that we are provisioning—

Mme France Gélinas: Mr. Anderson, any idea as to why we're respecting the precautionary principle, we have them in stock, you have a procurement, you have distribution, and yet nurses cannot gain access?

Mr. Matthew Anderson: I don't have an answer to that question. To your point—we do have the stock. We answer any requests for more supply. Nothing has been brought to my attention in terms of a supply challenge. So why nurses are unable to access—I do not know the answer to that.

Mme France Gélinas: Well, things have been brought to your attention, because I brought you letters from St. Joe's in my riding, who were not able to gain access to N95s.

I'll move on because I only have nine minutes.

The next one has to do with testing. Back to you, Ms. Colleen Geiger, at Public Health Ontario: Did Public Health Ontario recommend the testing of asymptomatic people in spring, as said in the auditor's report?

Ms. Colleen Geiger: In the spring, the testing strategy expert panel did make recommendations with respect to asymptomatic testing, and did not recommend asymptomatic testing in situations of low prevalence.

The Chair (Mr. Taras Natyshak): Just one minute left.

M^me^ France Gélinas: So they did not.

Did they recommend testing of essential caregivers in long-term care?

Ms. Colleen Geiger: Yes, we would have been recommending—now, for asymptomatic testing?

M^me^ France Gélinas: No contact, no symptoms, essential caregiver—the recommendation was that they be tested every 14 days, then it went to every seven days. The auditor tells us that it did not come from a recommendation from public health.

Ms. Colleen Geiger: Perhaps one of the ministry colleagues would like to address that. It looks like Fredrika Scarth would like to speak to this item.

1430

The Chair (Mr. Taras Natyshak): You've got 10 seconds.

Ms. Fredrika Scarth: The recommendation from the testing expert panel, as Dr. Geiger has noted, did not recommend regular testing of asymptomatic individuals in low-risk situations—

The Chair (Mr. Taras Natyshak): Thank you very much, Ms. Scarth. I have to cut you off.

We will now move to the government side. I believe Mr. Anand will start the nine-minute round for the government side.

Go ahead, Mr. Anand.

Mr. Deepak Anand: My question is for Ms. Scarth on the rapid test—well, we talked about the rapid testing. I actually wanted to talk about the testing, by the way. Right from the get-go, I have been asking for this, because my riding has the greater Toronto airport. We're not just a host, but there are many residents who actually work at the Pearson airport. Then, many of these new Canadians come through those doors and live in my community.

CTV had a report on January 25 talking about how more than 70 cases in two weeks were actually tested positive through international travel.

I want to ask this question: What was your suggestion for how we can reduce the risk posed by the travellers entering Ontario, and what happened after that?

Ms. Fredrika Scarth: I'm happy to address that question.

We agree that there are risks in terms of international travellers coming into Ontario. There is the risk of the spread of COVID-19. That's why we initiated voluntary testing at Toronto Pearson airport on January 6 of this year and then mandated the program on February 1 of this year, such that every international traveller coming into Ontario, with very few exceptions—really, only flight crew is exempted from that requirement—was being tested for COVID-19 on arrival at Pearson and then linked into contact management and contacted by public health authorities during their 14-day quarantine. We did see that this was an effective program. We were seeing positivity—that is, the number of tests that returned positive—in the 2% to 2.5% range, so quite significant numbers of people coming into the province and importing COVID-19. Our efforts identified those cases early.

That program was transitioned to the federal government on February 22. They're continuing to test incoming travellers on arrival and then on day 10 of their quarantine. We continue to partner with them to ensure that there is effective oversight in the quarantine provisions.

One further note I would make about our airport—

The Chair (Mr. Taras Natyshak): Mr. Anand?

Mr. Deepak Anand: Ms. Scarth, was there any time any of our members or anyone from the cabinet or the Premier was talking about this to you guys [*inaudible*] testing?

Ms. Fredrika Scarth: Absolutely, as we develop proposals and we respond to government direction and brief in the committees that you've heard about earlier today. We would have taken these proposals to the Health Coordination Table and to the Central Coordination Table and received input through those tables and received direction from our minister to implement this testing at Toronto Pearson airport.

Also, I would say, because this is actually an area of federal jurisdiction, we worked very closely with federal partners—to try to move forward the agenda of border testing with the federal government, as well.

Mr. Deepak Anand: I just wanted it on record that you did get a lot of requests for this testing. Thank you for confirming that. I appreciate it.

The Chair (Mr. Taras Natyshak): Mr. Kramp.

Mr. Daryl Kramp: Thank you to all of our witnesses for coming in here today. If we all had 20/20 hindsight, none of us would be in this position, but we are.

I would like to address one particular issue, given the limited time that I have, of course, and that is elective surgeries. Understanding that we had to address the capacity for ICU, obviously there was a cancellation of elective surgeries. Hence we have a backlog.

To the deputy minister: I'd like to know what our plan is. Do we have any time frames and/or plan to eliminate and address this backlog?

Ms. Helen Angus: Thank you very much for your question. I'll probably also ask Matt Anderson to join me.

I know that it's really important to provide every citizen in Ontario with timely access to care, and surgery is no exception to that. We took extraordinary measures to ramp down planned procedures in the spring of 2020. It allowed us, at the time, to preserve possible capacity during the first wave of COVID-19, but it also created a wait for certain surgeries and procedures. We've been monitoring those at the Health Coordination Table.

We have been providing support to hospitals to allow them to maintain services as much as possible through the second wave and have avoided further shutdowns.

There are parts of the province that have been less impacted by the second wave, and so those hospitals have been able to do more surgeries than they might have done in previous years, delivering important surgical care to deliver on the backlog.

As I mentioned, we ramped down surgeries in the spring, and we were able to begin ramping back up about 10 weeks later, on May 26—so two and a half months. We began to address the backlog right away.

We did provide updated recommendations to the sector. There was a measured approach to planning surgeries and procedures during the pandemic, and we developed a support

plan for hospitals for a potential second wave and avoided the shut-down surgeries that we saw in the first wave.

We have also provided additional funding—I think it's about $284 million—as part of our fall preparedness—

Mr. Daryl Kramp: Deputy, I would just like to interrupt you for one second.

Given the lowering of the trajectory as of late, are there plans to accelerate the access to ICU?

Ms. Helen Angus: Access to surgeries? Some require ICU capacity—

Mr. Daryl Kramp: That's correct. Given, obviously, that we have a reduction in a number of the ICUs, are we going to be able to accelerate the access to surgery?

Ms. Helen Angus: As long as the pattern holds and we continue to see decreases, the answer would be yes.

We have the great benefit of being able to—in February, we opened, for example, the Cortellucci Vaughan Hospital. It has been operating 172 beds, largely focused on COVID-19 at the beginning, and that has provided relief to other hospitals so that they can do COVID-19-related and non-COVID-19-related work.

I don't know whether, Matt, you want to add in here and give them a—

The Chair (Mr. Taras Natyshak): I'm just going to interject and give MPP Barrett the last minute and 20 seconds on the clock.

Mr. Toby Barrett: Good news on Cortellucci Vaughan Hospital.

We've seen some big changes at Joseph Brant Hospital.

To our Deputy Minister of Health: How are other hospitals doing? We know there are 3,000 new beds now. But how are some of our rural and small-town hospitals doing?

Ms. Helen Angus: Many hospitals have been impacted by COVID-19. I would say they're getting back to business. We see the numbers of COVID-19 patients in hospitals—I think we're in the high 600s today. That's down significantly from where we were in January, so we're able to do more of the work.

I think that the government—we're probably only a few weeks away from the budget. It's certainly not my job to pre-empt the Minister of Finance, but we're looking at the overall health of the sector and thinking about recovery—

The Chair (Mr. Taras Natyshak): Thank you very much, Ms. Angus. I'm sorry to cut you off; I know it's a shock there.

We've got three minutes left for the independent members. Mr. Blais.

Mr. Stephen Blais: To Mr. Davidson or perhaps the Ministry of Health: What plans do you have to modify the Ontario Agency for Health Protection and Promotion Act to identify the specific circumstances when Public Health Ontario's advice should be and would be made public?

Mr. Steven Davidson: Chair, with your support, I would defer that to the deputy of health. But I would say, just in doing that, that our transformative policy work is absolutely a key priority for us in the public service and, I know, for the government. Once the pandemic is over, we'll be able to shift gears into looking at some transformative policy work which could potentially include legislative change, as appropriate.

With the committee's agreement, I would just ask if Deputy Angus has anything to add specifically.

Ms. Helen Angus: Yes, thank you.

I think as you know, we were looking at the modernization of the public health system as we entered the pandemic, and we were in the early phases of doing some consultations under the leadership of Jim Pine. Those we put in abeyance while we had to respond to the pandemic.

There are going to be tons of learnings from this experience. I think, as good public servants, we want to unpack those and understand them, including the recommendations from both this audit and others that I know are forthcoming from the Auditor General. I think those will make their impact on the policy of the government. We will bring those forward in a thoughtful way as we have a chance to really learn from the experience of responding to this pandemic—hopefully never again, or never again in our lifetime. Certainly, it has exposed huge opportunities for us.

I'll point to another area of health care where it's so evident—the rapid use of virtual care, for example. It's unfathomable for me that that isn't embedded as a permanent feature of the health care system, given the benefits to patients, the convenience, and how well it has worked for patients, mostly, and for providers.

I think there will be other lessons from the public health response that we will want to look at carefully and provide advice on to the government of the day.

The Chair (Mr. Taras Natyshak): Ten seconds, Mr. Blais.

Mr. Stephen Blais: Thank you, everyone, for your time today.

The Chair (Mr. Taras Natyshak): Thank you to members of the committee.

Thanks to everyone for your efforts and for coming and presenting to the committee. We certainly appreciate your time.

Ms. Bell, did you have a point of order?

Ms. Jessica Bell: I don't know if it's a point of order or not, but I do want to get on the record that there is some information I would like to request. I'll just read it out now. One is that I am requesting documentation that clarifies the chief command table's decision-making structure, including terms of reference, names of people at the table, who were the decision-makers, who were the advisers—

The Chair (Mr. Taras Natyshak): Ms. Bell, we're going to move into closed session. You can do that in closed session, and if the committee agrees, then we can continue on with your request.

Ms. Jessica Bell: Okay.

The Chair (Mr. Taras Natyshak): With that, we are going to move into closed session.

Thanks very much, everyone.

The committee continued in closed session at 1443.

STANDING COMMITTEE ON PUBLIC ACCOUNTS

Chair / Président
Mr. Taras Natyshak (Essex ND)

Vice-Chair / Vice-Présidente
M^me^ France Gélinas (Nickel Belt ND)

Mr. Deepak Anand (Mississauga–Malton PC)
Mr. Toby Barrett (Haldimand–Norfolk PC)
Ms. Jessica Bell (University–Rosedale ND)
Mr. Stephen Blais (Orléans L)
Mr. Stephen Crawford (Oakville PC)
Mr. Rudy Cuzzetto (Mississauga–Lakeshore PC)
M^me^ France Gélinas (Nickel Belt ND)
Ms. Christine Hogarth (Etobicoke–Lakeshore PC)
Mr. Daryl Kramp (Hastings–Lennox and Addington PC)
Mr. Taras Natyshak (Essex ND)
Mr. Michael Parsa (Aurora–Oak Ridges–Richmond Hill PC)

Substitutions / Membres remplaçants
Mr. Vincent Ke (Don Valley North / Don Valley-Nord PC)
Mr. Sam Oosterhoff (Niagara West / Niagara-Ouest PC)

Also taking part / Autres participants et participantes
Ms. Bonnie Lysyk, Auditor General

Clerk / Greffier
Mr. Christopher Tyrell

Staff / Personnel
Ms. Erica Simmons, research officer,
Research Services