Legislative Assembly of Alberta

The 30th Legislature
Second Session

Select Special
Public Health Act
Review Committee

Thursday, August 27, 2020
9 a.m.

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Standing Committee on Public Health Act Review

Participants

9 a.m. Thursday, August 27, 2020

[Mr. Milliken in the chair]

The Chair: Hello, everyone. I'd like to call the meeting to order. Welcome to members and staff in attendance for this meeting of the Select Special Public Health Act Review Committee.

My name is Nicholas Milliken. I'm the MLA for Calgary-Currie and chair of this committee. I'm going to ask that members and those joining the committee at the table introduce themselves for the record at this time. I'll start to my right.

Mr. Rowswell: Garth Rowswell, MLA, Vermilion-Lloydminster-Wainwright.

Mr. Neudorf: Nathan Neudorf, MLA, Lethbridge-East.

Mr. Turton: Good morning. Searle Turton, MLA for Spruce Grove-Stony Plain.

Mr. Reid: Good morning. Roger Reid, MLA for Livingstone-Macleod.

Ms Lovely: Good morning. Jackie Lovely, constituency of Camrose.

Mr. Long: Martin Long, MLA for West Yellowhead.

Ms Renaud: Marie Renaud, St. Albert.

Ms Hoffman: Sarah Hoffman, Edmonton-Glenora.

Mr. Dach: Lorne Dach, Edmonton-McClung.

Mr. Nielsen: Good morning, everyone. Chris Nielsen, MLA for Edmonton-Decore.

Dr. Massolin: Good morning. Philip Massolin, clerk of committees and research services.

Mr. Kulicki: Good morning. Michael Kulicki, committee clerk.

The Chair: All right. Pursuant to the August 24, 2020, memo from the hon. Speaker Cooper I would remind everyone that outside of those who have an exemption, those observing the proceedings of the Assembly or its committee are required to wear face coverings.

Based on the recommendations from the chief medical officer of health regarding physical distancing, attendees at today's meeting are reminded to leave the appropriate distance between themselves and other meeting participants.

Please note that the microphones are operated by *Hansard*, so members do not need to manually turn them on or off. Committee proceedings are being live streamed on the Internet and broadcast on Alberta Assembly TV. Please set your cellphones and any other devices that you have to silent for the duration of the meeting.

I would also, for the record, like to note the following substitutions: Chris Nielsen for Kathleen Ganley, Lorne Dach for Christina Gray, Marie Renaud for David Shepherd.

Our first item of business is approval of the agenda. Does anyone have any changes to make? I see Ms Hoffman.

Ms Hoffman: Yeah. Thanks, Mr. Chair. Perhaps a clarification. We didn't have a breakdown as to time allocations for different items, but we did receive the presentations that those who are here to answer questions today provided yesterday in writing in advance. So I'm hoping that we can put a parameter around how long the presenting time will be, because I imagine that it's been a month since we last met, and most of us have spent a significant chunk of that time preparing for today. I've had a chance to review the presentation. I'd love if we could maybe limit the presenters to 10 minutes for their presentation to maximize our Q and A time.

The Chair: As of right now what it's sort of set out to be is 15 minutes with regard to the presentation. That's the notice that was given out at least for the first two presenters, and then I believe it's 30 minutes for the third and fourth presenters.

Ms Hoffman: I'd like to move an amendment that that be changed to 10 minutes across the board, like, that each presenter have 10 minutes.

The Chair: Okay. As of right now, respectfully, the presenters have all been given notice with regard to their timelines. Given that the actual time allocation for the presentation wouldn't be a situation that would require an actual amendment or anything like that – it's just the administrative side of the actual agenda itself.

Ms Hoffman: Except, as I understand it, Mr. Chair, just to clarify, we haven't set that agenda. We didn't set the time allocations of 15 and 30 minutes as far as I'm aware. Given that the meeting is of the membership, I'd like to propose that we limit the time, because I don't recall being given notice that we'd be allowing 15 and 30 minutes. I would've changed my questions if I had. I've been preparing for this for a month, so I'd really appreciate the opportunity for the committee to weigh in on limiting the presentations to 10 minutes or if we would've had an opportunity prior to today to establish that as a group. Giving those who are presenting notice is one piece. Giving the committee and the participants notice, I think, would also have been helpful.

The Chair: Yeah. Fair comments. I think that the presenters have been given notice as to their expected timeline allocation. I would also say that there is potentially the opportunity to go beyond the actual timeline of the full meeting as well, right? So there is the potential of going beyond 2:30. If there are, obviously, situations where perhaps we need to go beyond or maybe try to figure out certain aspects of their presentation a little further than potentially expected, then that might be something we might be able to go down at a future time during this meeting. However, at this stage, especially with regard to the fact that this is just an administrative side of things, especially with regard to the first two presenters, at this point they have been given notice of about 15 minutes for the presentation and 30 minutes for questions. I think that that should be – I expect that that will be ample time for questions. I also wouldn't want to ask presenters on such short notice to perhaps change their presentations for the purposes of making sure that this committee gets a fulsome idea from their presentation.

Ms Hoffman: My challenge, Mr. Chair, as we move forward, I guess, because the situation we're in today is that we weren't given notice – I appreciate that the chair gave notice to the presenters, but we haven't been informed of what the time allocation would be. We've all planned for this over the last month, to prepare for today, and I really do hope that we get an opportunity to ask all the questions that we've prepared over the last month. With that, I guess this is my notice that I'll probably have to ask for an extension to the length of the meeting.

The Chair: I appreciate your comments at this time.

Ms Hoffman: Moving forward, if we could be involved in setting the agenda and knowing what the parameters are for the presenters before they show up, I think that would be helpful. Thank you.

The Chair: Noted. Yeah. Thank you.

All right. With regard to approval of the agenda, if there are no changes to make, would a member please move a motion to approve the agenda. We have prepared a potential motion here, which would be moved by X, whoever the member would be, that the agenda for the August 27, 2020, meeting of the Select Special Public Health Act Review Committee be adopted as distributed. I see Member Turton willing to move that. All those in favour, please say aye. Any opposed, please say no. That is carried.

Moving on, approval of minutes from the previous meeting. Next up we have the approval of minutes from the previous meeting. Draft minutes were posted for the consideration of committee members. Are there any errors or omissions to note? Seeing none, would a member please move a motion to approve the minutes? I see Member Lovely has moved that the minutes of the July 28, 2020, meeting of the Select Special Public Health Act Review Committee be approved as distributed. Is that a motion that contains your goals, Ms Lovely? All right. All those in favour, please say aye. Any opposed, please say no. That is carried as well.

Moving on to the next item of business, we have four presentations that are on the agenda for today. Forty-five minutes have been set aside – this may also help Member Hoffman with regard to any clarification – for each of the first two presentations, which include up to 15 minutes of presentation time, and then 90 minutes have been set aside for each of the final two presentations, which include 30 minutes of presentation time. It is important that we remain on schedule and respect the time of our guests that are joining us today. When I do open the floor for questions, I hope everyone will keep their questions concise and, of course, focused on the mandate of the committee, which is, of course, to review the Public Health Act. I will also remind everyone that discussion should flow through the chair, obviously, at all times.

Before we proceed, I have a few other items I would like to note for the record. First of all, I would like to thank the officials from the Ministry of Health for their ongoing support of our review. Since our last meeting we have actually received six additional briefing documents to add to our understanding of the Public Health Act. These documents, of course, were distributed to committee members as they were received.

I believe that, with regard to our first presenter, joining us now via video conference, we have Mr. Mitchell Cohen from the Justice Centre for Constitutional Freedoms. Mr. Cohen, if you are there, please go ahead with your presentation.

Justice Centre for Constitutional Freedoms

Mr. Cohen: Thank you, Mr. Chair and members of the special committee. Good morning. My name is Mitch Cohen. I appear before this committee as the representative of the Justice Centre for Constitutional Freedoms. I am a Calgary native and have practised law here and have appeared before all levels of court throughout Canada for over 37 years. The justice centre is an Alberta-based, national, nonpartisan charitable organization whose mandate is to defend constitutional rights of all Canadians. It accepts no government funding. The justice centre provides education, publications, and pro bono legal representation for citizens. An emergency is a true test of a constitutional democracy and not an opportunity to shortcut and to diminish fundamental rights but should be seen as an opportunity for a democracy to shine by demonstrating how a free society can maintain its core principles of freedom in the most difficult of circumstances.

9:10

I do not propose in these brief comments to critique specific provisions generally of the Public Health Act, but I will comment on the Bill 10 and Bill 24 amendments to the act, which, in my opinion and that of my colleagues, are in large part unconstitutional and an unnecessary overstep and surrender of legislative powers. These amendments effectively nullify the last election, relating to oversight and debate, and suborn the enshrined powers of the Legislature to make law.

As I noted, an emergency is a true test of a constitutional democracy. A dictatorship might well appear to function much more effectively in such crisis situations, but that is not how enshrined democratic principles operate. They are not suspended by the act of a majority government. Sections 91 and 92 of the Constitution Act grant exclusive legislative authority to Parliament and the provincial Legislatures. Sections 55 and 90 of that act provide that royal assent is required in order to bring laws into force. Delegation of plenary legislative power to the executive branch circumvents the requirements of sections 55 and 90 and is an unconstitutional avoidance of Alberta's fundamental constitutional architecture.

Drawing on the democratic principle that citizens must have an opportunity to participate in the formulation of laws, the Supreme Court of Canada has affirmed that the constitutional architecture prevents Legislatures from undermining the basis of their legitimacy. Discussion, debate, and deliberation must occur before laws are made. A society of free citizens depends upon open legislative discourse. The democratic principle and rule of law have been clearly and unequivocally expressed by the Supreme Court of Canada. Ultimately, the rule of law limits the action of the executive branch and ensures that government action is found in a source of law.

The current circumstances demonstrate a reality of unreasonable unconstitutional overstep. The Bill 10 and Bill 24 amendments to the Public Health Act fast-tracked amendments to the act that are largely arbitrary and unreasonable. They represent an egregious example of an unjustified, unconstitutional exercise by a government. The amended legislation effectively unconditionally delegates legislative power to one minister by Bill 10 and grants effective legislative power to make and repeal legislation to a civil servant, the chief medical officer of health, by the amendments flowing from Bill 24. There is no justification for overriding democratic principles and constitutional checks and balances in lawmaking at any time.

The Alberta Legislature has sat throughout the emergency. It, in fact, passed more bills in the recent session, as I'm sure all of you are fully aware, than in six of the last 10 pre-COVID sittings. In view of today's technology there is no reason the Legislature cannot function, and you all have demonstrated that very well.

I urge this committee, in looking to make recommendations for revisions to the Public Health Act, to recognize, as I know you will, the modern world, our Constitution, and the rule of law. Many of the provisions in the current act predate current technology. It has never been challenged in court prior to the justice centre's current action challenging the amendments by Bill 10. The Bill 10 amendments to the Public Health Act vest lawmaking power in a single minister, suspending legislative oversight, debate, and the entire democratic legislative process.

An example of the need for oversight in debate is the poorly worded, in my view, police health record disclosure order by Minister Shandro. Bill 10 added section 52.1(2) and (3) to the Public Health Act, which effectively overrides all legislative authority and rule of law. It expressly permits the Health minister to, quote, make an order "without consultation."

The minister used this provision to issue an order providing for disclosure of individual health records only to police services upon request. The pretext for such a fundamental infringement of privacy rights was that if a person spits on a police officer and says that he or she is infected with COVID, it would be necessary to know whether the assertion is true to avoid unnecessary quarantines. The ministerial mandate contains no safeguards outlining the use, storage, and retention of the personal data by police. There are no express limitations on how the police may use this private and personal information. There is no provision that requires the destruction of the record by a certain date. Providing the personal health information on demand to a police service of citizens at the total discretion of the police service is, in effect, a warrantless, illegal search. The ministerial order does not provide for any judicial checks and balances, and it is an alarming and unnecessary breach of personal privacy and protected information.

This order demonstrates such a clearly and unjustified unconstitutional infringement of basic rights which, had it been subjected to legislative oversight and debate, I suggest would not have become law. Why? Because you as legislators would have noted in debate that such police powers are routinely subject to oversight by the Legislature and courts. You as legislators in the course of the debate would have noted that on-demand access to personal, private health information without recourse or controls on the police was an abuse of power and unnecessary. You as legislators would have noted that the courts are always available and accessible and will always consider requests for emergency orders and warrants every day of the year. Our courts provide a check on unreasonable infringement of individual liberty and privacy rights, which may in certain circumstances be justified but only on evidence being provided to the court and it being satisfied the situation merits such powers being granted on a limited basis.

The government exercised its power again on June 26, when Bill 24 came into force only eight days after its introduction. It amended 15 different laws simultaneously. This bill extends the government emergency powers in qualified situations to December 31, 2021. This is well beyond the exceptional circumstances of a temporary public health emergency. While perhaps well intended, this extension of emergency powers for use at any time without notice during nonemergencies has a decidedly draconian appearance. As a result of Bill 24, the Health minister was granted to make regulations based on orders issued by the chief medical officer of health under the Public Heath Act, which are effectively unilateral laws made by one doctor without any input from the Legislature. The Health minister explains it this way.

> The bill also proposes creating a new regulation-making authority to support and empower orders of the chief medical officer of health as required. This would give her the authority to act . . . as required without an official state of public health emergency being declared.

There are four chief medical officer of health orders that are referenced and form part of the Public Health Act as a result of the Bill 24 amendments. Those are orders 5, 10, 11, and 13. These orders, which now form provisions in a statute, may as a result of Bill 24 still be rescinded, repealed not by the Legislature alone but by the chief medical officer of health, with no oversight by the Legislature, any time prior to December 31, 2021. If and when one doctor decides to rescind one of her orders, it effectively amends the Public Health Act. Bill 24, as I've described, far from improving the situation, gives a public servant the power to legislate. This is so basic. It's a violation of principles of the rule of law. Bill 24 amendments to the Public Health Act as described are ultra vires the Legislature.

In preparation for my attendance here, I reviewed *Hansard* and noted the closing comments of Ms Merrithew-Mercredi, the deputy minister of public health and compliance, at the July 17 morning meeting. I know you were all there, but I will quote from the deputy minister's comments from *Hansard* when she said this at 9:40 a.m.

> We are also suggesting to the committee that it may be useful or that you may want to consider amending the act to provide a waiver allowing the ministers to use orders during extreme circumstances only and only if the Legislative Assembly is unable to meet due to the emergency. For example, in the case of a bioterrorist attack, it's not unreasonable to [suggest] that all of the people in this room might be the focus of such an attack and may not be able to in fact meet or be so ill that you would not be able to even participate via teleconference or some other means of public government.

9:20

She went on to say:

> . . . the second concern, ensuring that all of the orders are posted, we would suggest to you that you might want to make it a requirement, actually, in the act that they are posted online and could either be on the government website, the Legislature website, or the Alberta Queen's Printer . . . or perhaps all three, for that matter.

These suggestions by the deputy minister are a clear acknowledgement by a senior civil servant that, in her view, something is seriously wrong. From the public's perspective a review of these comments makes it clear that the government's own officials are of the view that this government has overstepped its authority in governing by decree, by fiat.

The deputy minister's comments also highlight and acknowledge that the nature of the orders, regulations, guidance, and directions formed from the government, its ministers, and civil servants during an emergency has put the public in a position of not knowing what the law is and not being able to in fact even look somewhere to find out what it is. Currently there is no formal mechanism for ascertaining what the orders are. They are not gazetted and likely violate the requirements of the Regulations Act, notwithstanding the provisions of the Public Health Act currently. The Regulations Act requires regulations to be published before they can become enforceable for the purpose of disclosure so there is a place to look for the law. This, in my view, should be clearly incorporated into any new public health act. Many of the current Public Health Act provisions predate modern technology. Publication and rules governing our lives should be fundamental in a democracy. They show clarity and precision of regulations and orders. The numerous orders of the chief medical officer of health provide examples of lack of clarity and confusion, which I would be happy to comment on in response to your questions.

My colleagues Jay Cameron, Jocelyn Gerke, and I, on behalf of the justice centre, commenced an action in the Court of Queen's Bench of Alberta challenging the amendments made by Bill 10 to the Public Health Act permitting government to effectively rule by fiat, expressly without legislative authority or oversight. The litigation is currently before a Queen's Bench case management judge, with portions of it being dealt with likely in October.

The reason I share this with the committee – and it's quite interesting that the government is not interested in the opinion of the court on the constitutional validity of its unconditional delegation of powers to single ministers. The government has indicated that it will seek to dismiss the case as not disclosing a cause of action and has gone so far as to challenge the justice centre's status as a plaintiff in the public interest. They're effectively advancing an argument, at least in current submissions to the court, that the justice centre should not be before the court representing the public interest. I find that

position rather surprising, both in light of the justice centre's reputation throughout the country and even this committee's request that we provide our comments to you here. It becomes even more interesting when one considers that the government in the lawsuit is also challenging the status of the Canadian Civil Liberties Association to intervene, another party that you have sought counsel from here.

As I said, public interest litigation such as this, brought by the justice centre, is not commercial litigation. The outcomes and rulings by various courts are instructive and provide guidance to government in the public interest and assist in public expectations and understanding. Our court proceedings can really be best characterized as a reference to the court, seeking guidance and clarification of the law. I would think that would be something all legislators would be interested in. An example of that type of litigation in the public interest is the reference, in the B.C. government case to the court in that province, to provide guidance on the constitutional validity of a bill relating to regulation of bitumen flow through the Trans Mountain pipeline. [A timer sounded]

Mr. Chairman, I will be finished very shortly.

The Chair: Okay.

Mr. Cohen: Many of the current public health orders are potentially unenforceable or void because they are without statutory authority, are not properly published, gazetted, or accessible. Some orders are confusing. A citizen or a court would be challenged to understand the limits or rules so prescribed. Some orders providing for close of businesses and those applying to the entire province are likely beyond the authority of the chief medical officer of health, with those powers vested only in the cabinet and/or the Legislature. I would be happy to discuss this further if the committee has questions in that regard.

In closing, let me say this. No crisis justifies nullification of an election. No crisis gives any government the authority to legislate without debate, oversight, or legislative involvement. Chiefs of police do not rewrite the Criminal Code even in a public emergency like gang warfare. Chief medical officers of health should not be making law. I urge this committee, when considering the major rewrite of the Public Health Act, to limit the authority of the chief medical officer of health to local, personal, and individual health issues and to that of an important and key adviser to the Minister of Health and the Legislature. Oversight by the Legislature is fundamental at all times but, as this crisis has demonstrated, is critical during an emergency.

Thank you, Mr. Chair.

The Chair: Thank you, Mr. Cohen.

I know that there are some members who are chomping at the bit to ask questions. I believe that the first member who caught my eye was Member Lovely.

Ms Lovely: Well, thank you, Mr. Chair. It's a nice opportunity for us to have Mr. Cohen here. Thank you for joining us and this opportunity to ask you some questions. I think that we can both agree that a situation like we saw where someone coughed or sneezed on a police officer and claimed to have COVID is abhorrent behaviour. You have previously criticized the clause that permits the disclosure of a person's COVID results to a police officer. Keeping in mind the real possibilities of future pandemics, how do you suggest we balance the need to ensure first responders are not needlessly sidelined in a crisis while protecting the personal information of Albertans?

Mr. Cohen: Thank you for that question. I think the merits of the position and the concern for public safety and police officer safety are very justified. Having said that, there need to be controls over the access to that information and controls over it, as I said. I'm not saying that there are no circumstances where those records couldn't be accessed. On the limited circumstances where it would be necessary and there was evidence to require it, certainly there could be legislation which would entitle the officer or someone on the officer's behalf or the police service's behalf to apply to the court and justify access to those records. As I said, you can get access to the courts any time you need to. Our courts are extraordinarily accessible in emergency situations.

The other thing that's important: while access to those records in unique circumstances, as you've described, Member Lovely, is merited, there need to be controls on the use of that information. Right now, based on the ministerial order, that information can simply be accessed and maintained by any police service, and there's no indication of where it's maintained, how it's maintained, when it's destroyed, et cetera. So it needs to be worked on. As I said, I think this committee, when looking at amendments to the Public Health Act, can look at those concerned. It was an issue during the HIV situation when people were – you know, needle pricks and things like that from time to time. Access to health records and privacy concerns that I know are the concerns of every one of the members of this committee – and they can be managed by putting controls on the use of that information.

The Chair: Thank you.

A supplemental?

Ms Lovely: I don't have a supplemental.

The Chair: Okay. Going forward, just so you know, I'll probably be looking towards the idea of asking whoever has a question – I will also afford them the opportunity to provide a supplemental as well.

Member Dach.

Mr. Dach: Thank you, Mr. Chair. I appreciate your attendance, Mr. Cohen, and your esteemed litigation experience of 37 years. It's evident that we don't need to ask you to tell us what you really think, and I appreciate your concise preamble to today's meeting. I want to get into some of the issues you spoke about a little bit more in depth, so forgive me for a little bit of a preamble myself. Your organization has been very critical of amendments made to the Public Health Act through both bills 10 and 24 during the past legislative session, and you have taken legal action in the courts.

9:30

I would like to begin with the extraordinary powers extended to individual ministers through Bill 10. As is well documented, the amendments allowed the government, as you said, to create entirely new laws through ministerial order while bypassing the Legislature, allow the government to exercise these new powers for up to six months after the end of a public health emergency, and created a new standard for what is public interest, which is now at the personal whim of a minister.

Now, initially I was going to ask you about the constitutionality of Bill 10 with respect to two issues. However, you've covered section 92 of the Constitution Act of 1867 fairly succinctly, so I will go to my second point, and that is that I would like to ask about the Charter of Rights and Freedoms, sir. The government did not invoke the notwithstanding clause in Bill 10, so the issue is whether this legislation passes the reasonable limits test in the Charter. I would like to know, in your view, whether Bill 10 meets the test

with respect to necessity, with respect to proportionality, and with respect to the extraordinary powers being sufficiently time limited.

Mr. Cohen: Thank you, Member Dach. The real fundamental question you're putting is one when you ask about necessity, and as I said, the real reason for this committee to consider the total disability of the Legislature, as the deputy minister raised, is because that's beyond the Public Health Act. That goes far beyond anything even contemplated at this time. So what's being demonstrated here: that there was no necessity for that amendment. That's why it's so shocking from a rule of law perspective, because it delegates all lawmaking authority to a minister.

When you look at that, you look at proportionality, well, there's no proportionality. It overrides, it nullifies the people's choice to make law. Each member of the Legislature is entitled to debate. And the reason I chose – I wasn't picking on Minister Shandro per se when I went to that health disclosure, but my point was that if you as legislators had debated that point, you may well have come up with a regulation that was fair, reasonable, and justified with protections in it.

I guess my answer is long, but the short answer to your question now is that there is no justification for those amendments, and I'm strongly of the view that they will not survive a challenge. I mean, historically this type of delegation of authority to a single minister is called a Henry VIII clause. That's where Henry VIII used to rule by edict, delegate his proclamations down the line and make them law. The government's position in our litigation is that that's perfectly legitimate and justified. Well, you know, one of the important things in a constitutional democracy is to recognize that the Legislature and its ministers are answerable to the people, and that's why this committee is doing its work in considering submissions from all sorts of people and civil servants.

Having said that, the reference to a court that I've just raised is another – as this committee goes on and does its important work, not only relating to emergency situations but the overall Public Health Act and its role in our society, you know, it's worth while to consider, if there are very controversial matters, court references from time to time. Like, the B.C. government, not that I supported the B.C. government's attempt to shut down the Trans Mountain pipeline, made a reference to the court and got a ruling, which gave some finality and closure.

I'm answering more than your question, but having said that, Member Dach, I'm saying that there is absolutely no constitutional or fundamental justification for the Bill 10 delegation of full legislative power to a minister without any consultation. It goes so far as to say "without consultation," so you're not supposed to talk to anybody. You're certainly not bound to, which is abhorrent to basic constitutional democratic principles.

Mr. Dach: I do have a supplemental if I may.

The Chair: Please go ahead.

Mr. Dach: Certainly, I do like your reference to the fact that you appreciate the work of this committee in seeking the opinion of various and sundry presenters to us although there were a number of presenters that we wished to have come such as members of Cargill's UFCW union and other public servants that were denied by the government members on the committee.

However, sir, my question 2. By way of background, recommendations to modify the Public Health Act, as the committee is considering this, I'd like to ask for your views on legal advice and disclosure. By way of background, before Bill 10 was introduced, the Official Opposition was provided an embargoed briefing on the legislation, and we asked point-blank whether the government viewed this legislation as being both constitutional, in the sense of section 92, and whether it was Charter proof. Point-blank. Now, the government refused to answer, and the minister, through his office, ultimately invoked solicitor-client privilege. The view of the Official Opposition is that during an emergency like a pandemic governments often need to move quickly, but in return they have an obligation to the Legislature and, through them, to the public for proactive disclosure. That did not happen with respect to Bill 10 or, for that matter, Bill 24. So I'd like your take on whether we should insert in the Public Health Act a requirement that all legislation, regulations, and ministerial orders put forward by a government during a public health emergency be accompanied by a legal opinion on their constitutionality signed off by the Attorney General.

Mr. Cohen: That's an interesting proposal. You know, the question of privilege in the context of lawmaking has been debated forever. Governments from time to time get advice and rely on that advice, but the people and people's representatives don't know what that advice is. My answer to your question is that I think, from a transparency perspective and in understanding matters, it makes a lot of sense. That's not a lot different, in many respects, than making a reference to the court because that's going to be a public ruling as well. You could include in the act – I mean, that's open to the Legislature to do, but the authority to do that, that, one, whatever the legislation is be subject to a review if there's a basis for a validity debate and, secondly, that if there are significant issues or differences, a reference be made to the court for a determination of constitutionality on recommendation of whatever committee or whatever the legislation proscribes, I think is progressive. That is progressive.

The Chair: Thank you, Mr. Cohen.

I would just remind all members, per my previous comments, to try to ensure that their questions are as concise as possible.

I believe that the next member who caught my eye is Mr. Reid.

Mr. Reid: Thank you, Chair. Thank you, Mr. Cohen, for your presentation and your time. I appreciate you being with us this morning. Regarding the Public Health Act, there's absolutely no question that there are provisions that provide broad powers to the government to respond to an emergent public health issue. Section 75 of the health act specifies that the Alberta Bill of Rights remains paramount over the Public Health Act. The Public Health Act also contains provisions for Albertans to appeal decisions through the Public Health Appeal Board or the court system in sections 3, 49, and 61. Do you believe that these existing checks are sufficient, and if not, how could they be made more robust?

Mr. Cohen: Thank you, Mr. Reid, for your question. I mean, they're there, but operationalizing them, from the public's perspective, is not easy. I mean, you'll recognize that even in this emergency, when we brought our lawsuit, it took us three months to get before a Court of Queen's Bench judge notwithstanding that it's a constitutional issue, and it's a live issue. Part of the problem – and I won't go on ad nauseam about this – is a lack of funding to the courts by governments in Alberta for years. So if you're going to create a statute or provisions in a statute that are going to be operationalized in an emergency, the courts have to be adequately funded so that they can respond. The Court of Appeal has been able to respond and sit normally because they're a small court, and they had the electronic means to function. The Court of Queen's Bench barely functioned at all. They did their best. The judges did their best, but the limits on electronic – it's a broader question. They're there. The rights are there, but if there isn't a vehicle to operationalize them, it's a serious problem.

9:40

More importantly than that, in the context of, like, the legislation we're talking about here today, or at least that I'm talking about – your mandate is much broader than what I've talked about – you know, you look at Bill 10 and the power that's vested, and then you look at some of the chief medical officer of health's orders that, in my view, are clearly beyond her authority: how does a citizen get that and run that before the courts? I mean, the justice centre and the Canadian Civil Liberties Association are trying to do that. It's taking us months and months and months. So unless there's proper access to the courts and proper funding for the courts, rights are empty, especially in a crisis. Especially in a crisis.

The Chair: Thank you, Mr. Cohen.

There is the opportunity for a follow-up.

Mr. Reid: Thank you, Mr. Cohen. I appreciate your input on that. Just as a follow-up, probably more a point of clarification for me. During your presentation – I just need to check – statements that you made saying that laws are unconstitutional: just for clarification, is that based on your opinion, or have you had agreement from courts on that regarding Bill 24?

Mr. Cohen: No. Of course not. I think I indicated that that was my colleagues and I, our view, and we're seeking a ruling from the court, which the government is resisting, as they're entitled to. That remains to be seen.

Although, you know, in many respects some of the matters that aren't precisely dealt with in our litigation and some of the orders by the chief medical officer of health that are effectively given the force of law are vague, unclear, can't be adequately accessed by the public, and in some respects are simply beyond her jurisdiction to deal with. I mean, those are the kinds of things that this committee is going to be challenged with in making recommendations to the Legislature, because the current Public Health Act – I mean, when you read the act in its entirety, as I know you all have – is focused not on shutting down the economy and quarantining the entire public as it were; it's focused on an outbreak of disease in specific locations or dealing with specific people. That's why it exempts – the act has a specific provision in it saying that the Regulations Act doesn't apply.

Well, why would that happen? You're not gazetting rules that apply to the general public. Well, that's in the act because the act can be read that the chief medical officer of health's orders and medical officers of health from the particular health regions, as they existed before the change to the operation of the Health department in Alberta, could make orders, but they would apply to individuals or a specific location. An example would be the order the chief medical officer of health issued with respect to the Misericordia hospital. Orders that apply to the whole province need to be gazetted. They need to be published somewhere. There needs to be a place to find them. In that context you look at some of the orders that have been issued. I can't understand them, not that I'm brilliant, but a normal person reading can't understand their limits and where they go.

In response to other questions I'll be happy to go into more detail on that.

The Chair: Thank you, Mr. Cohen.

I see Member Dach.

Mr. Dach: Thank you, Mr. Chair. Mr. Cohen, if I might continue, I would like to continue on the theme of public disclosure. Now, when Bill 10 was being debated in the Legislature, the opposition put forward an amendment that would have compelled the government to quickly make public all ministerial orders issued by the government. The idea was that if the government created or amended a new law under the guise of a public health emergency, the public deserved to know. Unfortunately, government members in the Legislature voted against this amendment. They voted against public disclosure of new laws issued at the sole discretion of the minister.

I would like your advice on whether this committee should recommend adding a legal requirement to the legislation that all orders issued during a public health emergency be made public, and if not, why not? Why should the public not be informed of the laws that they are being subjected to?

Mr. Cohen: Thank you, Member Dach. The question is a fundamental one in a constitutional democracy. Access to laws and clarity of law are fundamental. You know, I remember as a young lawyer going to the *Alberta Gazette* and trying to find regulations, because they were all – you had to flip hundreds of pages. Now you should be able to press a button. In the old days the *Gazett*e of regulations: you would have to go to the printer, typeset it and print it off, and it would take days. Now you can do it in minutes. That's one of the things where what you're suggesting makes so much sense. There needs to be, particularly in an emergency, a depository of this information.

In preparation for my comments here today I did a bunch of google searches looking for the law, and it's intriguing. Looking for the chief medical officer of health's orders: they are listed in a whole bunch of different places, and it's impossible, really, to ascertain which are – they keep getting overridden and repealed. Similarly with ministerial orders the question is, you know: what is their scope?

Another suggestion to you, Member Dach, is that in an emergency situation, if the crisis is such that there needs to be some sort of ministerial fiat, which, I would suggest, would be very unusual, it should be published in a particular place that could be notified to the public, but it also should contain a commentary explaining what it relates to, what its limits are and what the powers are that are so vested, what its scope is, and what its duration is because without that, the transparency doesn't exist. That puts the limits on the ministerial fiat, as it were, so if you're going to permit that by the act, the minister or some other official should be forced to provide that commentary.

Mr. Dach: I think that's particularly important, to have that commentary, so that clarity is gained.

I'd like to continue on, if I may, by asking you about the challenge of the administration of justice during a pandemic and if there's anything that we can do to make things easier and more effective. Bill 10, in my view, is unconstitutional. I didn't attend law school. I was accepted to the U of C law school on the wait-list, didn't get in. However, that's another story. But in my humble opinion Bill 10, in my view, is unconstitutional. It's a piece of legislation that limited civil liberties and rights in a fashion that was fundamentally and demonstrably unjustifiable in a free and democratic society.

When Bill 10 was brought forward and was rammed through the Legislature in roughly 48 hours, we in the Official Opposition did our best to amend it and make it constitutional, but we had limited hours to consult with experts and get amendments drafted, so, like everyone in Alberta, our immediate recourse was through the courts. But with the pandemic, the courts were not readily available or easily obtained, so we had a challenge with the administration of justice. The courts were simply not set up to deal with the pandemic and the public health orders. One could not easily meet with counsel, draft an appeal, arrange to meet with a judge, have the

courts opened. To challenge Bill 10, it took time. So my question is this. Is there anything, in your view, that this committee should be looking at in terms of the pandemic, public health emergency orders, and the administration of justice, something, for example, that codifies in legislation that some courts must be sufficiently accessible, even virtually, so that citizens can challenge the government if they bring in draconian laws that limit civil liberties?

The Chair: Thank you, hon. member. At this stage I will allow this question.

I would like to take this opportunity, however, to remind all members that supplementals, with regard to their previous question, should be at least in some way tangentially associated with the initial question. Otherwise, it's essentially akin to just figuring out a way to jump the queue.

Mr. Cohen, if you could please answer Member Dach's question.

Mr. Cohen: Yes. Thank you, Mr. Chair. I think that on the issue of the administration of justice in this pandemic let me say this as a senior member of the bar in Alberta. You know, Chief Justice Ken Moore, Chief Justice Neil Wittmann, and their predecessors have argued for years, for decades for better funding for the courts in the best of times.

The Jordan decision from the Supreme Court of Canada on timeliness of criminal trials resulted in some action by the Legislature, but the underfunding of our courts has gone on for decades, and it's demonstrated – an example is this lawsuit that the justice centre commenced. The government took the position it wasn't urgent, and the government position may well be – and I'm apolitical. I usually am, but in this I've got strong views. The government position: it wasn't urgent. There was a means set up with the Court of Queen's Bench for getting the case considered on an expedited basis if it was found to be urgent, and you have to make an application to do that, et cetera. We chose the route of going for case management. I can tell you we wrote to Associate Chief Justice Rooke, who responded in four days, but then we couldn't, from the administration of justice standpoint, get before a case management judge for about 60 days.

9:50

That wasn't the judge's fault; don't blame the judiciary. They're ready, willing, and able to hear cases. They don't have courtrooms, they don't have clerks, and they don't have adequate electronic access to things. The way the Court of Appeal is set up, it sat continuously throughout the emergency remotely, ran continuously, heard cases normally, but it comes down to financing the administration of justice. So the act – I mean, it's probably beyond your mandate of this committee, but it's certainly important for the administration of justice. This pandemic provides an opportunity for the Legislature to step back and for this committee to perhaps recommend that these matters be dealt with.

You could describe in the legislation that matters relating to orders of chief medical officers of health or ministerial fiats are to be treated by the courts as urgent whether or not during a pandemic. You could include that in your legislation, and in the circumstances that I've been dealing with in the courts right now and facing opposition from the government on that point precisely, whether justified or not – I'm not judging that; that's the position they've asserted – you'd certainly avoid further complicating matters in the court and emphasize to the public at large how important it is for the merits of issues in the public interest to be dealt with quickly and efficiently in a pandemic, where people are in enough of a crisis themselves and their lives are totally disrupted. At least they know the courts are there.

So in response to that question, I think that approach of defining urgency for purposes of court hearings would be a very useful addition to your recommendations for amendments to the act.

The Chair: Thank you.

Member Neudorf.

Mr. Neudorf: Thank you, Mr. Chair. Thank you, Mr. Cohen, for your presentation. I wondered if you would mind following me back to the Public Health Act and the definition of public interest. This has been deliberately broad in the past because of societal norms and concepts of what constitutes public interest, which will differ depending on any future health emergency, which could really vary drastically depending on what that health emergency was. With this in mind, do you believe that the term itself "public interest" in the Public Health Act should be more explicitly defined? I'm interested in your comments there.

Mr. Cohen: Thank you very much for that question. It's incisive, and I think it's very important that this committee address that issue because it lacks definition. Everything the Legislature does, one would expect, would be in the public interest. There are no limits or parameters. It may be in the public interest or perceived to be to nullify the last election and proceed by ministerial fiat. That can be done in good faith, so the test of public interest can't be taking the view of a government or a minister or a department that it's in the public interest that we do this unilaterally, directly, and without oversight. I think the use of the term "public interest," in my view, should be avoided. It really has no meaning, and, you know, defining it can be a problem unto itself.

I think, more importantly, the parameters of the specific legislation and the provisions need to specify as best they can the limitations and the criteria for implementation of certain steps and orders, whether they be legislative or whether they be regulations. I mean, in that context, the authority to regulate and recommendations in that respect under the Public Health Act obviously need to be clarified, and a statement in the provision providing for subordinate legislation simply saying that regulations under this act must be in the public interest, really, tells you absolutely nothing.

That's a long answer to your question, that I think it's a very dangerous provision to put in the statute because it provides undefined power, effectively.

The Chair: Thank you, Mr. Cohen. Cognizant of the time and knowing that we have to respect the time, of course, of our other presenters as well and as I have a couple of people still on my list with regard to questions but we're out of time, what I'd ask you is: would you be amenable to having the other two members who are on the list read their questions into the record and then perhaps providing a written response within a reasonable amount of time, say two weeks?

Mr. Cohen: I think that as part of our overall role, I'd be happy to do that if you could just send me an e-mail of them.

The Chair: Sure. We'll make sure that we get you the exact wording.

The individuals that I have on the list are Member Nielsen and Member Rosin. If you could please read your question into the record – and also you after Member Nielsen – then we'll move on to the next presenter.

Mr. Nielsen: Just for clarification, Mr. Chair, would that include the supplemental?

The Chair: Please. Yeah.

Mr. Nielsen: Thank you.

Well, thank you, Mr. Cohen. Albertans have never had the type of mass restrictions on their individual liberty that, you know, we've seen occur over the course of this pandemic. What I'd like to do is set aside bills 10 and 24 and the powers that they confer on the government because I think that everyone has come around to the idea that it was a dramatic overreach and a big mistake. To focus on other restrictions on mass liberty that occurred in Alberta, those restrictions might well have been necessary to protect the public health and our society, but balance must be had.

As we look to the future, my question is whether this committee should investigate legislating a standard in the Public Health Act to help adjudicate what are the responsible limits on civil liberties on the one hand versus public health protections on the other. Should we look at that? Should that be left up to government? Should it be left to the courts? I would like your take on that.

My supplemental is: because there are so many questions, would you be willing to reappear at this committee to follow up on those?

The Chair: Thank you.

Member Rosin.

Ms Rosin: Okay. My question is back in relation to the appeal process, so in looking at the Public Health Act, the words "shall submit to" or "shall be subject to" in relation to treatments, examinations, surgery, vaccinations, or the removal of infection altogether are in the act 34 times. I'm just wondering: from your legal perspective, is an appeal process through the courts enough, and if not, what kinds of checks and balances would you recommend that could be added to the act to ensure that Albertans have a proper appeal process when they are subject to or must submit to X, Y, or Z?

The Chair: Thank you, Member Rosin.

On behalf of the committee I would of course like to thank you, Mr. Cohen, for joining us this afternoon and contributing to our review of the Public Health Act.

That concludes the first presentation. We are now moving along the agenda to the second presentation. It's my understanding that we do have the representative of the Canadian Civil Liberties Association on Skype. Joining us by video conference we have Mr. Michael Bryant, executive director and general counsel for the Canadian Civil Liberties Association.

Mr. Bryant, if you are there, please proceed with your presentation.

Mr. Bryant: I am here. Can you hear me, Mr. Chair?

The Chair: I can, yes, loud and clear. Please continue.

Canadian Civil Liberties Association

Mr. Bryant: Thank you. I thank all members of the committee, and I thank Mr. Cohen for his presentation. We are in agreement on everything he said. I don't have anything to say that's different from Mr. Cohen, so I'll try to avoid repeating him.

Let me tell you a little bit about the CCLA. We were founded in 1964. Canadian Civil Liberties Association is an independent, national, nonprofit, nongovernmental organization dedicated to furthering human rights, civil liberties, the rule of law, and government accountability. Its national membership includes thousands of paid supporters drawn from all walks of life. The underlying purpose of our work is to maintain a free and democratic society in Canada that balances civil liberties and competing public and private interests.

10:00

Besides bringing CCLA's perspective and experience, I'm going to bring my personal experience. I've sat where you are sitting, I say to committee members of the Legislative Assembly. I sat on committees in opposition and also in government. I served as the 35th Attorney General of Ontario for over four years, a cabinet minister for six years, and an MLA for 10 years. We call them MPPs in Ontario. I'm originally a B.C. boy, so I'm used to the MLA language. Our government assembled and legislated a major overhaul of our public health emergency management laws in the aftermath of the SARS epidemic, and that was the law that ended up being used by the current government of Ontario during its emergency management, until they brought legislation to the Legislature last month. As Attorney General at the time, our ministry had the opportunity to wrestle with the issues that you're now wrestling with, but we did so without the fear and the hurry that clouded the Bill 10 legislative process.

The key point that CCLA wishes to make about the changes that Bill 10 enacted is that they do not simply clarify, as the government has tried to argue, the powers that ministers have during emergencies. They expand those powers so that the minister can add new provisions to a statute that don't simply modify an existing provision. Cabinet ministers can create new legal powers that limit individual liberties and freedoms. This vests in one person too much power that can do too much harm to the rights of your constituents. This ministerial overreach is exercised, by necessity, in secret or in camera, without legislative oversight. That's how orders in council are made. They are not made in public. There's no opportunity to ask the minister questions. You may not even have an order in council that's been reviewed fully by the Attorney General, depending on the makeup of the cabinet at the time that the chair signs the order.

CCLA's concern is that this circumvents the legislative process. And in Bill 10, despite it being temporary, it is both unconstitutional and it's harmful to your constituents. I argue that it's unconstitutional. We are seeking intervenor status in the case that Mr. Cohen referred to.

How is it harmful to your constituents? Why does this matter? Because your constituents are free to go about their business in Canada as they see fit, subject to constitutional legal limits. We go about our lives with the presumption of freedom, and that presumption gets rebutted through constitutional laws. So a man can't show up at my condo one day, knock on the door, and confine me or detain me or imprison me or my kids. A police officer can't do that either, except to the extent that he is authorized by the law to limit my liberty. That law permitting the interference with my freedom needs to be a constitutional law passed by the Legislature, reviewable by the courts. If that democratic constitutional step is skipped and it doesn't get to go to the Legislature, there is a greater opportunity for error, there is a greater chance of harm, and there is zero opportunity for accountability. If that step is skipped and the minister can just make up the law him- or herself, then maybe the minister gets the order, not at a full cabinet meeting but by way of a walkaround, such that it doesn't even get properly reviewed by the constitutional law branch of your government.

From a public health perspective I say that there is a risk, an empirical risk, that arises when a public health order is made without a democratic process. It's much more difficult to figure out whether this is a public health order being driven by science and by the public health civil servants or if it is being driven by political

staff in a minister's office, not by science, not by necessity, and not with proportionality.

Even the science is constantly changing. In 2005 epidemiologist John Ioannidis of Stanford University in California suggested that most published findings on epidemiology are false. Since then a string of high-profile replication problems has forced public health science to rethink how they evaluate results. Statisticians are constantly looking for better ways of thinking about data to help scientists to avoid missing important information or acting on false alarms. As the Stanford statistician and physician Steven Goodman puts it: if you change your statistical philosophy, all of a sudden different things become important.

My point is that I know that your chief medical officer and other public health experts appearing before this committee will admit that the science is indeed changing. For example, for reasons that made sense at the time, we weren't wearing masks at the beginning of the pandemic; now we are. The public health recommendation changed. When a new public health power is created and put before the Legislature, however, there is an opportunity for opposition members and for journalists to find public health professionals to comment or dissent from the proposed public health law. A debate is permitted. It may be that the chief medical officer reveals during that legislative debate or during committee hearings before the law is passed that this new power does not have the medical necessity or proportionality that it ought to have. We may find out that it's actually just something that the police union wanted or something that a tough-on-crime politician created for reasons having nothing to do with public health or it was based on the whim of a minister or a Premier.

When I was in politics, I was known to play the tough-on-crime card. I'm not suggesting for a moment that it doesn't come from a good place. I thought I was acting in the public interest when I was there, just like all of you believe that you're acting in the public interest when you do what you're doing. But when I had to actually reveal the reasons for which, you know, I was taking a particular position and have the data and the evidence exposed and held up to public scrutiny, that could render a very different result. Sometimes the truth is that I needed to be protected from myself, and I always felt that my job as Attorney General was to protect the government from itself. I think that's the job of government MLAs, and I think that's obviously the job of opposition MLAs, to protect a government from your constituents.

If a new public health law is created by cabinet order, which is, by necessity, in secret and in camera, then it's done, and cabinet solidarity causes the government to circle the wagons and defend it at all costs because reversing that order in council becomes politically too costly. That's not like a bill amendment, which is rarely a political calamity and comes across as democracy in action. Most importantly, the legislative provision amended at a clause by clause or otherwise at committee has done no harm to people's rights and freedoms. Nobody's privacy or liberty gets robbed if a bill provision gets changed during debate on the bill. It hasn't had a chance to do its harm. The ministerial order, on the other hand, starts doing its harm sometimes before the public even knows that it's the law of Alberta. The transparency over new ministerial orders and regulations is entirely open to manipulation, and it requires this committee's special attention.

10:10

CCLA is asking the committee to recommend that a requirement for all orders under the act be made public in full in a manner immediately accessible in a centralized location online that's tweeted out by the government at the time that they are executed. Right now it's very loosey-goosey under section 52.4. It just says the government "shall publish and make available the details of an order . . . in the manner the person considers appropriate." That leaves a lot of room for delay and a lack of transparency.

Back to the Henry VIII clauses. You know, we've argued and agree that they offend constitutional separation of powers between the legislative and executive branches, that this is foundational across the Commonwealth and elsewhere, including Ireland and the United States, and that this risk is real, not theoretical, as evident from the Minister of Health's reliance on amendments to issue Ministerial Order 632 of 2020, granting the chief medical officer the authority to disclose individual persons' health records to police services to enable police officers to determine whether they've been in close contact with an individual.

I'm happy to get into that particular one as an example of an order that ought never have been made because, amongst other things, we just still don't know if there was a necessity for it. Most importantly, it wasn't necessary. There is already a way in which a police officer could get a warrant or get an order requiring somebody to provide a test, but, inevitably, the person is going to have to get tested, too, because we know that the state of the tests right now is such that the person in the example given, spitting on a police officer – and we had no evidence that this was actually happening, right? Did we have an epidemic of people spitting on police officers? Was this constantly happening? Was there any data to support this supposedly scientifically necessary public health order? It in fact could have been done under the existing laws.

Now, the constitutional arguments can indeed be made to the judiciary. I understand, and you may ask yourself why an MLA or the general public would be concerned with something so arcane as legal separation of powers; is this just a formalistic technicality? I want to say, in the next couple of minutes before my time is up, why it's important.

You have to vote yea or nay on a bill, unless it's a voice vote, and that forms a record to which you're all held to account in the next election. How you voted on Bill 10 will be a ballot question for some residents, potentially. Maybe not, but it could be. That democratic accountability is impossible if a new legal power is created behind closed doors by a cabinet minister.

Secondly, requiring new legal powers to be authorized by the Legislature is an extremely important, practical, democratic public interest function. The business of your Legislative Assembly may not be watched closely by a majority of your constituents, but that business, that legislative debate, each day that it takes place, does focus the attention of provincial and sometimes national press galleries, and it can create a momentum, I'd say a democratic momentum, which permits a public consensus to develop through daily news and hourly broadcasts and social media. Question period can become dominated by the subject of the legislation, and that's what happened two months ago with the New Brunswick Premier announcing that his government would drop its Bill 49 from the Order Paper after the public outcry over some of the overreaching laws.

This kind of result is a good democratic moment, and a government gets a second chance to bring a new bill towards the Legislature, but if we put it in the hands of what happens behind closed doors, by way of order in council, it can be political euthanasia. It means that there's nobody to protect the government from itself. There's nobody to protect the people's liberties and to protect you, government MLAs, from being held accountable by your constituents for something that you never even voted for.

For opposition MLAs, of course, you're never even given the opportunity to do your job to slow down government or go on the record opposing government action. So the function . . .

The Chair: Thank you, Mr. Bryant. I hesitate to interrupt you. That concludes the portion of the presentation time allotted.

Mr. Bryant: Thank you. Sorry.

The Chair: No. Don't apologize at all. We're grateful that you're here.

The first member who caught my eye with regard to a question for you is Member Reid.

Mr. Reid: Thank you, Chair, and thank you, Mr. Bryant, for your presentation and your time today. I very much appreciate it. I want to refer back to the June 2020 report that you released entitled Canadian Rights during COVID-19. In the report you ranked Canada's emergency measures based on the following principles: rationality, necessity, proportionality, and time-limitedness. Moving beyond the COVID-19 context and, as you certainly emphasized, the reality that science changes – and we all know from early in the pandemic this year that things were very fluid. Based on your suggestions, how can you make some specific suggestions to the committee on how Alberta's Public Health Act could be updated to ensure that these tests are met while still ensuring that the government has the tools that it needs to respond to unknown future pandemics?

Mr. Bryant: Thank you for the question. The rational connection and the need for necessity and proportionality: really, the necessity and proportionality are the key aspects to it. That's the constitutional test: is it really necessary to have this new law to restrict this person's liberty, and are you restricting it basically as little as possible or in a reasonable fashion? I mean, I think that every time a public health law is limiting an individual's liberty, you know, by way of quarantine or requiring that they have to do something that maybe they don't want to do, then that's the test that legislators have to ask themselves each time for each of these legislative provisions. If you delegate the power to create new powers to a minister, there's no way to hold them to that necessity and proportionality test, and the only way for it to be checked is through the courts.

The problem with that safety valve, as we heard from Mr. Cohen, is that, unfortunately, right now Canada is not built for that. We are not built to permit the kind of judicial review of democratic laws and regulations that takes place in some other jurisdictions like the United States and Israel. You know, in Israel the government passed a law that the equivalent of CCLA thought was unconstitutional. Two days after it passed, they were in front of the supreme court. Two weeks later they were in front of the highest court in the land, and they got a result within a month. Mr. Cohen brings an application, and we'll be lucky if we get a hearing on the matter in 2020, let alone have it appealed through the system in time for it to have a real impact. That means that the Legislature really is playing a critical role in limiting the powers of a government and that we can't just rely on the judiciary to fix a mistake. It's too important, because it's our liberties and freedoms, to delegate that power to a cabinet minister.

Our recommendation, the key recommendation we'd make, is that these Henry VIII clauses, this ability to create new powers that are not prescribed – I mean, you can prescribe areas in which a minister may create a public health law and set out the parameters. You know, maybe you have one in there that says that they can make laws with respect to people getting tested against their will if they spit on a police officer, but you put that in the bill.

You don't let the cabinet minister make it up because, whether we like it or not, governments need to work with the laws they've got, not the laws that they want. You're going to hear this, I think, from the public health experts. They're going to say that the laws are based on what's in the rear-view mirror, but we've got to deal with what we have right now. To that I'd say: "Yeah; but you've got to do it consistent with the laws you've got right now because otherwise you're actually doing more harm than good because you're violating the Constitution. I bet you can do what you need to do with the existing laws. It just may take an extra day to make sure that you get it right and that you have the tests in place." It's just harder to do it consistent with the law. It doesn't mean that they don't have the tools they need to do it.

10:20

The Chair: Thank you, Mr. Bryant.

I see Member Renaud.

Ms Renaud: Thank you, Mr. Chair, and thank you, Mr. Bryant, for appearing today and for the work of the Canadian Civil Liberties Association. Given your role as executive director and general counsel at CCLA and your previous roles as Attorney General and minister of aboriginal affairs in Ontario, I'd like to make use of your government expertise to help inform our work. You've spoken publicly at some length about the role of the AG in the context of this pandemic. The CCLA has described them as "superintendents of the rule of law in their respective jurisdiction."

I'd like to ask you about Bill 10 in Alberta, which we believe, obviously, to be unconstitutional on a number of fronts; for example, violating section 92 of the Constitution Act, which expressly invests power in the provincial Legislature to enact laws and not ministers by ministerial order. Obviously, we also have constitutional concerns with respect to the Charter. With respect to the role of the Attorney General, which was Minister Schweitzer, now Minister Madu, and Bill 10, can you shed some light on the role that the Attorney General's agents should be playing in terms of oversight to ensure that legislation emanating from another ministry, in this case Health, and the Public Health Act is constitutionally sound and that the rights of Albertans are protected?

Mr. Bryant: Thank you for the question. I think that the agents of the Attorney – I would expect that they would be embedded in the Ministry of Health. They would be ministry of Attorney General employees, but they would be in the Ministry of Health, and they would be agents of the Attorney. Therefore, they would have quasi-judicial powers to give advice to policy-makers and to decision-makers in the ministry, even before it gets to the politicians, even before it gets to the deputy minister or assistant deputy minister, to outline where the risks are and what the problem is.

If, on the other hand, you don't have those people involved in the process and instead it's primarily – and I don't say that this is something that's necessarily evil; I just say that this is something that happens. Certainly, it happened when I was in government. If you've got political staff working with policy staff and there's nobody there from the ministry of the Attorney General, there's no one there to protect the government from itself, and there's no one there to say: you know, this might be offside the Constitution. If it's offside the Constitution, then not only do you have to look at what the public health impact is going to be, but you have to look at how this is going to harm somebody's freedom or liberty or equality or privacy. If you don't have those people there and participating in that process, then you don't get that constitutional assistance, if you like.

Similarly, it requires a democratic and political effort by the Attorney General him or herself. That means sometimes that the minister will come up to the Attorney and say, "Your lawyers are telling me this, and your lawyers are telling me that." Then the

minister has to be a good advocate and explain to the cabinet minister: "Look, this is why we need to do it. We don't want to in fact create a power that will embarrass the government. We don't want to create a power that's going to harm your constituents. We could do it in this way, and that way it won't be unconstitutional."

Similarly, the minister has to stand up in a cabinet meeting – and I mean that figuratively, not literally – and say: "Look, I have to stand aside from cabinet and give you this advice, that you're at risk of violating the Constitution. Here's why, and here's why it matters." And if need be, the minister has to do something in public to signal that there's – the minister doesn't come out and resign and do a Jody Wilson-Raybould. The minister can communicate in a way that makes it clear that this deserves some attention from everybody. That's a difficult line to hold, but it's one that some Attorneys General have been able to do. Whether I was or not – I don't know – I'll leave for others to decide.

If the Attorney General instead decides to not fulfill their quasi-judicial role and say, "Look, I want to be the minister of – whatever – Finance one day; I'm just going to politically go along with what the government is doing," they're not doing their job, and the Legislature is undermined, and the system is undermined. You know, it's left to the civil servants and to the Attorney General officials to have their say, but if the AG's not backing them up, then it's really no good. It's a difficult job, but it's a great job, and any MLA is honoured to have it. That's the role that they're supposed to play in all this.

The Chair: Thank you.

Related supplemental?

Ms Renaud: Yes, please. Thank you. Thank you for that.

In addition, while all cabinet is ultimately responsible for government legislation, here in Alberta the Attorney General is also the chair of the Legislative Review Committee of cabinet, so he would have had an additional role in signing off on Bill 10 before it went to the Legislature. Given what we know about this legislation, do you see a failure of the AG to safeguard the rights of Albertans and to protect democratic traditions?

Mr. Bryant: Well, you know, I guess it turns on – let's put it this way. The Attorney General may have come out in public and made an excellent case as to why it was a constitutional law and engaged in that advocacy in the Legislature and in the media. I didn't see or hear that. That may be my failure, not the Attorney's.

But in the absence of that, the silence is really quite an omission, and the failure to explain to everybody, the opposition and the general public, why something that we've been characterizing as a Henry VIII clause, in fact, is not something that belongs to the history of despotism but is a necessary public health law for the following reasons – I think the Attorney would be hard pressed to make that case, but at least they would make it. That's not what happened in this case. Because of the rush, there was a deficit of wisdom necessarily and a deficit of time that could be allocated to it. As a result of that, it happened like that, and I suspect that it was entirely cobbled together. You know, obviously, you're getting a chance to take a second look at it now, but the harm that was done was done.

Amongst other things, the Attorney has to, I think, ensure that the government is behaving in a constitutional fashion because that's the role that the Attorney plays. That's their main job, and if they're not doing it, then it doesn't get done. There's no one else in the government who can do it. I guess that will be an ongoing debate over the course of the history of this government.

The Chair: I see Member Lovely.

I would also just make sure, for the benefit of all members, that we do try to keep to the mandate of the committee. That last question and answer went a little bit beyond, I believe, simply reviewing the sections of the Public Health Act.

Member Lovely, if you could please continue.

Ms Lovely: Well, thank you, Mr. Chair, and thank you, Mr. Bryant, for your presentation. Now, you know, I do want to remind everybody that we found ourselves in unprecedented times, in unpredictability during this pandemic. The world didn't know what we were dealing with, and I think that's something that we need to note, something that's important. In the event that the Legislative Assembly cannot meet physically due to a pandemic, what are your expectations for the passing of legislation or legislative amendments? Further to that, what if MLAs and legislative staff are personally impacted by the threat and unable to participate either in person or electronically?

Mr. Bryant: Yeah. No. I think that this experience is going to require some changes to your parliamentary rules of order, is going to require some changes to the relevant statutes and regulations impacting legislative procedure and that the Speaker is going to have to address how the Legislative Assembly functions during an emergency, with a premium placed upon the participation of Members of the Legislative Assembly rather than a premium being placed on the presence of all staff being made available. It's more important that democracy takes place and that it takes place as best it can with the circumstances that it's in and that you create some flexibility in the rules that err on the side of permitting debate and transparency and accountability as opposed to ensuring that, for example, people be in their seats in the Legislature. The point is that it is the voice and the vote, the scrutiny and the participation rather than the process surrounding all of that.

I hope that addresses your question.

10:30

The Chair: Thank you.

Any supplemental? I see Member Renaud.

Ms Renaud: Thank you, Mr. Chair. Like many provinces the government of Alberta issued a number of public health orders and public health guidance to help combat the transmission of COVID here in Alberta. On the basis of these orders and guidance the Alberta Energy Regulator, a Crown agency responsible for regulating the energy sector, suspended the bulk of the environmental monitoring requirements for industry. The agency's rationale is that they had to comply with public health orders on physical distancing and travel restrictions. Government ministers have maintained that they have no role or decision rights on the decision to suspend monitoring.

Mr. Rowswell: Point of order.

The Chair: A point of order has been called.

Mr. Rowswell: I just think we're straying away from the mandate of this act, and – under 23(b). Like, we're not reviewing government actions here. We're reviewing the act and the powers that are contained within it. I think we should stick to that.

The Chair: Member Nielsen.

Mr. Nielsen: Yeah. This is not a point of order. I think context sometimes is everything. In order to have the presenter answer the question fully, there has to be a little bit of context here. I think we're jumping the gun here a little bit.

The Chair: At this stage I would find that there is not a point of order. That said, I would ask that the hon. Member Renaud please, with regard to creating context, move to the crux of your question regarding the Public Health Act.

Ms Renaud: Absolutely. Thank you.

I'd like to ask you about the role of the Attorney General here and as it relates to the Public Health Act. We have First Nations who appealed this decision, saying that constitutional treaty rights were violated because they weren't consulted on the environmental suspensions. Now, the Chief Scientist of Alberta wasn't consulted. The representatives of the scientists who do the monitoring, namely the Alberta Society of Professional Biologists . . .

Ms Rosin: Point of order.

The Chair: A point of order has been called.

Ms Rosin: We're here to discuss the legislation that is within the Public Health Act, not legislation or decisions related to the Alberta Energy Regulator or to decisions or court challenges that have been filed with regard to other legislation or environmental policy.

The Chair: Are there any members of the opposition?

Mr. Nielsen: Well, assuming this was probably, maybe under Standing Order 23(b), since it wasn't stated, again it's not a point of order. Member Renaud needs to form that point of context in order to ask the questions. Some patience must be exercised by members opposite.

The Chair: It was my understanding that this was under 23(b), so thank you for pointing that out.

Similar to my previous ruling on a point of order that was related to this one, I would say that we are getting closer to a situation where perhaps the question is causing disorder. The goal of this committee is, obviously, to expeditiously ask questions, given timelines, the strict timelines that we have. If the hon. member could please continue, but, please, if you could relate it to the Public Health Act specifically as that's the mandate of our committee.

Ms Renaud: Well, thank you, Mr. Chair. I appreciate the patience. I think that not all questions are as clear as, for example, you know, giving health information to law enforcement, so it's just going to take me a little time to get to the question. It certainly does relate to the work of this committee.

The question I have is: what happens when a Crown agency, during a pandemic, infringes on indigenous constitutional rights in a manner that is legally questionable, and what is the role of the AG to protect those rights?

Secondly, is there anything we can do in this legislation, in the Public Health Act, to ensure that government agencies don't use the cover of a public health emergency to issue their own orders that unduly infringe on civil and constitutional rights of the citizens of Alberta?

Mr. Bryant: The federal Attorney General of Canada does have a certification requirement to formally certify that government bills presented to the House of Commons are consistent with the Charter of Rights and Freedoms. You could require in your Public Health Act that where an emergency has been declared and it's in the context of an emergency that a Public Health Act power is being exercised, in those circumstances the Attorney General has to certify that he or she has reviewed, attest that they formally take the position that it's constitutional.

The legislation could also include that other legislative officers have been consulted. So has the Privacy Commissioner been consulted? Has the chief medical officer been consulted? Has the Human Rights Commission been consulted? And so on. You know, it doesn't necessarily require their attestation, but it at least requires a positive obligation on the government to consult with these offices.

You know, it could include some reference to indigenous rights, but I believe that if you made the requirement for the Attorney General to attest as to its consistency with the Charter of Rights and Freedoms and, I should say, the Constitution Act of 1982, because section 35 is outside of the Charter of Rights, then you, if nothing else, force a bit of a process around that so that for every bill you at least have ministry officials doing due diligence to try and make that assessment, and you do have the accountability of the Attorney General standing up and saying, "Yes, this is constitutionally kosher," and if it turns out not to be constitutionally kosher, there is some democratic accountability in that.

The Chair: Thank you.

Mr. Rowswell: Do you believe that the state of public health emergency should be continued as long as it's necessary, for example, till the end of the COVID-19 pandemic, with all the authorities, or is it more appropriate for the government to end the state of public emergency and use a more limited set of powers for a continued response when the full state of the public health emergency authorities are no longer required?

Mr. Bryant: The latter is my short answer. It's a very interesting question that Alberta did address, Alberta being the first to come out and say: we're actually not in an emergency anymore. Our organization was supportive of that because we can't have – you know, our argument is obviously to protect the liberties and freedoms of people, and if we're in an emergency, we understand that the limitations on liberty may be necessary and proportionate. But if we're no longer in an emergency but just in a new normal or a twilight zone of an emergency, if, in fact, it's not in an emergency situation, then those limitations ought not apply.

I think that this is going to be – and particularly in circumstances where emergency management was decentralized across Canada, you do have the ability for different provinces to say, "We're now in an emergency; no, we're no longer in an emergency," and other provinces can conduct themselves and govern themselves accordingly. I think, in the way that you described it, that it was the latter, not former, that we would be supportive of because I think it's more honest.

The Chair: Any members looking – I see Member Renaud.

Ms Renaud: Thank you, Mr. Chair. I would like to come back to Bill 10. As you're likely aware, the legislation was rammed through the Legislature in short order. I think it was 48 hours. As the Official Opposition we tried our best to amend it and make it constitutional, or at least tried to, but I must admit that it was difficult to consult with experts, as my colleagues have said, to draft amendments during a pandemic, when the Legislature was moving at lightning speed. After the legislation passed in record time, the only recourse in Alberta was the courts, and this brings me to the problem of the administration of justice during a pandemic. To challenge Bill 10, you need to consult with legal counsel, as I said, draft a legal challenge, find a judge, et cetera.

So my question is this: is there anything, in your view, that this committee should be looking at in terms of the pandemic, public health, emergency orders, and the administration of justice, something, for

example, that codifies in legislation that some courts must be open so that citizens can challenge the government if they bring in draconian laws that limit civil liberties? Obviously, the first speaker talked a lot about the need to properly fund the courts – that certainly is another issue – or some mechanism that ensures that there continues to be reasonable access to the courts.

10:40

Mr. Bryant: Yes. The changes to the Judicature Act, legal changes to the administration of justice, need to clarify the bare minimums because constitutionally there's no question that the courts have to be open to the public in some fashion. Also, it should be said that Alberta was an outlier compared to the other provinces in terms of the availability of its superior court. Other provinces were able to make their superior courts available for hearings. It had to be emergencies, and you had to bring a motion and prove to the court that it was an emergency. It might take 20 minutes. In most cases it was usually pretty obvious.

In Alberta, unlike B.C. and other provinces, everything was shut down, and there was no way, like, literally no functional way, no place to call, nobody to call to get a court open in circumstances where constitutionally, for example, the constitutional right to habeas corpus could not be exercised. You know, this is a fundamental freedom that one is able to walk into any court at any time that a court is open and get that order heard. There was no court to go to. There has to be some court made available 24/7, and I mean 24/7 during an emergency. In the same way as there's greater pressure on our hospitals and our health care system, we need to have, in turn, an administration of justice system that can respond to the emergency as it is. Instead, what happened is that it just shut down.

The Chair: Thank you. And a follow-up?

Ms Renaud: No. No follow-up.

The Chair: The next member who caught my eye is Member Turton.

Mr. Turton: Yes. Thank you, Mr. Chair, and thank you, Mr. Bryant, for coming here today. In my understanding the declaration of a state of public health emergency works more like a light switch rather than a dimmer. By that I mean that once a state of public health emergency is declared, the full suite of emergency powers becomes available. In your view do you think that introducing parameters that create stages or levels of severity would be appropriate, and if you do think it is appropriate, can you give any suggestions of how those parameters could be put in place and civil liberties protected?

Mr. Bryant: Yeah. I think that the short answer is yes. You know, all we can do is base it on the experience that we've had now with recent history: SARS but, obviously, also Ebola and, most importantly, in COVID. There were different stages, and there were different stages of emergency, and I believe that from a public health perspective there's always a desire to have a little more leeway and flexibility to adapt to the situation. From a civil liberties perspective there's a desire to restrict that as much as possible, so it is a light switch, but there could be a few light switches for a few lights. There could be a full emergency, there could be partial, and so on. It could be staged, or it could be that you have a stage 1 emergency or a stage 4 emergency.

What that would look like exactly is not something – I wish I could answer in brief, but I couldn't other than to say that as the emergency increases, it does increase the necessity of limiting the individual civil liberties, but it doesn't change the proportionality. It always ought to be the case that a government is trying to limit the freedoms as little as possible, but it also creates a circumstance where the government can say, "Well, this is something that requires our immediate attention," but in fact, you know, it may be that at any given time more people are dying from fentanyl overdoses than from COVID, and you don't want to shut the entire province down because of fentanyl overdoses, but you do want to create some particular powers that allow the government to respond.

More flexibility is better, but proportionality and necessity always has to be the litmus test for each stage of the emergency.

The Chair: A follow-up?

Mr. Turton: Yes, thank you, Mr. Chair, and thank you for the answer, Mr. Bryant. I guess a supplementary question is: in your opinion, you know, with the light switch approach that the current Public Health Act is, how would you recommend flexibility be added to the ability of the chief medical officer when you're talking of different regions of the province, different levels of severity or health threat? You did mention that you agree with the idea that there should be different stages, but can you also describe any other jurisdictions that perhaps already have a system that Alberta should be emulating when it comes to that regard?

Mr. Bryant: I'll certainly undertake to e-mail the committee with my response. I'm sorry that I didn't show up with the answer to that question, but answer it, I will.

The Chair: Thank you, Mr. Bryant.

I see Member Renaud.

Ms Renaud: Thank you, Mr. Chair. It's been said by many that emergency legislation, even in the context of a pandemic, cannot empower a government in a way that is contrary to the Constitution or contrary to the Charter unless section 33 is invoked. However, in the case of Bill 10 the Official Opposition is virtually certain that the courts will find this legislation unconstitutional, and the organizations and legal scholars that we've consulted all seem to agree on this point. It's our view that during an emergency like a pandemic governments need to move quickly, but in return they have an obligation to the Legislature and through them to the public for proactive disclosure, and we know that that didn't happen with Bill 10.

So, much like the first speaker, I would like to get your take on whether we should insert into the Public Health Act a requirement that all legislation, regulations, and ministerial orders put forward by the government during a public health emergency be accompanied by a legal opinion on their constitutionality which is signed off by the AG.

The Chair: Mr. Bryant, if you could please be brief just given the time constraints.

Mr. Bryant: Yes, some version of that would be helpful. Similarly, you could establish something akin to a human rights tribunal, which responds to the human rights code. You could create a special judicial review court or tribunal that provided preliminary attention and was built into the system to consider matters in a timely fashion without all of the procedures that normally attend to a court proceeding.

The Chair: Thank you, Mr. Bryant. The presenter before, Mr. Cohen, graciously offered up an opportunity to provide written

response to a couple of questions. I believe I have a couple still on the list. I know that you already offered to do an undertaking for Member Turton's supplemental just a few seconds ago. Would you be amenable to providing written response to a couple last questions if they're read into the record?

Mr. Bryant: Of course.

The Chair: Then, first, I have Member Rosin.

Ms Rosin: Okay. Thank you. Section 29(2)(i) of the Public Health Act authorizes the medical officer of health to issue orders that prohibit a person from attending a location for a period of time and can also subject them to any conditions that the medical officer considers appropriate if the activity being engaged in could transmit the infectious agent. It also says that the medical officer of health can take, quote, unquote, whatever steps are necessary to lessen the impact of the public health emergency. As a national civil liberties organization, I'm wondering if you can comment on how these powers compare to other provinces and what legislative changes you think could be made to increase oversight on these decisions to ensure that civil liberties are protected.

The Chair: I believe that I have one last question from Member Renaud.

Ms Renaud: Thank you, Mr. Chair. Members of this committee obviously have questions for the Ministry of Justice and the AG that would be specific to Alberta, questions that could help us understand how we ought to balance issues of rights and freedoms in the Public Health Act versus reasonable requirements for government to take action and restrict the rights for public good. So two questions: first, do you think it's reasonable to bar the AG from appearing at this committee, and, second, in his place and given your experience as former AG, how would you address this issue of balance in legislation? Is this a matter of getting it right in the legislation or a matter exclusively for cabinet or a matter for the courts and a judicial review or a matter that should be decided at the ballot box?

Thank you.

The Chair: At this time, noting that the time for questions has now come to an end, I do want to thank you, Mr. Bryant. Your time is very appreciated, so thank you for accepting our invitation and joining us at our meeting today.

I will now call for a very brief recess of, say, five minutes, so if we could all meet back at 5 to 11, we will continue with the next presentation at that time.

Mr. Bryant: Thank you, Chair.

[The committee adjourned from 10:50 a.m. to 10:58 a.m.]

The Chair: Welcome back, everyone. I'm going to once again call this meeting to order.

Joining us now for our next presentation with regard to AHS, Alberta Health Services, we've got Dr. Laura McDougall, senior medical officer of health; Dr. Judy MacDonald, medical officer of health, Calgary; Dr. Kathryn Koliaska, medical officer of health, north; and joining us in the gallery is Lynne Navratil, director of environmental public health. If there are any questions for Dr. Navratil, she's welcome to answer questions at the podium.

If you would please proceed whenever you are ready. For the information of all those present, this is scheduled, administratively speaking, for 30 minutes for the presentation.

Alberta Health Services

Dr. McDougall: Great. Thank you very much. Thank you very much for having us. I'm Dr. Laura McDougall, as you mentioned, the senior medical officer of health for Alberta Health Services, and I'm joined today by two medical officers of health: Dr. Judy MacDonald, a provincial leader in the area of communicable disease control for more than 10 years, who practised on the front line in the Calgary zone for almost 20 years, and Dr. Kathryn Koliaska, on my right, the lead medical officer of health for the provincial environmental public health program, who practises on the front line in the more rural north zone.

We're grateful for the opportunity to highlight the essential services that public health workers in Alberta Health Services provide every day in ensuring the safety and health of our communities. We'll do our best to bring you a perspective of the Public Health Act from the workforce that applies it. I'll provide an overview of public health and how it is practised in AHS, how we apply measures under the act, and describe a few areas where, if the Public Health Act was modernized and amended, we could operate more efficiently and with greater impact on Albertans' health while balancing the need to protect individual responsibilities and liberties.

Medical officers of health and executive officers are appointed by the regional health authority, now Alberta Health Services, to carry out the act and its regulations. MOHs are trained to be physicians, and AHS requires that MOHs have specialist training and experience in public health. Under the act executive officers are required to be board certified by the Canadian Institute of Public Health Inspectors. Both MOHs and the other executive officers may receive direction from Alberta Health's chief medical officer of health in carrying out their responsibilities under the act and are monitored in this regard by the CMOH, although this is not a reporting relationship.

The communicable disease regulation permits an MOH to rely on community health nurses and executive officers when carrying out their duties. The senior medical officer of health within Alberta Health Services and the chief medical officer of health within Alberta Health work together closely. In the next session Dr. Hinshaw will speak more about the difference in roles between AH and AHS and will provide more background on the history of the Public Health Act. From an AHS perspective the senior medical officer of health, in collaboration with provincial and zone-based medical officers of health and teams, is responsible for co-ordinated delivery of public health services. Through a reporting relationship to the AHS vice-president and medical director and with accountabilities directly to the president and CEO, the senior medical officer of health ensures that AHS offers comprehensive public health supports to communities across Alberta and that prevention services are integrated across a full continuum of health care delivery.

As public health physicians and MOHs Drs. MacDonald and Koliaska and myself have obligations to communities of people as well as to individual patients. Just like our physician colleagues who practise in direct patient care settings, we use a variety of tools in our practice, reserving the most intrusive for the circumstances that truly require them. In much the same way that a cardiologist with an arsenal of drugs and procedures for treating heart disease will reserve the defibrillator for when all else has failed, we in public health reserve invoking enforcement authorities granted under the Public Health Act as a means of last resort. We pursue every other remedy to issues that involve a conflict between the health of the public and individual rights, and we only issue orders under the Public Health Act when a consequence of not doing so is

potentially dire and all other options for education, support, and voluntary compliance have been exhausted.

As public health practitioners we are also very aware that income is one of the strongest predictors of good health, so we do not want to get in the way of people earning a living. We only intervene if the way the business is operated presents a significant risk to the public or an individual infected with a communicable disease. We are also very well aware that the long-term success of all our programs and interventions is dependent on the public maintaining trust and confidence in our motives and approaches and that more coercive measures to prevent inconsequential dangers can be highly counterproductive.

The greatest advances in human health in the last century came from public health, estimated to have extended life expectancy in Canada by about 25 years while all other modern technologies added about five years. Yet it's often hard to point to public health successes in real time. Public health is a heart attack or stroke that never developed, is the outbreak of food-borne or water-borne illness that never occurred, and the infants who sleep on their backs and don't die of sudden infant death syndrome. Public health is a polyp that was detected and removed before it turned into colorectal cancer and the environmental disaster that was mitigated without widespread harms or destruction. It's the birthday that was celebrated that otherwise wouldn't have been and the Albertan who was able to build a family and advance in their career because they weren't exposed to hazards in their workplace or community and they weren't injured on the job or in a traffic collision on their way home.

11:05

How does public health achieve this, and where does the Public Health Act fit in? After the SARS pandemic in 2003, David Naylor's call for strengthening public health in Canada suggested that effective public health practice consists of numerous activities, most of which can be grouped into the six core functions shown here. In examining public health in the context of health system renewal, the Canadian Public Health Association recently noted that in general provinces and territories with more recently revised public health acts tend to address a broader range of these core public health functions while those with older legislation, such as Alberta, tend to be more limited in breadth.

Alberta's Public Health Act focuses almost exclusively on health protection and communicable disease prevention and control. Before we discuss how AHS goes about discharging our responsibilities in those areas, I'd like to point out the potential value of expanding the scope of the act in Alberta to include population health assessment, health promotion, and the prevention of injury and chronic conditions.

Much the way our colleagues who focus on direct patient care take a history from a patient, use a stethoscope, and order diagnostic tests, population health assessment serves as public health's ears and eyes, providing important information about the level of well-being in our communities and the factors that underlie good health or pose potential risks. Population health assessment allows us to ascertain the health and well-being of our communities, and then we work closely with the communities themselves so that we can focus on issues that matter most to them, and together we develop programs that improve their overall health. To help ensure that we have the robust population health assessment infrastructure we need to practise effectively, our Public Health Act could be amended to mandate these core public health functions, much the way they've been contemplated in B.C.'s Public Health Act.

Health promotion is the process of making it easier for people to increase control over and improve their health. Disease and injury prevention differ from health promotion because they focus on specific efforts aimed at reducing the development and severity of diseases and injury, often by addressing specific risk factors. Health equity is a lens brought to health promotion and disease prevention to help ensure that all Albertans have the opportunity to reach their full health potential and are not disadvantaged by social, economic, or environmental circumstances.

There's an abundance of evidence that investment in health promotion and prevention related to cancer, chronic diseases, and injuries prolongs life, improves quality of life, and saves money. Currently in Canada health system focus tends to be on acute illness and the demand for expensive treatment services, limiting resources available for health promotion and disease prevention. Health promotion is not dealt with at all in Alberta's Public Health Act, while disease and injury prevention is mostly limited to communicable disease control, missing, for example, cancer, chronic disease, and injury.

In 1907, when the Alberta Public Health Act was first written, it made sense for the focus to be on food safety, sanitation, and preventing infectious diseases since these were leading causes of illness and death at the time. But most of the diseases, injuries, and mental health conditions that are beginning to overwhelm our treatment system arise from a complex array of social and behavioural factors. These largely avoidable factors are costly to the health system. A recent estimation is that 22 per cent of treatment costs in Alberta are linked to smoking, physical inactivity, alcohol, and eating habits, and a further 15 per cent of Alberta's annual health system costs are related to social inequities. Ontario and British Columbia have expanded the scope of their public health acts to deal with these priorities.

Specifically addressing cancer, chronic diseases, and injury in the Alberta Public Health Act and providing for the articulation of standards would better position Alberta Health and Alberta Health Services to face current and future challenges. As Canada's most fully integrated health system, with public health embedded alongside treatment services, AHS is well positioned to join high-performing health systems around the world that put a premium on prevention. Within a supportive framework Alberta Health Services can embed prevention and health promotion into the tens of thousands of daily patient and family encounters and work with local partners to improve health outcomes for the whole community. The result would be a more sustainable health care system for generations to come, with no one left behind.

The act could also be amended to have mechanisms to enable the ability to act on conditions or activities that have cumulative effects over time and clear evidence of causing significant chronic disease. An example is the consumption of trans fats, that the Heart and Stroke Foundation of Canada estimated being responsible for 3,000 cardiac deaths in Canada each year. By 2008 the Calgary health region had reduced the consumption of trans fats by restricting their use in food service establishments as a condition of permits. British Columbia used their Public Health Act to restrict trans fats in 2009, but implementation across Alberta did not occur until federal restrictions came into effect recently by Health Canada. Ultimately, Alberta banned trans fats from food service establishments. Alberta has similarly controlled access by youth to artificial tanning salons.

However, it is likely that these public health achievements could have been more efficiently achieved had there been appropriate measures in Alberta's Public Health Act. With the ability to address conditions that contribute to chronic conditions over the long term and that tend to affect disadvantaged groups disproportionately, public health could have more impact on issues such as the sale of food and beverages in school settings, for example.

Health in all policies is an important concept related to prevention and health promotion. It recognizes that a healthy province is the

foundation for a thriving economy and the innovation essential for Alberta's future, and it acknowledges that only about 20 per cent of what makes us healthy is related to treatment services. In 2002 Quebec integrated health in all policies into their Public Health Act thereby introducing an approach to policy-making that systematically considers the health implications of all government decisions. Incorporating something similar in Alberta's Public Health Act would help to ensure we're not missing opportunities to create the conditions for every Albertan to live healthier, longer, and more productive lives.

As mentioned earlier, most of Alberta Health Services' current activity under the Public Health Act is related to the core function of health protection. Health protection includes actions to ensure the safety and quality of our water, air, and food and the general environment; a regulatory framework to control communicable diseases; and the management of outbreaks and other incidents that threaten the public health. This work is important. As many of you know, Walkerton, Ontario had a contaminated municipal water supply problem in 2000, that resulted in seven deaths and more than 2,000 illnesses. While this is now 20 years ago, it still serves as an important warning of what can happen without appropriate regulatory control. A major contributor was the reliance on voluntary guidelines rather than binding regulations specific to water quality. The Alberta Public Health Act needs to retain regulations in such areas to avoid significant public health risks to Albertans and attendant risk to provincial reputation and the ability to attract new investment.

For both public health inspectors and notifiable disease practitioners the work can be loosely categorized into proactive and reactive. In accordance with the regulations under the act, AHS inspectors routinely inspect public facilities, including restaurants, daycares, personal service establishments, and outdoor venues such as recreational water. Inspection activities take into consideration recommendations from fatality reviews where the opportunity for prevention was identified and recommendations made to change practices. By identifying hazards and supporting owners and operators in implementing controls, the public can enjoy these services without concerns for safety.

There is a provincial risk framework that determines which businesses are inspected and how often. Out of the approximately 83,000 inspections last year just over half were proactive inspections. For example, new restaurants are inspected prior to opening. The remainder of the inspections are conducted in response to a concern such as in follow-up to a previously noted issue or a request from a member of the public.

11:15

In all cases inspectors operate from the principles of least infringement, ensuring their responses balance the good that can be achieved against the harm that can be caused. If they identify infractions, the first step is almost always education and offering support to help people mitigate risk. For instance, public health inspectors want to ensure that foods distributed to the public are protected from contamination and handled safely, and they also want to see businesses succeed. A food-borne outbreak tied to a food establishment can destroy that business. There are situations when compulsory measures are the only reasonable option, and during 2019-20 the inspectors issued 594 orders for an average of seven per 100 inspections.

Legal enforcement actions in environmental public health are few and far between and always the last resort. There were a total of 53 in 2019-20, or 0.06 per cent of inspections; 16 were Public Health Appeal Board hearings regarding appeals of executive officers' orders. These hearings are an opportunity for AHS to work with the appellant to come to a resolution that is helpful to both parties. None of the executive officers' orders in the last two years have been overturned in full, but some have been varied; for instance, to clarify wording or change timelines.

There were 18 Court of Queen Bench civil matters in the most recent year. These related to situations where AHS was seeking a court order to enforce an executive officer's order or to gain access to a property in order to conduct an inspection. As an indication that AHS does not pursue frivolous matters, AHS has had a very high success rate with civil court applications brought under the Public Health Act. In most circumstances the matter proceeded by way of consent, and in the rare situations where they did not, AHS was able to obtain an order from the court enabling the environmental public health team to perform their functions under the act.

For example, during a cold snap in late 2019 the owner of an apartment complex turned off the heat to the entire building in response to a conflict it was having with the tenants. Steps were taken by AHS to try and persuade the owner into turning the heat back on, but none were successful. An executive officer's order was issued, but the heat was not turned on. AHS proceeded to the Court of Queen's Bench and secured an order requiring the owner to comply with the executive officer's order on an urgent basis.

Separate from civil matters there can be prosecutions under the Public Health Act. AHS rarely proceeds to prosecutions, with only 19 pursued last year. The vast majority of cases yield a guilty plea based on an agreed statement of fact.

Though not specifically mentioned under the Public Health Act, immunization is an important part of the work we do to protect individuals and populations from vaccine-preventable diseases. Alberta's immunization programs have been a public health responsibility for decades, including infants, preschool, and school-aged children in particular. Vaccine-preventable diseases are still with us globally and in Alberta, and measles is a good example. Measles was declared eliminated in the Americas by 2002 due to extensive immunization programs. However, due to rapidly decreasing immunization rates, we have seen a resurgence of this potentially deadly and highly contagious illness both within North America and our own province, with large outbreaks in Alberta in 2013 and 2014.

With respect to communicable disease control responsibilities under the act our work almost always begins with a report from a lab or a health care provider about a confirmed or suspect case of a notifiable disease. The subsequent investigation by public health seeks to identify the likely source of infection and whether there has been any risk to others. It also identifies whether the reported case presents an ongoing risk of disease transmission, usually because of occupation or contact with other persons such as in food establishments, health care settings, and daycares. The MOH may take restrictive action under the Public Health Act such as issuing temporary exclusion orders to reduce these risks.

Exclusion orders require an individual to not work or attend daycare until their symptoms have resolved for at least 48 hours or they test negative for the infectious agent, depending on the agent. In 2019 approximately 145 exclusion orders were issued, primarily related to gastrointestinal infections that are easily spread by fecal-oral transmission.

For other diseases such as tuberculosis TB services routinely assess, diagnose, and treat affected individuals for their benefit and also to protect the public. There were 130 cases in 2018 and 147 in 2019. In a world with strains of extremely drug-resistant tuberculosis the risk to the public of allowing transmission is prohibitively high, yet only twice in each of these years was the authority of the MOH, under the Public Health Act, required to apprehend, detain, and treat infectious individuals. In fact, the use

of authorities given to MOHs by the Public Health Act has declined substantially over the past decade due to successful efforts by TB services through outreach and flexibility to engage individuals where they're at.

The Public Health Act could be updated to maximize its potential to improve the health of the public. AHS is considering specific recommendations within the general themes or categories of modernization, environmental public health, information sharing, and communicable disease control. Albertans have changed the way we live and do business since the act was last updated. For example, methods of communication and socialization have changed. Online sites provide ways for people to get together without divulging their identities. This impacts communicable disease control.

The work of environmental public health executive officers and the potential technologies available to them have also progressed since the act was last revised. Confidentiality is a top priority within AHS, and privacy can be safeguarded while looking at ways to improve our collaboration with trusted partners. Information sharing between trusted partners would enable us to respond more efficiently and effectively, particularly when carrying out contact tracing. We can ensure that individuals' privacy rights remain protected by having appropriate safeguards in place.

Revisions could be made to the sections on communicable disease control to further support efficient, effective, timely, and respectful responses.

As discussed above, our final recommendations pertain to broadening the scope of the act to reflect modern-day public health challenges that centre more on chronic diseases, an aging population, and the recognition that creating the conditions for health requires close collaboration between many sectors and departments.

Alberta is a leader in business and economic innovation, and this leadership has made Alberta resilient when faced with significant global economic shifts and downturns as well as health challenges such as the current pandemic. At its core this resilience depends on a workforce and a population that is healthy, safe, and productive. At the same time the act needs to retain the special authorities given to the medical officers of health and executive officers, which are used judiciously to ensure the health of the population is protected against the threats of existing as well as new and emerging infectious diseases of the future. Modernizing the Alberta Public Health Act will help keep Albertans healthy throughout their lifespan, which is the best guarantee we have for continued resilience in the face of the rapid changes that are occurring in our economy and society.

Thank you.

The Chair: Thank you, Dr. McDougall.

I am now taking the opportunity to open it up to questions. The first individual, however, who caught my eye was Member Turton.

Mr. Turton: Yes. Thank you, Mr. Chair. Thank you very much, Dr. McDougall, for coming here today. I have two questions here that I'd like to ask. I guess my number one question I would like to ask is: do you support mandatory vaccination?

Dr. McDougall: Thank you for the question. As public health practitioners and people who've worked in public health for many years, we know that the evidence definitely suggests that immunization is one of the best investments for protecting the health of the population. We are absolutely convinced of the value of immunizations for, again, that protection. But just as we manage every other public health issue, our approach really is in working with groups in informing, in educating, in sharing our evidence and our experience, and in the case of immunization, again, allowing the people and groups to make their own decisions on this front.

11:25

Again, the issue around the policy of immunization and whether it's mandated or not clearly isn't an Alberta Health Services issue. That's a decision for Alberta Health. What we would do as experts within Alberta Health Services would be, really, just to share our experience and the evidence.

Mr. Turton: Yeah. I guess that my supplemental question also has to do with civil liberties. For example, section 59 of the act allows AHS inspectors to inspect any public place at any reasonable time. That makes some sense to me if we are talking about some businesses like restaurants, for example. However, I understand that the act defines a public place as someone's home if the person rents their home as opposed to owning it. Why is someone's private home considered a public place simply because they are a renter as opposed to an owner? If someone does not want AHS to enter their private home, why should AHS be allowed to enter the home against the wishes of the people living there?

The Chair: Thank you, hon. member.

I would also take this opportunity to remind members again that supplemental questions should, hopefully, be at least tangentially related to the initial question.

If the hon. doctor could please continue.

Dr. McDougall: All right. Thank you very much. I think I'll pass this question to Dr. Koliaska as it applies very closely to environmental public health practice.

Dr. Koliaska: Thank you for your question relating to the definition of the public place in the act. It does include the accommodation facilities, including all rental accommodations. The concern really is that if there is a concern that arises in a rental accommodation facility, the executive officer may inspect the public place for the purpose of determining the presence of a nuisance.

We find most specifically in environmental public health that the vast majority of the inspections are actually inspections requested by either the tenants themselves – in some cases these are maybe not the tenants themselves but maybe a neighbour or someone because sometimes the tenants aren't able to ask for themselves, remembering that, one, if you're living in a rental accommodation, you may not be able to fix some of the problems in the rental accommodation. It isn't your responsibility; it's the owner's responsibility to fix those.

The other situations that we've run into – and there have been many, many, many stories about how when the inspector goes out, they discover that the tenants are having difficulties with an infestation of either rodents or cockroaches or other pests. That may be a bigger issue than just the rental accommodations themselves.

There are examples, as well, where the tenants have required additional assistance. One example that comes to mind is an elderly individual. There were some horrible odours coming from the apartment unit, and that particular tenant had not requested an inspection, but the neighbouring units had. Then when the inspector did go in to inspect, it was actually a relatively elderly individual who needed an additional level of care, so then our inspectors were able to work with the other stakeholders and the other parties to actually assist beyond the initial inspection.

Keeping in mind, too, that when the inspectors are involved in these types of inspections and approaches, professionalism is very

much a part of what environmental health inspectors are trained to do, and Alberta Health Services values uphold as well that making sure whenever possible, unless there's an absolute urgent issue or there's some other reason, usually those inspections are conducted with notice and the prior consent and awareness of that tenant.

Just to finally close on this answer, we had a prominent case recently where the plaintiffs were effectively denying access to environmental public health to inspect some of their rental properties. The Court of Queen's Bench in Alberta gave AHS access to the property in this particular example for the purpose of the inspection despite the allegations by the plaintiffs challenging AHS's earlier inspections. The matter was actually examined by the courts and went all the way to the Court of Appeal, where the judgments were issued against the plaintiffs, not AHS. So there definitely is an oversight mechanism as well that was exercised in that one example, which is a rare example, but it does again illustrate kind of the small slice of the enforcement part that came after all of the other education and collaboration mechanisms were exhausted.

The Chair: Thank you, Dr. Koliaska.

I should have mentioned at the outset that the microphones are operated by *Hansard*, so there's no need to manually deal with them or anything along those lines.

Thank you again for the answer.

The next member who caught my eye was Member Hoffman.

Ms Hoffman: Thanks very much, and thank you for joining us here today. As we conduct our review of the Public Health Act and suggest possible amendments to the legislation, there are a few topics that I'd like to expose or, rather, probe a little bit with you today if possible. The first is AHS's role in a pandemic in general, specifically as it relates to responsibilities and operational decision-making and authorities, as well as AHS's role with respect to schools. This fall, of course, it's top of mind, but really in any public health crisis or during any pandemic I think we need to make sure we have legislation that supports us in having the best framework.

I'd like to take you back to what was the largest outbreak to date, and that was, of course, around the meat-packing plants and specifically Cargill and JBS. We saw 1,400 workers infected, and ultimately three deaths have been linked to that outbreak. We know that workers raised questions and concerns about the protocols, so I'm hoping that today you can share with us the roles and responsibilities of various parties in this tragedy. Let's start with AHS. What's the role of the medical officer of health on the ground, how did they report through the medical director for central and southern Alberta, and was AHS or the AHS CEO or other senior-level leadership involved in the decision to keep the plants open? Where were . . .

Ms Rosin: Point of order.

The Chair: A point of order has been called.

Ms Rosin: Well, I think I can see where Member Hoffman is going with this question. I would just ask that her question pertain specifically, I think, to the Public Health Act and not how the CEO or the medical officer of health may have reacted to the COVID-19 crisis. Just to reinforce, I guess, under 23(b) for relevance that we are here today to address the act itself and not the government or the CEO of Cargill or anyone else's response to COVID-19.

The Chair: Member Renaud.

Ms Renaud: Thank you, Mr. Chair. I don't believe this is a point of order. I think these are really complex issues with a lot of levels of bureaucracy and involvement. Just like the previous block, I think it takes a little bit of time to get into that and then to get to the question so that we can understand going forward what is the best advice to make changes to the Public Health Act. So I don't see this as a point of order.

The Chair: I would like to take this opportunity to just remind all members that pursuant to Government Motion 23, which enacted this committee, the purpose of this committee is to strictly, specifically to use a better term, review the Public Health Act, not perhaps decisions that were made in one specific instance or another specific instance. It seems to me that the focus should be more with regard to the tools that are available under the Public Health Act, not necessarily during some given pandemic scenario or something else, some other public health issue, not how those tools are actually used.

We've had a little bit of a wide berth with regard to some of the questions, so at this stage I will not find a point of order on this matter; however, I would say that my thoughts with regard to relevance may change on further points of order, especially if it's shown that a relevance issue is leading towards disorder for the committee, which would in effect make it difficult for the committee to operate effectively.

So if the hon. member, likely, I'm guessing, would like to rehash the question in order to ensure that the doctors have an opportunity to answer specifically what you're looking for. That said, again, I would just remind the hon. member that this isn't a review of government action; this is a review of an act, specifically the Public Health Act.

Please continue.

Ms Hoffman: Thank you, Mr. Chair. As I tried to say in my opening, it's the act that governs the current public health crisis that we're in today, so my questions are absolutely about the tools and the reporting authority as they relate to the act.

The Chair: And potential future public health situations as well and past ones.

Ms Hoffman: Yeah, absolutely. So I think, personally, to make sure we have the best act and that we're giving the best recommendations to our colleagues through the Assembly, understanding the act as it relates to the situations we're in today: this is the crux of my question.

Maybe I'll reiterate the . . .

11:35

The Chair: Again, what I would say, though, is that I find it potentially troublesome for the effectiveness of this committee if we were go down individual circumstances; say, a specific store in a small town, right?

Ms Hoffman: Sure.

The Chair: So the idea of this committee, of course, is to deal with the Public Health Act itself, not necessarily how decisions were made by one government or previous governments or scenarios like that. It's what is potentially available to ensure the safety of our citizens of the province.

If you could please continue.

Ms Hoffman: Yeah. Thank you, Mr. Chair. I'm not even asking about government. My question is around the tools that are available to AHS as an agency, board, or commission in relation to the Public Health Act as it relates to pandemics in general. What's

the role of a medical officer on the ground as it relates to pandemics? What's the reporting relationship between the medical director and the public health officials on the ground? What's the relationship through the organizational chart? Who ultimately under the current legislation, as we're considering whether it is adequate or not, is responsible for decisions as they relate to specific sites, whatever they might be in the future, where there could potentially be an outbreak?

Dr. McDougall: Okay. I will try my best to break that down. I think some of what you're asking about pertains to Alberta Health Services structure and governance. I'm not sure that's as pertinent to the review of the act necessarily. But, again, the responsibility of the MOH under those circumstances is to, again, apply the act. You're asking about the relationship between the MOH and that decision-making and medical directors and others within Alberta Health Services. As you can see from the governance chart there, public health is connected very closely to the local on-site decision-making within each of our zones. We have a zone medical director and zone chief officer in each area. Again, our collaboration with those zone directors is very close, but the authorities under the act clearly rest with the MOH. The teamwork and the team that winds up coming together in order to take action connects back up to those systems within that local geography and then, of course, ends up reporting back up through the VP level and to the CEO.

The Chair: And a follow-up?

Ms Hoffman: Yeah. Thanks. Just to clarify. MOH: sometimes people say "Minister of Health." Sometimes they say "chief medical officer of health," CMOH. I just want to clarify, and I think it relates to this question around the interactions with the chief medical officer of health, the Minister of Health, their respective bodies, and AHS. I think the answer was around the chief medical officer of health, but I'd just like that clarification. What happens if there's advice that conflicts with what decisions are made?

Dr. McDougall: Got it. Thank you for that. Medical officers of health in Alberta Health Services. Again, we do connect closely with the chief medical officer of health in Alberta Health, and it is clear under the act and in practice that we are guided in our practice by the chief. We work very closely together. We have regular routine interactions as well as under any circumstances that require extra conversation or discussion. Certainly, under an outbreak situation we are guided by the chief medical officer of health in decision-making.

The Chair: Thank you.

Ms Lovely: First of all, Doctors, I'd like to thank you very much for joining us today. You have been under a tremendous amount of pressure and so much worry over the past several months dealing with a pandemic that is world-wide. No one knows exactly how to deal with this effectively, so I just want to thank you and to your teams. You know, my daughter is a nurse, and not a day goes by where I don't worry about her and the exposure for not only herself but her colleagues as well. Thank you so much for your work.

Now to my question. Under section 17(b) it states that government employees who are authorized by the minister may "enter and inspect any place under the jurisdiction of a regional health authority." Can you provide examples of what places or categories of places could be subject to this inspection?

Dr. McDougall: Absolutely. I think that section pertains specifically to inspections from the government of our facilities and our practices.

I'll hand over again to Dr. Koliaska to perhaps provide some examples in detail.

Dr. Koliaska: Yeah. Thank you. I would just expand a little bit on that. For example, 17(b) would outline the minister's and the government's authority to enter and inspect places under the regional health authority and could include AHS acute-care facilities, AHS-owned and -operated long-term care facilities as examples.

Ms Lovely: I do have a supplemental as well. Section 52.6(1)(a) to 52.6(1)(e) gives AHS the sweeping powers to conscript and enter property without warrant, among other things. Have these powers ever been used, and what kind of oversight exists to monitor the use of these powers if they are so exercised?

Dr. McDougall: Again, that's under the circumstances of states of public health emergencies. Again, in our principle and our practices, as Dr. Koliaska has pointed out, we use the least intrusive method under every circumstance that we possibly can. I'll turn it to Dr. Koliaska to think of any circumstance when those powers specifically have been invoked.

In this current circumstance I'm thinking about when we were looking through these current practices of how we could make sure that people who were requiring isolation supports would be able to have those if they were struggling with homelessness or other circumstances and needed spaces to be able to isolate safely. Again, the effort was undertaken to make sure that we worked proactively on ensuring that those spaces were created voluntarily and collaboratively with partners in the community to ensure that we didn't have to actually invoke those clauses.

Again, I can maybe turn it to Dr. Koliaska to think if there were any other circumstances when we have.

Dr. Koliaska: Thank you. We don't have any examples of where we've actually needed to use the act because the vast majority of the work that happens prior to using any of the enforcement and the legal mechanisms is all of the education and collaboration that Dr. McDougall has already outlined.

I would like to speak a little bit about the oversight mechanisms, though, as well. Specifically from a public health inspector point of view, certainly, the supports and practice support documents and resources are provided and generated by our teams based upon best evidence and based upon the policy guidance that is provided by Alberta Health. If there are any questions beyond the support and potential problems outlined beyond that education and collaboration, public health inspectors have an instructing official assigned, which is typically their manager or a covering manager, who also then has supports through Alberta Health Services, legal, and the reporting structure within safe, healthy environments, which houses the public health inspection and the environmental public health.

There are those levels of support and scrutiny and then, of course, also crossing over to the other part that Dr. McDougall described as well with our close collaboration working with Alberta Health and the chief medical officer of health in terms of established working relationships.

The Chair: Thank you.

Member Hoffman.

Ms Hoffman: Thank you very much. Just to clarify – I'm sorry if I'm being slow in my understanding. I want to understand. Under the current legislation the ultimate person responsible for whether or not a health care facility, a school, a workplace of any sort, including, for example, meat-packing plants – the ultimate person responsible today under the current legislation for it being open or not open is the local medical officer of health, who is an AHS employee. Is that correct?

Dr. McDougall: That is a very good question. Again, the final authority under the act as the act it is currently written: the only people who have those powers under the act are executive officers and medical officers of health and the chief medical officer of health. If it is under the act and there's a decision being made under it, then yes, that is where that decision would rest. Again, the chief medical officer of health under the act has the authority to remove a medical officer if it's deemed that the medical officer, again, isn't living up to what's expected under the act, but right now the only people with those authorities under the act are those three groups.

11:45

The Chair: A follow-up?

Ms Hoffman: Thank you. Under the current legislation, if I'm to understand correctly, Mr. Chair, the medical officer of health for each specific region has the ability to maintain, open, or close a workplace or a place of residence. As well, the chief medical officer of health has the same authority to be able to close or has the ability to remove the person who has the ability to open or close. Then who was the third?

Dr. McDougall: I was just mentioning about the role of executive officers depending on what the issue is that's actually happening within that school environment. Again, you will have the opportunity to speak with the chief, I know, in the next session coming forward in terms of her clarifying her opportunities, obligations, and responsibilities under the act. I believe that she has the same authorities as the medical officers of health have in addition to a few others, that she will be able to tell you about in the next session.

The Chair: All right.

The next member is Member Neudorf.

Mr. Neudorf: Thank you very much, Mr. Chair. Thank you, doctors, for your presentation. COVID-19 obviously has redefined the world and, obviously, the Public Health Act. It's placed a huge demand on resources, not only human but also financial, and we've learned a lot from that for the future, which is part of the reason why we've convened this committee, to help review some of those kinds of issues about the Public Health Act. As I understand it, the Public Health Act is defined and refined by the past, but it is needed to anticipate and manage the future. I really appreciate your input in your presentation about broadening the use of the Public Health Act in the future for general and overall public health and safety.

My question is in consideration of some of that context, looking at what we've learned and then also looking forward. In some bodies, like municipalities and the AGLC, the Alberta gaming, liquor, whatever the "c" stands for, they retain a portion of fine revenue resulting from prosecutions that they're involved in. This is not necessarily the case with prosecutions under the Public Health Act. I'm just wondering if you could comment on thoughts from the learnings that you've had. Would you deem it appropriate to redirect those fines or contributions or monies recovered under the Public Health Act to go back to Health in managing that? If you wouldn't mind commenting on that.

Dr. McDougall: Thank you for the question. Again, I think that the answer to that question probably lies with groups beyond our group. I think my only comment would be wanting to ensure that we aren't put in any sort of a conflict situation. I think we have done everything we can over the, you know, 100-plus years of the public health service in Alberta to build that trust with communities and with our partners about what our interests are when we're applying the act. Wanting to ensure that we weren't ever introducing something in there that put us in a conflict situation would be, I think, the consideration we'd want to bring to that decision.

Mr. Neudorf: Thank you very much. A supplemental, Mr. Chair. That is the crux of the problem. It introduces or potentially introduces different motivations when there are fines introduced. But having said that, there is an appropriateness as well if the fine introduced for a public health violation, those monies, would be directed to help address that said public health thing as opposed to going somewhere else or general revenue or whatever the case is. I think there are complexities to that.

The reason I ask that is that in Bill 10 there was a dramatic increase in the size of fines, placed, I think, under necessity, to show the severity and the potential impacts of what a public health emergency and disobedience to those requirements would be. If you don't mind commenting on – your opinions only; I understand that – the size of the increase of those fines and whether those funds recovered under those fines would be appropriate to help AHS do the job that they've been tasked with, which is general public health. Hopefully, you can see the question in there a little bit. There are two parts to that.

Dr. McDougall: Yeah. I mean, I think the second part is kind of back to that issue of the actual flow. I would just probably repeat what I said the last time: I think that ensuring that we are separated from any perception or real notion of conflict would really be important for us.

In terms of the value of the fines I know that the point of the fines is again to ensure that there is a reasonable deterrent as one of the mechanisms to ensure that we don't wind up having to invoke other measures under the act itself or to have the workforce in place to be able to do that as well, but I really don't think I could – and I'm not sure my colleagues could – speak about what level of fine would be appropriate under those circumstances.

Mr. Neudorf: Thank you. I can appreciate that.

The Chair: Member Hoffman.

Ms Hoffman: Yes, please. Thank you for your examples about real-world situations like preventing colon cancer. I find those kinds of examples really helpful. Thinking about my own experiences, I know that before the re-entry of Fort McMurray was allowed, the chief medical officer of health came in and talked through what questions and concerns there were that needed to be resolved before she felt confident in safely allowing people to return to their homes so that those changes could be made. I found that really helpful, to have one person who was the ultimate decision-maker in saying yes or no as to whether or not it was safe.

In terms of the executive officers – that was mentioned as well – I'm trying to understand who that is today under the current legislation and how, moving forward, we can ensure that there is one ultimate decision-maker because it sounds like there's some ambiguity. I know that in times of public health crises it's important

that we have clear lines of reporting and responsibility. Who are the executive officers today that add to that sort of third group that has the ability to make the decision about safe or unsafe? Moving forward, what, in your lived experience, would be the appropriate authority that the buck stops with? Who is ultimately responsible in the ideal world, in the legislation that we're considering drafting as we move forward?

Dr. McDougall: Thanks. Again maybe I'll start, and I'll ask both of my colleagues to weigh in on that as well. Again, just to define, to make sure that it's really clear, the executive officers are the public health inspectors that work together as a group and report up within Alberta Health Services to Dr. Koliaska and her group.

In terms of ultimate authority and again thinking about all of those day-to-day decisions that medical officers of health make every day as well as executive officers, the accountability for their decisions, they are, again, responsible for those decisions on that day-to-day basis and conduct their business with their, again, zone partners and their teams. But the orders, the exclusions, the decisions that wind up being rendered by the medical officer of health wind up being that ultimate decision.

Where the chief medical officer of health comes in, again, is as an oversight, as a monitoring – and I think that's the exact word that's used in the act, "monitoring" – function for the medical officers of health and ensuring that there is, again, adequate resource on the ground for making those decisions. But the day-to-day practice of medical officers of health and those decisions do rest with MOHs.

Maybe I can pass to Dr. MacDonald, who may wish to add from her years of experience.

Dr. MacDonald: Thank you. When I think about your question, Member Hoffman, I think about levels of issues, basically. Many of these things are decisions that can be made either by the local executive officer or medical officer of health or often together, but there are some circumstances, as an MOH in the past, where I may not know exactly how to proceed, looking at the options and the implications. I have contacted the chief MOH for a discussion and decision about how to proceed. I think that emphasizes that it's not: you know, it's my job to make that decision. I have other options. If it's something that is a little more not quite clear-cut, there are other options to involve the chief MOH. That is always available to us.

The Chair: A follow-up?

Ms Hoffman: Yeah. In the past we've had examples where ministers other than the Minister of Health have expressed that they were involved in decision-making regarding public health and these decisions. For example, the minister of agriculture said that he was actively involved in the plants in support of the decision to keep them open. We know that the Canadian Food Inspection Agency was also involved. At the end of the day, though, there is somebody who needs to be ultimately responsible for decisions that result in significant outbreaks and fatalities, and I'm trying to get a really clear understanding of who the buck stops with. The chief medical officer of health has a relationship with the Emergency Management Cabinet Committee as well as with the minister. At the end of the day, under the current legislation, who does the buck stop with?

11:55

Dr. McDougall: Again I might pass to Dr. Koliaska as well. I think that it really is a very good question, and the question expands beyond, in some ways, the scope of the Public Health Act because you're quite right that there is more than one set of legislation that ends up impacting on that decision-making.

Dr. Koliaska, I'm not sure if you want to add to that at all.

But I think that might be something for consideration as you're digging into some details here.

Ms Hoffman: Thank you.

The Chair: Thank you very much.

Member Reid.

Mr. Reid: Thank you, Chair. Thank you very much for your time and your presentation today and just a personal thank you for your leadership over the last number of months. Professionally, I thank you for your teams as an MLA reaching out to AHS for some direction and some input that was always responded to in a very timely manner even with all the pressures that were on, so thank you for that. I appreciate that very much.

I guess I want to follow through with a couple of things also related to our executive officers. I come from food service prior to this, so the proactive work of inspectors: appreciate it as it helped me to make sure that I ran a good business and a healthy business and had great relationships with our health inspectors. We have had some discussions even earlier today about the notification and ways to do that, and I guess, first of all, I want to look for some clarification, a little bit. Section 52.4 of the act relates to the publication of an order in the manner that a person considers appropriate. Again, as we look at modernizing the act, we have multiple ways of doing that now that were not available in 1907, when the act was written. But I'm also curious, I guess. Section 52.83 states that the Regulations Act does not apply to these same orders. Can I get some clarification in terms of how these two sections can be understood, working together, and how they apply in real-world practice?

Dr. McDougall: I am definitely going to turn to Dr. Koliaska for that one.

Dr. Koliaska: Thank you, and thank you for the question. It is a good question. Section 52.83 talks about the Regulations Act. It talks about the regulations that need to be published in the *Alberta Gazette*, and that's just so that the regulations are obvious and everyone knows where to go and what's in them. That part is a bit separate from 52.1, 52.2, and 52.21. Those orders don't need to be published in the *Alberta Gazette*. Those are the ones that go into where it's most appropriate. From a regional health authority and a medical officer of health point of view we don't suspend or modify any enactments under 52.1 or 52.21. That would be left for the minister.

What we could potentially do, from a regional health authority or a medical officer of health point of view, in a theoretical situation where a local state of public health emergency would need to be declared under 52.2 – that would be potentially where we might have some activity, but respectfully we would defer any questions about the minister's orders under 52.1 and 52.21 to be further addressed by Alberta Health because that wouldn't really be some place that we'd have any activity.

Thank you.

Mr. Reid: Thank you.

I have a supplemental.

The Chair: You have a follow-up?

Mr. Reid: Also related to the executive officers and inspectors, you gave some examples earlier of enforcements. We've certainly seen

that there have been cases where we've got to that point. As I mentioned, we had a great relationship with our inspector, so it was always a positive piece. You know, certainly, the direction with education and making sure that we were moving forward was great. Back when the world was a little bit more normal, I used to have the opportunity to travel quite a bit. I have in mind the different experiences that you have at border crossings with customs agents, so a little bit of concern over, again, some of the insight, some of the checks and balances that are in place for these executive officers in terms of, you know – I don't know if rogue is maybe the right word, but sometimes maybe they feel a little bit too much power. What kind of checks and balances are in place to ensure that procedures are being followed properly in the education pieces and we're not getting to somebody who is maybe too intent on extreme pieces, I guess?

Dr. Koliaska: Okay. Thank you for that. There was kind of a lot in that. I would just say that public health inspectors work extremely hard to be positioned as a resource for the community, for the business, and for the health of the public. In terms of checks and balances and the oversight, I would, again, reference my previous answer to start with. Any public health inspector certainly has the resources and the strength of colleagues in terms of resource material, education, all of those other things to work in a particular situation such as food, such as border crossings, within the defined role – of course, that isn't a specific, exclusive role to public health inspectors – and then that instructing official and that supervision happens within the Alberta Health Services structure, and then the connection to Alberta Health and the chief medical officer of health. So that's the one piece.

What I might expand on my answer a little bit more is more recently with the spread of infection due to the pandemic and knowing that, as people were returning back to Alberta, public health inspectors were asked to assist with making sure that reasonable public health measures were being taken in airports, just to make sure that returning travellers, if they were already sick with COVID-19 or potentially infectious – that those public health measures were in place in the airports, which needed a rather quick system redesign because this is something where we're all on a steep learning curve. We haven't dealt with this before. Public health inspectors in Calgary and Edmonton airports were asked to attend 12-hour shifts, seven days a week to help set up and ready the airports for setting up physical distancing and sanitation and making sure that those types of procedures were being followed so that both returning travellers, sick and not sick, as well as anyone working in that space would have the best protections against becoming sick with the virus.

We have certainly worked very closely with the airport stakeholders and set up plans, but that level of support is currently not required, so we're currently performing a more monitoring role as well as a resource role. At no time in the last several months has any sort of enforcement become necessary. It's very much an education and collaboration and a supportive role that public health inspectors have played.

The Chair: Member Hoffman.

Ms Hoffman: Thanks. I appreciate the example and how it relates to current realities because that's ultimately what we're in and what we want to ensure we get right moving forward.

Moving forward, as we consider the legislation, we've heard Dr. Hinshaw recently say some similar things to what you've said around who sort of local authority decision-makers are. Hence, AHS could have responsibility with regard to a school, or potentially even a board could have some authority with regard to the Minister of Education and the Minister of Health. It seems like there are multiple responsibilities between the local AHS medical officers of health, the chief medical officer of health, school authorities, two ministers. It's not clear to me in the legislation today who really, ultimately, decides about the safety of a school, for example, remaining open or closed, and I want to make sure we get it right as we move forward.

I'd like to have some clarity about what your understanding is as of today as it relates to a school environment and, ultimately, in drafting legislation that's clear. This legislation – and I think you said that you even think there could be other pieces that ultimately this committee could provide clarity on, on needing to be updated so that they can fit together. Who should have the final say? This is so important, and we're watching what's happening around the world. Parents are rightfully concerned and want to know who's ultimately responsible and the ultimate decision-maker.

12:05

Dr. McDougall: Again, I think it would be really good to continue this conversation with Dr. Hinshaw into the next session because she may have some different perspectives as well. It's really clear under the act, as I said before, what the authorities are of the medical officer of health. If there was a circumstance that the local medical officer of health felt needed action within a school setting or any other setting under their geography, that would be decision-making that the MOH would make as they would in any other circumstance or in any other venue as it pertained to that particular situation.

My understanding would be that, in terms of figuring out what the overarching strategy is for the schools and sort of the provincial approach, that level of decision-making – setting the framework, setting the policies, putting in place maybe those different levels of action – might be from a provincial point of view. Education and presumably the chief medical officer of health would work on that framework in that frame setting. I think the MOH's role winds up happening when the risk is happening and when the need for action to prevent the transmission of infectious disease as defined in the act has become clear to the MOH, and the authorities that they have would allow them to make decisions about what might be needed in that circumstance to help manage that outbreak, if that's what's happening at that time.

Again, I will pass to Dr. MacDonald, but you're probably going to keep hearing this theme over and over again. It is very rare that a decision is made in isolation of the circumstance, of the players, of the partners in that local situation. I think we would understand that there's a competing interest, especially in the school environment, between parents' needs, parents' needs for being able to pursue their jobs and their employment, superintendents' needs. The decision-making: there's, again, a gradation of how those decisions get made in collaboration with that local circumstance. It would really be only at the time when there's something that the MOH would be concerned enough about to need to invoke those authorities under the act when that decision would actually end up being taken. Again, I could maybe pass to Dr. McDonald from experience of, again, working in communicable disease control and with schools and other groups over the years.

Dr. MacDonald: Thank you. Member Hoffman, just to elucidate that a little bit more, medical officers of health, local medical officers of health, on the ground are authorized to take action if there is some risk that they see in a particular setting in their authority area. So if there was an outbreak, for instance, at a school, what steps would need to be taken to make sure? Now, some of that

is already prescribed, as I understand, but are there additional steps that would need to be taken? It's talking about those levels of responsibility. I think if the MOH was aware that something was happening in more than one school, there is that communication channel certainly with the chief MOH. If there was something that we saw that was indicating that maybe there needed to be some changes more broadly based on the experience of what we were seeing locally, that would definitely be communicated, and that, I would suggest, would be something that the chief MOH may want to be addressing more broadly as well.

Ms Hoffman: Thanks. To supplement that, my understanding is that today under the current legislation if there's an outbreak in one specific school – and I don't know exactly how you'll define outbreak, but let's say that there are kids who have COVID or adults or both who have COVID in one specific school or any other potential public health outbreak – the medical officers of health for that local area would make the decision about what to potentially close, whether it's classes, whether it's the whole school in that area. But if there was the risk for it impacting other areas, it would be the chief medical officer of health who would be the ultimate decision-maker beyond the local school authority.

I guess my remaining question is: what's the relationship between other partners, like the local school boards and the Education minister, and what if their hopes are counter to what the advice is of the medical officer of health or vice versa? If the medical officer of health thinks that two classrooms should be shut down, but the school authority or the principal thinks the school needs to be shut down, how does that get remedied? How does that get addressed or vice versa? Maybe they don't think the whole school needs to be shut down because they care about educational continuity for the remaining students in the school.

Dr. MacDonald: That's a great question. Thank you for that. Really, I think it speaks to how we do our work on a regular basis. We are, unfortunately, quite familiar with outbreaks, various kinds of outbreaks in different settings, including schools. Similar to what the other executive officers do, we do not just come in and say: this is how it's going to be. There's a lot of communication, conversation, discussion with the appropriate stakeholders – that would include principals; it could involve school board superintendents – to talk about what's happening, what the risks are from a public health perspective, what the risks are from a schooling perspective. It's always got to be that conversation about what's happening, what's the best way to mitigate that risk. Ultimately, I would say that at a local level the MOH does have the authority to say: because of the risk to public health, this is what needs to be done.

In the past when we've had outbreaks of, say, norovirus in the schools, there's been a fabulous amount of co-operation. Schools tend to work well with us, and they know that their interests are being protected and that the MOH has the ultimate decision there.

The Chair: Thank you.

The next member is Member Rowswell.

Mr. Rowswell: Thank you. Sometimes it appears that orders are overprescriptive, like getting micromanaging into details. I'd just like to cite a few examples here and have you say why you need to have that specifically. With respect to pools, the pool standards under regulations required clocks and certain soap dispensers in a pool. There are many other specific requirements that make sense, and it would be good from a customer relations perspective to offer that. So why would that be required?

Dr. McDougall: Again, in terms of clocks, obviously, pools are a recreation facility, but they're also extremely important in terms of training people in life-saving, and there are circumstances when life-saving happens in the pool. The ability during those times of training or that time of action to have ready access to a clock to identify when somebody has stopped breathing, what the appropriate actions are during a short period of time and a longer period of time is something that has come up in previous reviews. I think that actually comes back to a safety issue and a safety standard.

In terms of soap and handwashing, again, contamination in pools of fecal material is something that, unfortunately, has been experienced in our pool settings and probably pools that you've been in. I think that if this pandemic has taught everybody anything, it's that probably the cheapest and most effective thing that we can be doing for keeping all of ourselves and each other healthy is ensuring that we have that soap and handwashing capability anywhere, but especially if it's going to be bringing back into a common place and common use such as pool water and all of those high-touch surfaces around pools.

Mr. Rowswell: Okay. Then with regard to food prep, why is the use of raw milk prohibited, and why would we dictate what people can drink?

Dr. McDougall: Okay. I'll throw that one to Dr. Koliaska, too.

12:15

Dr. Koliaska: Thank you. In terms of the consumption and the sale of raw milk, that's really in the public sale and public realm. There are actually known preventable risks to consuming raw milk: harmful bacteria known as brucella, campylobacter – you may recognize a few of these; you may not – cryptosporidium, E. coli, listeria, salmonella. Some of these names may be familiar from other issues and other major incidents in recent Canadian history. Raw milk is often consumed by young children, sometimes pregnant women, immunocompromised, other people who may have a disproportionate adverse effect to an infection by some of these bacteria, and it is completely preventable by a simple pasteurization.

We also had an example not too long ago, a couple of years ago now, I think. There was an outbreak of illness associated with Gouda, so the cheese made from raw milk. In Sicamous, B.C. there were five E. coli cases that were reported. E. coli can cause not just a stomach ache and vomiting and diarrhea but can potentially cause hemolytic uremic syndrome, shut down kidneys, have an effect on someone's health for the rest of their life, and occasionally cause death as well. I just want to reiterate that this is – so the Public Health Act is there to protect the public and to make sure that this information is available. What people do privately, and if they are privately producing and consuming their raw milk, isn't something that the Public Health Act or the executive officers or MOHs would be involved in. It's definitely in the public lens and the public realm that we're concerned.

Dr. McDougall: Maybe can I just add. I think that this whole idea, that notion that public health has truly improved the lives, the length of life, the quality of life in people over, you know, the decade-plus since the act has been here, again, as I said, it's hard to point to any individual one thing that's made all that difference. It's the compilation of all of these smaller manoeuvres and the lessons learned over the course of those decades of what was actually taking years and quality away from people, the measures that really can make such a big difference in terms of, again, people's lives and outcomes, in terms of the sustainability of the health care system that ends up not having to manage or take care of the downstream

consequences of some of those decisions. Again, I just really want to re-emphasize what the value is of the work that underlies many of these decisions and the way that they're applied.

The Chair: Thank you.
Member Hoffman.

Ms Hoffman: Yes. My next couple of questions, I think, are going to be around trust and the relationship between AHS and government and the public. Many Albertans, I think, are rightly concerned that public health advice may not be fully considered or fully acted upon, and this naturally makes the public a little bit skeptical, I think. So when we often hear statements, for example: we considered public health advice or a plan that was based on public health advice – while that can literally be true, that doesn't mean that the public health advice resulted in the exact decision.

Mr. Neudorf: Point of order.

The Chair: A point of order has been called.

Mr. Neudorf: Just under 23(b) again. I was trying to give the member a chance to share that, but it seems a leading question on, again, the response of the government in terms of the COVID crisis and not related to the Public Health Act and what's included in that act. I just feel that, again, this conversation is veering off into grounds that are beyond the scope of this committee.

The Chair: Member Renaud.

Ms Renaud: Thank you, Mr. Chair. You may not like the words that the member is using, but I think, once again, we're using real-time examples to try to dig into, you know: what is this act about, how can we improve it, what can we do differently? I think, certainly, doing everything we can to improve the public trust, particularly as it relates to this piece of legislation, is key in my opinion. So I don't believe this is a point of order, and I think the direction this question is going is actually very relevant.
Thank you.

The Chair: Thank you. At this stage I don't find a point of order; however, what I would do is that I would remind all members that the purpose of this committee is simply to review the actual Public Health Act not individual circumstances. What I would invite the hon. member to do would be, perhaps, to use a hypothetical circumstance.

Ms Hoffman: Thanks, Mr. Chair. I didn't even use the word "COVID". I was very specific in making sure I didn't because this is about the relationship between those bodies, in my opinion, and that certainly transcends beyond today.
I guess my questions are: can our presenters please tell us about how AHS provides advice to those who are ultimately the elected decision-makers in a health emergency, including the emergency response committee? What's done verbally, what's done in writing, how advice gets filtered up, and what is considered confidential and protected either by cabinet privilege or as advice to the minister, in terms of giving medical advice?

Dr. McDougall: Again, I'm just a little bit at pains of where to start. The relationship that we've described from the public health side with our colleagues in Alberta Health: we, as I said, work extremely, extremely closely together. In terms of actually providing very formal advice, I would suggest that it is more informal advice between us and, again, the chief medical officer. In any questions or consultations that are requested, we absolutely do our best to comply, and I think that in all matters we work very closely in helping to advise from our experience on the ground and, you know, work together to give whatever information might be most useful.
You're right that during the Emergency Management Cabinet Committee Alberta Health Services was invited both from the CEO and the senior medical officer of health to provide information at the beginning of this pandemic. As you mentioned, so little was known and it was really all hands on deck, really working together and being able to share both from two groups of people the collective knowledge and information and decision-making of how that would impact the application on the ground from a public health point of view but also from the rest of the health system point of view, with the involvement of the CEO in some of those decisions that went forward.
In terms of things being protected, I can't recall too many things coming along where that happened. I think we freely share our advice, again, as we're requested to do under any circumstances.
I'm not sure if either of you can think of examples of that.
It really is very collegial. I think both teams are extremely committed to making decisions that are in the best interests of the health of the public of Alberta. It's not adversarial from any of those perspectives, so I think it really has been, at least during my tenure here, a co-operative coming together of ideas and really sharing wherever we're asked to do that.

Ms Hoffman: Thanks for that clarity. Just to supplement, the two groups that you're referring to are the medical officers of health and the chief medical officer of health and their related teams. I appreciate that.
A number of school authorities have raised concerns about overcrowding as it relates to today, or, really, it could relate to other infectious disease prevention. In terms of giving information to folks, typically they would give information to the Minister of Education and the relevant department. Are they now supposed to give information about their concerns around classroom conditions to the medical officers of health and their local authority?
There was a recent media event where Dr. Hinshaw said that she wasn't aware of concerns around capacity and overcrowding, but definitely that information has been given to the Minister of Education and the department. So, I guess, how are they supposed to make sure that the relevant information regarding the lack of physical distancing and those types of things is given to the authority-makers around whether or not a situation is safe? Should they be going directly to the local medical officers of health with their specific concerns around capacity and the ability to distance and follow the advice and guidelines that have been set forward by the chief medical officer of health?

Dr. McDougall: Dr. MacDonald, do you want to take a first crack at that?

Dr. MacDonald: Thanks for that very challenging question. I think what your question highlights is the critical need for there to be communication, not only as we've described it that exists from local MOHs to the chief MOH but when we're talking about within the government of Alberta, between the different ministries or departments, when there are concerns. I really can't speak to how that works or doesn't because I don't have any experience with that. But I think the role of the local MOH would be if there were specific concerns that were brought to them that that MOH thought were actually broader than just at that particular school, that communication channel to the chief MOH is always open for us to share those concerns over whatever the case may be.

12:25

Dr. McDougall: Maybe if I could just add one thing to that. I do suggest, again, from Dr. MacDonald's comment: we are, I think, really lucky in Alberta to have a single health authority. Just reflecting back on, you know, your comment. I think that in other provinces or in the years before we had a single health authority, that flow of information between jurisdictions, between MOHs, and co-ordinated up to the chief medical officer of health – I can speak from experience – used to be much more problematic and challenging and, from speaking with colleagues in other jurisdictions, remains so.

As issues come up – and this might be the issue today, but the issue next week might be in a different community or different environment – that chance for all of us from across the province to get together, to be hearing what's happening in other jurisdictions, to be sharing lessons from the south of the province to the north of the province and everything in between and then to bring in the office of the chief medical officer of health in terms of how to communicate issues or concerns that we're seeing on the ground and then for that office to work together with other ministries: I think it is a recipe for success, and I think there's a lot of commitment to working through those issues. And, you know, as I said, there are different issues every time, but the same sort of sequence of events tends to happen, where we pool our own local knowledge, our own local experiences, and then actually help inform and shape the reactions or the actual decisions that end up impacting the whole province.

The Chair: Thank you.

Mr. Long: Thank you for being here. I don't have the benefit of *Hansard* in front of me, but earlier, Dr. McDougall, you made a comment, something to the effect of expanding the scope of the Public Health Act to deal with current and future issues. I was wondering what sort of future health concerns and/or issues can be anticipated that we should consider expanding the scope of the Public Health Act to prepare for.

Dr. McDougall: Well, thank you very much. I think, again, as we think back to where the act has come from and where we've come from as a province over the many years under the act – again, just reflecting on the fact that many people do have a notion that public health really is limited to communicable disease and environmental protection, because that is definitely the essence and the beginning of public health over time. We can absolutely see that the health challenges that face all of us, face Alberta Health Services, and face our communities and all Albertans – again, there are so many other challenges now as people are living much longer, as we have access to different sorts of risks in the community, from gambling, of sorts of facilities that maybe wouldn't have been here back in the day, to all of the factors that contribute to chronic diseases. As we're thinking forward, that opportunity for the act to be able to really communicate to all Albertans what public health is; it is so much more and it can be so much more than focusing on the communicable diseases and environmental public health.

As we're thinking all together as a province about what we need to do collectively within our communities, within all of our decision-making as we're building new communities, creating built environments, creating policies that support consumption of healthy food and making sure that's available to everybody everywhere, opportunities for physical activity, et cetera: those are the kinds of things that public health can do and be successful in the whole next realm of challenges that we are going to be facing as, again, our population is rapidly aging and increasingly faced with those sorts of challenges, again, global warming. There just are a lot of other public health issues and concerns that I think we can be anticipating coming forward.

Thinking about the success that we've had taking that very proactive, reasoned, evidence-based, multistakeholder approach to tackling so many of the problems that we've been successful at, those same approaches can be successful with our new challenges. I think the act and how we frame it is an opportunity for us to really work together and communicate with Albertans that this isn't something that public health practitioners do to people; this is something that we all can do together to really create those conditions that make it easier for everybody to be healthier.

The Chair: Thank you very much.

So that concludes the question portion of this presentation. On behalf of the committee I would like to thank you for contributing to the review of the Public Health Act.

With that, I will now adjourn for a short lunch break.

Ms Hoffman: Can we read in questions like we did for the other presenters?

The Chair: Well, in this case this question period was twice as long as previous question periods, and there is always the opportunity to bring presenters back in the future. However, if I see general consensus from both sides, I think that we could read in a question from each side if the presenters would be willing to provide written responses to these two questions.

Dr. McDougall: Absolutely.

The Chair: Okay. Yeah.

Please, Member Hoffman.

Ms Hoffman: Thanks very much, Mr. Chair and colleagues. Not just the last six months, but of course the last six months have really given us an opportunity to grapple with this legislation and understand what its strengths and definitely what the holes or weaknesses are within it, so my question would be with regard to outbreaks that could be forthcoming. What have we learned in the last six months, what would be the legislative areas, and what would be the takeaways that you would suggest require greater clarification and honing in? What would you believe to be some appropriate amendments to this legislation and other related pieces of legislation that are directly impacted by this legislation to ensure greater protections for the people of Alberta and clarity for all with regard to reporting responsibilities?

The Chair: And Member Turton.

Mr. Turton: Yes. Thank you, Mr. Chair. While the emergency powers under the Public Health Act are a focus of this committee, we've been tasked with a review of the act as a whole. With that in mind, I want to ask about sections 18.1 to 18.4 on the disclosure of information, specifically children's information, for the purpose of communicable disease control. Can you clarify how and why these powers may need to be exercised? And then my supplemental would be: it is my understanding that the number of individuals who derive their authority from the Minister of Health – you know, specifically to the powers under the act, can you provide the total number of people, based on past or present numbers, who have these authorities?

Thank you.

The Chair: Thank you.

With that, I would like to thank you again for your attendance today.

With that, we will now adjourn for a short lunch break. I would ask that everyone return to their seats, hopefully prepared then to hear the next presenter at, say, 5 to 1, if that's okay. Of course, you may leave all your binders and other materials at your desk, but if you have napkins or cups, please dispose of them yourselves. I will see you shortly.

Thank you.

[The committee adjourned from 12:33 p.m. to 12:56 p.m.]

The Chair: Thank you, everybody, and welcome back.

Our next presenter that I would like to welcome to this meeting this afternoon is Dr. Hinshaw. Just as a reminder to all those present, we're scheduled for a 30-minute presentation and 60 minutes for questions, and then if for whatever reason at 2:30 the goal would be to continue past 2:30, we would require unanimous consent from the committee to do that.

Thank you very much for making the time in your busy schedule to be here today. If you are ready to proceed, I will cede the floor over to you, Dr. Hinshaw.

Dr. Hinshaw: Sure. I'm assuming that sound is all monitored.

The Chair: Sound is all monitored. The microphones take care of themselves. Yeah.

Dr. Hinshaw: Okay.

The Chair: Perfect.

Dr. Hinshaw: Great. Am I advancing my own slides, then, by use of the computer? Just double-checking.

The Chair: Yes.

Office of the Chief Medical Officer of Health

Dr. Hinshaw: Okay. Perfect. Thank you so much. First of all, I want to say thank you for the opportunity to be here today. This is a really important subject, so I appreciate the chance to have this conversation. The presentation you've just heard from my colleagues from Alberta Health Services covered a lot of key points. Some of the topics that I will be discussing will be building on the content that they've already shared, but I will be speaking particularly about my role as the chief medical officer of health and then speaking briefly about some recommendations from my own experience that you may wish to consider as you deliberate potential future changes to the act.

Just a quick overview of what I will be talking about: I'll cover the origins of the act and the CMOH role as well as some key parts of public health history in the province that I think are relevant to consider. My colleagues have described the core functions of public health, so I'm only going to touch briefly on those and then spend a bit of time on my role and some of my forward recommendations.

Interestingly, even before Alberta was a province, there was a role similar to mine which was established for the North-West Territories, as it was called at that time, and this was because there was a recognition that this role was critical in responding to public health threats, at that time mostly infectious in nature. The province did decide to create a public health act shortly after it was created, so the first public health act was in place in 1907. Even before that, the first chief medical officer of health was appointed in 1906, again because of that historical recognition that the role was important and played a role in keeping the citizens of Alberta safe and healthy.

The public health laboratory is a key part of our infrastructure, and that has been in place, again, for longer than the province has been in existence. The public health laboratory: it was recognized that it was critical to have lab expertise to diagnose and monitor public health threats, again, at the time, in the late 1800s, mostly infectious diseases, so the public health laboratory was put in place to be able to diagnose diseases like smallpox and has been a part of Alberta's public health infrastructure since 1907, when the public health laboratory was set up, actually, in the Terrace Building; for those of you who know the provincial buildings, that one right next to the Legislature. About four years after it was set up, it was moved to the University of Alberta, and we have had a robust public health laboratory infrastructure in place since that time. As the chief medical officer of health, that is a really key part of our infrastructure that I rely on heavily.

Alberta has been a leader in public health since the province was created. Dr. Malcolm Bow was the chief medical officer of health of the province from 1927 to 1952, which is a long duration for someone to take on that role. He really did champion the health of the population in several areas that were nationally leading practices such as providing free treatment for tuberculosis and providing free rehabilitation to those who suffered from polio, with the recognition that a healthy population is one of the province's greatest resources, so we do have a long and strong history of recognition of the importance of public health.

The Public Health Act has always reflected the issues of Albertans. When it was first created, in 1907, it really focused on the issues that were causing the greatest illness and burden of death in the population. At that time issues like diphtheria, whooping cough, smallpox, tuberculosis, and measles killed and harmed thousands of Albertans, and the Public Health Act was set up to be able to ensure that those kinds of infectious diseases were stopped, were minimized, and that measures could be put into place to protect the health of Albertans. As you heard earlier from my colleagues at AHS, this has changed over the years, and our greatest disease burdens now are chronic diseases.

Another piece of historical interest that explains how some of our Public Health Act came to be: the emergency powers section in the Public Health Act was created in 2002 as the Alberta government of the day sought through legislation to prepare Alberta for various types of threats and emergencies, particularly after witnessing what had happened with the terrorist attacks of 9/11 and the subsequent anthrax attack that was seen in the United States. It became a very real possibility that we could experience something similar in Alberta, and preparations needed to be made, and the results of that were the amendments in 2002 that brought in those public health state of emergency measures.

Those specific measures were, for the most part, taken from general emergency management legislation, so this current review is a really excellent opportunity to consider whether those general emergency management measures that were taken from that legislation and put into the public health state of emergency are indeed the best focus for a public health state of emergency or if we need to make any adjustments.

In summary, the Public Health Act has served Alberta well for the last 100-plus years, but our health problems have changed. We need to make sure that we have a good opportunity to consider how to best support Albertans' health now and into the future.

You've heard from Alberta Health Services about the core functions of public health, so I won't go into detail on this slide, but I do just want to underline the fact that the legislative tools that we have with the Public Health Act are only one part of the work that public health does, that public health is much broader than the Public Health Act, and that the act, really, underpins only a subsection of all the work that public health is responsible for.

My colleagues have given a really good overview of the roles of medical officers of health, but I do want to reinforce a few key points that I think are relevant to how the Public Health Act is framed as well as to my own role as the chief medical officer of health. First of all, as you heard, medical officers of health do have specialized training that equips us to treat populations as our patients. I want to underline the point that, just as our colleagues, who treat one patient at a time, our practice is founded on core ethical principles and values that are a part of our five-year training program. Chief among these is the principle that restricting liberties and freedoms is justified only when there is risk of harm to others. To state this in another way, my freedom to swing my arm ends where your nose begins.

Legislative authorities are used only when other measures are not sufficient to prevent harm to the public. The chief medical officer of health is a role that all provinces and territories have as well as most countries around the world. While there are structural differences amongst the 13 provinces and territories with respect to the chief medical officer of health, there is a common core set of rules and responsibilities that all of us have.

1:05

As mentioned earlier, chief medical officers of health are medical officers of health and therefore are public health physicians. Therefore, we have training and practice based in large part on population focus, and that training provides us with a deep understanding of subjects such as molecular biology, human anatomy, and other basic science that's essential to understanding the interaction between people, their environment, and the social environment as well. Physicians in this role have a tremendous responsibility to provide a trusted, credible voice both when there is an urgent need to assess risks, contend with fear, and galvanize groups to act during an emergency as well as in day-to-day responses to public health issues in the province.

Almost all provinces and territories have requirements for the qualifications that their chief medical officer of health must have. Alberta is the only province that does not specify those qualifications. It is important to note also that the chief medical officer of health is appointed by the Minister of Health and therefore is subject to oversight within the democratic structure of this province.

I want to speak a bit about the role of the chief medical officer of health as it's laid out in the Public Health Act. There are two main overarching roles that I have in this position. The first is to assess the health of the population and provide recommendations to the minister, to the deputy minister, and to the regional health authority or, in our case, Alberta Health Services to protect and promote the health of the population.

The second, as you have heard from Alberta Health Services, is to give directions to others who are specified in the act such as medical officers of health and executive officers in the exercise of their responsibilities and authorities although they do not report directly to me through a line reporting structure. Just to give a bit more clarity to that point, I want to show you this particular work structure.

In summary, as I said, the chief medical officer of health does play a leadership role in Alberta's public health system within government and giving advice to the regional health authority, but the chief medical officer of health is not an independent officer of the Legislature like the Auditor General or the Child and Youth Advocate.

I was appointed Alberta's chief medical officer of health last year by the Minister of Health, and I serve at the pleasure of the minister although I report directly to the Deputy Minister of Health. As the chief medical officer of health, as I mentioned, I do advise the medical officers of health and executive officers in Alberta Health Services although they do not report directly to me. You can see in the slide – that should be a dotted line, actually, down to Alberta Health Services rather than a solid line.

As I mentioned earlier, I also work with the Provincial Laboratory for Public Health, which operates currently under Alberta Precision Laboratories as a wholly owned subsidiary of Alberta Health Services. This lab most recently has been a really critical part of our COVID-19 response and is, as I mentioned earlier, foundational in all of our public health work.

The chief medical officer of health and the Ministry of Health, as part of government, provide high-level direction and set policy, and Alberta Health Services carries out the operationalization of that policy, so that is the distinction between those two groups. As the chief medical officer of health I do also have the responsibility to provide advice on occasion to the Premier and cabinet in certain situations; for example, when there is a serious threat to the health of the public, to advise on the need to declare a state of public health emergency, and to take action in response to a pandemic.

I've referenced the specific legislative role, in an earlier slide, of the chief medical officer of health. This is simply to note that the general authorities of the chief medical officer of health include those two roles I mentioned earlier of assessing health and making recommendations to promote and protect the health of the population, but also the chief medical officer of health has all the authorities of all medical officers of health and executive officers. This is true both with general authorities that apply day to day as well as emergency authorities. The only additional chief medical officer of health specific power in a pandemic or state of public health emergency that I have is the authority to authorize absence from employment for someone who is ill or caring for an ill individual.

This slide gives you a sense of the nested responsibilities and authorities of medical officers of health, executive officers, and the chief medical officer of health. You can see again that executive officers have a small subset of authorities. Executive officers have the smallest, medical officers of health have those plus more, and the chief medical officer of health has all of those plus a few more specific responsibilities, as I've outlined.

As you've heard from Alberta Health Services, medical officer of health authorities are used as a last resort when other measures are not successful or not possible. They are, however, sometimes necessary, as in the example mentioned earlier of someone with tuberculosis who refuses treatment and therefore is putting others at risk. Used when needed, these authorities are important to ensure that health of the public is protected and that individuals whose condition puts others at risk are treated appropriately to minimize that risk. Medical officers of health also have tools in communicable disease outbreaks or a state of public health emergency, and you've heard from AHS of the importance of having these tools judiciously apply restrictions when necessary to intervene on outbreaks and in public health emergencies.

Although chronic diseases cause most of the illness and death that we see in Alberta, infectious diseases have not gone away, and we must not be overconfident and lose attention to these threats. As you heard in Alberta Health Services' presentation and in the earlier presentation from the Ministry of Health several weeks ago, new infectious diseases have been emerging more frequently in the past several decades, and we have to have the tools that are flexible enough to deal both with the infections that we know about as well as the ones that may emerge.

Executive officers, also called public health inspectors, as you've heard about from Alberta Health Services, have a smaller subset of authorities mostly focused on environmental risks. These authorities,

as Alberta Health Services outlined, are also used sparingly and are focused on occasions when other approaches have not worked or are not possible.

To give a couple of examples – you've heard already from Alberta Health Services about authorities that medical officers of health have and how they're utilized – one of these powers that MOHs have is to prohibit people from working or attending school if they could be a threat to others. For example, we keep students home if they have a diagnosed case of measles. They are not allowed to attend school. Another example as outlined in this slide is that if you have someone who works as a food handler who has an infection that could cause risk to others through that food such as salmonella, they are required to stay home until they test negative for that particular infection.

Another example of an authority of a medical officer of health is the ability to remove the source of infection. For example, in the United States in 2001, as I mentioned earlier, powdered anthrax spores were mailed through the postal system in a bioterrorism act. Envelopes containing anthrax infected 22 people, and five died. Ninety-three bags of anthrax-contaminated mail were removed from the New York post office as a part of decontamination efforts.

White powder incidents have happened in Alberta, sometimes in a deliberate act to imitate this particular anthrax. While anthrax has not been found to have been deployed in Alberta, if it were, we would need to ensure that any particular location or any particular area that was contaminated was cleaned safely and appropriately to make sure that there's no ongoing risk to public health. Again, some of these powers, while they may seem extreme, are needed to deal with extreme circumstances.

With respect to some of the recommendations that I have for your consideration, one is going back to the point that Alberta Health Services made about the prevalence of chronic diseases in our population at the moment. Increasingly, as you heard, the availability and productivity of Alberta's workforce is impacted by chronic diseases, and there are serious complications. There is a strong case to be made that chronic diseases require a similar focused approach as communicable diseases in order to be able to address them effectively.

For example, Ontario and British Columbia have taken this approach and included the prevention and management of chronic diseases in their legislation. To give you a specific example, in British Columbia's Public Health Act the minister has the authority to require a public body to make a public health plan.

There are also powers given in the act for regulation-making authority for health impediments which could include, quite broadly, conditions that put people at risk of chronic diseases, and there are requirements for local and provincial governments to monitor health outcomes, including health outcomes for chronic diseases, as well as health impediments. These are considerations, as you look forward, to think about the kinds of tools that we may need in Alberta to deal with the risks that we currently are seeing in our population.

1:15

Another suggestion I would have for this committee is that, given the significant responsibilities of the chief medical officer of health, there be a requirement, similar to other provinces, to ensure a basic standardized training that is required for this position to make sure that the person who has the responsibilities that are outlined in the act has adequate training, experience, and the ability to take these responsibilities on.

Finally, a clear limitation on the current wording of the act is to limit the response of pandemic provisions only to pandemic influenza. As we are currently experiencing, pandemics can be caused by other viruses, and I recommend the word "influenza" be removed as a limiting factor in the act. This could support potentially a stepwise approach to the use of authorities with specific provisions for pandemic being in place not requiring a state of public health emergency to be called.

My closing comment is that it is critical that we think broadly about the authorities in the Public Health Act. It is important to learn from our COVID response as we consider any changes, but we must not create an act focused on the specifics of COVID. Our next public health threat could be a radioactive dirty bomb. It could be a new virus that is as deadly as SARS but spreads as easily as COVID or something else that we haven't yet imagined. I ask that as you deliberate on the amendments that you may wish to make to the Public Health Act, you consider both our past experience as well as our future possibilities and the importance of retaining flexible tools to deal with new and emerging threats.

Thank you again for the opportunity to present, and I'm happy to take any questions.

The Chair: Thank you, Dr. Hinshaw.

Moving now to the question portion of this presentation, I see the hon. Member Hoffman.

Ms Hoffman: Thank you very much, Mr. Chair. I appreciate that. Thank you, Dr. Hinshaw, for joining us today. As we consider changes to the Public Health Act, there are a number of topics that we'd like to cover, including the role of the chief medical officer of health and how that works in the context of any public health emergency. We want to understand how things are working in practice so we can evaluate whether we need to modify the legislation; for example, to make reporting lines more clear. I appreciate your presentation outlining the way it is currently. We also think it might be necessary to make more clear who the actual decision-makers are in various scenarios.

We've heard the Premier say on the record that the relationship with you is iterative, that cabinet asked for revisions to advice, and that ultimately 80 to 90 per cent of advice is accepted, so the key takeaway here for us is the distinction between giving advice, modifying advice, and who ultimately is decision-maker. My specific questions. For the benefit of the committee can you shed light on these distinctions: when you are responsible for giving advice, how you revise your advice based on input from elected officials, and when in your role as the chief medical officer of health you can make decisions independently from elected officials?

Dr. Hinshaw: The Public Health Act lays out that role of the chief MOH. As I said, the role is very clearly specified as a "shall." The chief medical officer of health does not have discretion, but the act requires the chief medical officer of health to monitor the health of Albertans and provide advice and recommendations to the Minister of Health and the regional health authority. In my role as chief medical officer of health I have done my best to monitor the health of Albertans and provide recommendations based on the state of current evidence. That evidence, with respect to COVID in particular, of course, changes and evolves over time because this is a new threat and we continue to learn new things about it. In that role as CMOH that advice that I give is always my best advice. My advice doesn't change based on the – I'm not directed what advice to give. I give my advice as I am directed to in the act.

The ultimate decision-making authority, as is laid out in the Public Health Act, the particular powers under a state of public health emergency but also outside of a state of public health emergency: the chief medical officer of health is not a decision-maker in the act. The chief medical officer of health is an adviser and someone who recommends. As is appropriate with respect to

the construct in the legislative process, the decision-makers take the chief medical officer of health's advice as one part of the considerations in very difficult decisions that they need to make. I have always felt that the advice that I have provided has been met with respect and has been considered.

Ms Hoffman: Thank you.

The Chair: A follow-up?

Ms Hoffman: Yeah. My follow-up. We know the roles and responsibilities of chief medical officers internationally and across Canada vary significantly. A recent academic article in the *Canadian Journal of Public Health* examined the legislative roles of the chief medical officers of Canada and grouped them into three different models: loyal executive, everyone's expert, or technical officer. For Alberta they categorized the role under the current legislation as loyal executive, who ultimately supports key decision-makers, which is, I think, consistent with what you've just said in terms of who is ultimately responsible. So I'd like to understand how decisions are made right now under the current act and if you feel your feedback, should we make a decision to amend that model in the future – how could we do that to ensure that your feedback is as public as possible?

Recently in public you said that if an outbreak occurred in a school, the decision to close a school would be the responsibility of the local medical officers of health, the school, the board, the Minister of Education, and the Minister of Health. At least that was my summary from what I heard. I'd be happy to have further clarification today. It's unclear, in turn, to Albertans who's ultimately responsible and calling the shots specifically around those types of situations should they ever occur in this public health crisis or any other and who actually makes the decision at the end of the day. Can you tell us from an operational perspective under the current legislation: who does the buck stop with? Who's ultimately responsible?

Dr. Hinshaw: I'll start perhaps with the paper that you referenced. I think that paper does a good job of laying out the pros and cons of different approaches. I don't think there's any one perfect way to structure the role of a chief medical officer of health. I think there are advantages and disadvantages to any kind of legislative framework. I think that would be something that – I would feel comfortable that I could work within whatever framework the government chose to set out. This particular framework: I have been comfortable working within it. Again, there are advantages and disadvantages of different models. Ultimately, again, with the framework for my role and how I provide advice to government, the final policy decision-making authority rests with elected officials, as, again, is appropriate to the act, as is laid out in legislation.

With respect to local individual decisions such as a school closure we are working out the details of the processes. I think it's really important that if there is something – for example, an individual school closure versus making a decision where there's perhaps a regional issue, where there may need to be a model shift. Those are different decisions, so different individuals would need to be involved. If there's a specific school that has a very large outbreak that's very unique and targeted to that particular school, that may be a more local decision whereas if it's a larger regional decision, that may be more of a policy decision that's more appropriate for the Ministry of Education to be making with our advice.

I think that in that list of all the people involved, that's listing all the people involved for different kinds of scenarios. With each specific scenario we want to be sure that the right people have input and that considerations can be taken into account because, of course, there are implications not just for Health but for Education, so we need to be sure that we're listening to all the stakeholders as those decisions are made.

The Chair: Thank you.
Mr. Reid.

Mr. Reid: Thank you, Chair, and thank you, Dr. Hinshaw, again for your presentation and your time and your input. It was an interesting spring in terms of pulling out the existing Public Health Act, and it was really one of the first pieces of legislation that I did deep, deep digging into. I'm curious, of course, like most Albertans, about checks and balances and those kinds of things. My question is really related to concern that several constituents also brought up in relationship to the Public Health Act and addressing mandatory immunization with respect to COVID or any other disease. Has Alberta ever mandated vaccinations for Albertans in our history?

Dr. Hinshaw: To my knowledge, Alberta has never mandated any population province-wide vaccine in its history.

Mr. Reid: Okay. Now a follow-up question to that: do you support the idea of mandatory vaccination?

1:25

Dr. Hinshaw: The current provision in the act with respect to giving the government power to require Albertans to be vaccinated within a public health state of emergency: I don't see an example where that would be used. I think that if we have a piece of legislation that we're unlikely to use, I'm not sure it provides much benefit. So I would be comfortable with that particular piece of the legislation being removed.

Mr. Reid: Thank you.

The Chair: Member Hoffman.

Ms Hoffman: Thank you very much. As we consider our work, I think it's important for us to consider, if we make legislative changes, how information sharing works currently, whether that's between ministries in particular. During a recent public event you said that you weren't aware of concerns regarding overcrowding in schools and the ability for physical distancing. Again, my summary. As a former trustee I know that these issues are regularly raised with the Minister of Education, being the minister most closely related to those local authorities and staff in the minister's office as well as folks in the Department of Education, and I think it's particularly important now in light of challenges regarding physical distancing, especially in our largest cities and other growing communities, where they're at capacity already for schools before the recommendations around physical distancing were brought in.

What's the information sharing between the minister's office, the department, local AHS medical officers of health, yourself, your office, the Minister of Health with regard to overcrowding classrooms, and should folks be notifying you rather than working through the Minister of Education's office or their local medical officers of health? I think there are a lot of patients, staff, families, and boards that are deeply concerned about their inability to physical distance and follow your advice to date when kids are back next week.

Dr. Hinshaw: One of the things that we have talked about with respect to the modernization of the Public Health Act and some of the additional authorities or enabling pieces of legislation that could

be considered is related to information sharing. I'm not sure that it would be relevant to the specific example that you provided. I don't know that there are legislative impediments to that kind of information sharing. Perhaps it's more in that kind of broad theme that we do see examples where some of our current legislation can be an impediment at a policy level to having information shared across ministries when it comes to program planning, when it comes to looking at particular individuals who interact with social services, with Health, with Justice and being able to use the datasets in a way that still respects the privacy of individuals yet at a population level may give us a better sense of where we can do better to prevent poor outcomes across multiple systems.

I guess that with respect to information sharing as it pertains to the act, I would suggest that that is something that could be considered if you are thinking about ways to improve our ability to intervene and make sure that people have the best access to services. Information sharing may be one of those opportunities to look at so that any barriers that may currently be in the way are potentially addressed. Again, that's sort of at a more general level.

The Chair: A supplemental?

Ms Hoffman: Thanks, Mr. Chair. I think the situation, for example, is that I think that the school authorities were of the opinion that they were sharing the information with the proper authorities, their minister, but for the chief medical officer of health to not have the information that they thought was naturally going to be shared I think is concerning to many parents and to school authorities.

With regard to information on HVAC systems and the age and inefficiency of them, with regard to the actual number of students in specific classroom settings, with regard to following your recommendations around physical distancing and the ability to hand wash, for example, at many schools, these recommendations as they stand today will not be able to be implemented a week from now given the physical constraints. I think people thought speaking to the minister or the minister's office was sufficient to ensure that you received that information. So as it relates to the current legislation, should they be going to you directly? Should they be going to their local MOHs to ensure that the information – you're giving advice based on the information you have, but if you don't have the information, how can you give sound advice, I would say. That is the question. So what's your advice under the structure of the current legislation as we consider how to move forward to ensure that it's effective?

Dr. Hinshaw: I think if there are concerns – I will say that more recently my teams have been having specific conversations with their counterparts in Education about some of those specific issues, trying to understand classroom sizes, especially now as we understand how many parents have decided to have their children be schooled at home and what impact that has on classroom sizes. My team is having those conversations with their counterparts, trying to understand the current state, for example, of ventilation infrastructure in schools. I think that if individual parents or individual schools do have concerns, the best way to voice those concerns – I know that schools: typically it flows from parents to schools to school boards and then to the Ministry of Education. Again, my teams have been doing their best to get that information, but perhaps we could do a better job of making sure that we have it and that I understand all of the details.

As you can imagine, there are many, many things happening with COVID, so I don't always have all the details of all the different responses in all the different sectors, but I do think that the current information-sharing process is appropriate to make sure that all those who are involved in this have the information about those specific concerns.

The Chair: Thank you.
Member Rowswell.

Mr. Rowswell: Thank you. You can imagine that, like, when we're not under restrictions and all of a sudden there are restrictions put on, there are lots of conversations about overreach. You know, do you have the power? It's just that people don't like being restricted. Given that the power to conscript seems like a gross overreach in the context of a public health emergency, however, when I think about the possibility – and you mentioned it earlier – about weaponized diseases or biological warfare, the existence of these powers could be appropriate. If there was a bioterrorist attack in Alberta, do you as the chief medical officer of health have enough authority under the Public Health Act to respond effectively? And are there any powers that you don't require that are there right now, or are there any powers that you might need in the future; for example, like with regard to conscription. If it's never been used, could you see a situation where you might want to use it?

Dr. Hinshaw: Conscription is one of those examples that came from the general emergency legislation. You can imagine, for example, that if there's a sudden flood, then people may be conscripted to help with sandbagging or something that's of that nature. I think what we've realized through this response is that conscription probably isn't the right tool for a public health emergency.

What may in fact be more appropriate is the ability to provide a temporary permission for people who wouldn't ordinarily be qualified to do a particular task but make a temporary ability for them to do a particular task by adjusting qualifications that are necessary or allowing perhaps shorter training if we have a shortage of people, but that would be for those who are interested and willing to do that job. I think that would probably be more appropriate for a public health emergency.

If we did need to conscript people for a particular task that would be more like a general emergency response, the emergency response legislation could always be enacted for that purpose whereas for the public health emergency I would suggest that conscription is likely not going to be used. It may be, in fact, as I say, more appropriate to consider enabling rather than requiring people to help with certain tasks.

Mr. Rowswell: Just to look at – like, I want to make sure that you're able to do your job, right? Have there been powers that, in hindsight now, you've been able to look at: "Boy, I wish I could have done this"? Like, are there any new powers that you can see that we should consider when we're reviewing the Public Health Act?

Dr. Hinshaw: Aside from the specific examples I've mentioned – for example, instead of restricting pandemic to just influenza, being broader with that definition – I would say that the current act does provide sufficient flexibility. While I recognize that you may be also looking at checks and balances, which I think is an important question and conversation to have, I think it's really important that some of those general statements remain in the act about allowing medical officers of health and the chief MOH as a medical officer of health to take whatever actions are necessary because having that flexibility means that we don't have to imagine the specific things that are necessary. We need to have the appropriate checks and balances, but we need to allow that flexibility. I would say that the current act is sufficient, and I wouldn't have any other specific powers or authorities that I think are necessary.

Mr. Rowswell: Okay. Thank you.

1:35

The Chair: Thank you.
Member Hoffman.

Ms Hoffman: Yes, please. I've been thinking about the Public Health Act and how we distinguish between a public health order or public health guidance or guidelines and possibly how Albertans could see sanctions. Because we, obviously, balance liberties with public health protections, let me ask you about your public health guidance when it comes to sending children to school and possible sanctions to Alberta families if they are not following that advice. This is a scenario that a parent raised with me recently. They have three young . . .

Mr. Neudorf: Point of order.

The Chair: A point of order has been called. Mr. Neudorf.

Mr. Neudorf: Thank you, Mr. Chair. As stated before, again we're trying to review the Public Health Act, not necessarily the government's response, especially outside of the public health that we have had. Going back to school doesn't fall under that at this point in time because that duration has been expired. Again, we're here to talk about the Public Health Act and its relevance to changing legislation, not on every circumstance, from building permits to classroom sizes, and I just ask that the question be directed about the Public Health Act.

The Chair: Ms Renaud.

Ms Renaud: Thank you, Mr. Chair. I think, you know, as Dr. Hinshaw noted, we really do need to think broadly about the act, and what the member is talking about and questioning is indeed part of the act, as was talking about clocks in swimming pool arenas or whatever they're called. I do think that we're talking about decision-making and lines of reporting, and I do believe this is in order and is not a point of order.
Thank you.

The Chair: I do think, especially based on some of the previous decisions on points of order that have been made in the past today, that we are starting to venture towards something that could be getting close to a point of order with regard to relevance. I think that in a previous decision the term was perhaps that instead of taking specifics – this committee, of course, is not here to judge government action; the committee is here to ensure that the tools are there, perhaps through an effective Public Health Act, for the safety, of course, of all our citizens. I think in a previous decision I'd used – the idea of perhaps hypotheticals rather than specifics that may or may not have been done in one small city or one small town, I think, was part of the previous decision as well. At this stage we're not quite at a point of order, but I do recognize that if the hon. member is making statements that ultimately lead towards causing disorder, then that would obviously be a problem for our effective use of our time here.
If the hon. member could please continue.

Ms Hoffman: Thanks, Mr. Chairman. That certainly isn't my intent. I've been very careful in revising my questions throughout the morning to ensure that I'm following your rulings, and my intention is to ask questions about the application of legislation today so we know if we need to change the legislation for tomorrow.

As it relates to the current Public Health Act, orders versus guidance versus guidelines is what my question is specifically about. There's an example where there's a daily screening questionnaire, and I'm not clear if that's an order or if that's a guideline actually, so that would be sort of a preliminary part to this question, when things like a daily screening questionnaire are brought forward for this or for any other scenario. In this example it's about schools, but it could be about a screening questionnaire for visiting a long-term care facility, for example, or for visiting a daycare that's experiencing other types of outbreaks completely separate from the realities of today.
In terms of the questionnaire one of the questions is about – let's say a generic questionnaire could have a question: do you have any of the following symptoms? And one of them could be something like: are you feeling tired? Do you have a runny nose? And if anyone in the family has any of those symptoms, the expectation – and again, I'm not clear if it's an order or if it's a guideline. If everyone in that household can't be engaged in certain environments for . . .

The Chair: Are we – just for the purposes of my clarification because I'm getting a little lost with regard to how this applies to the Public Health Act specifically. What I mean by that is that it sounds like what you are doing right now – and feel free to correct me or clarify – is that you're simply discussing current government policy, but I'm just trying to make sure that that's not the case. Again, feel free to clarify my misunderstanding if so.

Ms Hoffman: My question is around the relationship between the act and orders and guidelines and sanctions. As the act is framed currently, there can be orders that are issued, and if somebody breaches those orders, then a sanction, including a fine, can be issued. I'm trying to understand the difference between the orders and the guidelines and the sanction.

The Chair: I think of that as a good question. Is that your question, or are you still talking about specific parts of different orders instead of orders generally? I'm just trying to figure that out.

Ms Hoffman: My question is: if somebody, either intentionally or unintentionally, breaches filling out something properly on a form and sends a child to school, is that going to result in the breach of an order or the breach of a guideline? Could it result in a sanction; for example, if somebody had a runny nose that day in the family but it wasn't the specific child who was at school? Things like that.

The Chair: Again, are you talking about . . .

Ms Hoffman: The legislation.

The Chair: I'm just trying to figure out: are you talking about orders and guidelines, or are you talking about specific government policy and how it currently relates to the Public Health Act that we have today? That would be about government policy, not about the Public Health Act review itself.

Ms Hoffman: I'm asking about orders and guidelines.

The Chair: Orders and guidelines does sound like a very good question.

Ms Hoffman: The example was just like the example that was used a few minutes ago about unpasteurized milk. That's the example.

The Chair: Okay.

Dr. Hinshaw: The framework in the current Public Health Act: medical officer of health orders and executive officer orders are enforceable through a Court of Queen's Bench application. To the best of my knowledge – and we can take this away and make sure that this is correct – the ability to fine someone for breaching an order would only be after there's been escalation of enforcement to the Court of Queen's Bench and then a fine for noncompliance. The ability to levy a kind of fine at that point for a violation of an order would currently not be a part of the framework, to the best of my knowledge. I'll make sure that we get back to you on that to make sure that that's correct.

The question about guidance versus orders. It is a bit challenging to – typically there wouldn't be a penalty for contravening guidance. In our framework for COVID, just to use that as an example, we have an order that requires people to apply guidance to the best of their ability. Therefore, the guidance is actually a part of the overarching order, and as such there could be, again, sanctions.

But I want to go back to something that my colleagues said earlier when they presented from Alberta Health Services, which is that we don't go in from a public health perspective with enforcement as our first tool. That's just not how public health works. With respect to this particular situation, as we're all learning the new normal, particularly, you know, again using this example, as schools go back in, everyone is going to be learning about the new normal, trying to adjust. The first step is always education, support, what additional resources are needed in order to meet that public health requirement. Typically enforcement is reserved only for those instances where all other attempts have failed. Whether it's in this example or another example, the approach that we take in public health is that stepwise approach where enforcement is not the first way of going in and requiring someone to do something. It's, rather, that last resort.

Again, with respect to the Public Health Act framework, I think the question might be about whether there are other tools for enforcement that you as the committee might feel are needed. But right now those tools for enforcement are that when there's an order and it's violated, a Court of Queen's Bench application and any fines that would be levied would be following after that process.

The Chair: Thank you.

Ms Hoffman: Sorry. Do I get a supplemental?

The Chair: Oh. Yes. Go ahead with the supplemental. We obviously only have a limited amount of time, so I would caution individuals. I won't be policing this too heavily or anything, but when you're asking a question, try not to ask several questions in one, which could lead towards having six questions if you do three at each time, right?

Ms Hoffman: This is directly related to the example that was just given. My question is: under the current situation that was given as an example, if a parent checks off "no" on the form but a child was tired that day or did somewhere have a runny nose, is it possible that that parent could be sanctioned for sending their children to school?

Dr. Hinshaw: Again, the general approach we take in public health, if someone does something that's against an order, would be to understand the reasons why, to offer support, resources, education. If there are repeated and egregious offences despite every attempt to educate and support, it's really only at that point that enforcement comes into play. With the particular example that you've provided, with someone acting in good faith, doing the best that they can, I can't see that we would enforce that particular example, again, unless there's a pattern of repeated and egregious offences despite all attempts to educate and support. That's generally, again, the approach that we take in public health, the least restrictive means, moving to enforcement as a last resort.

1:45

The Chair: Member Rosin.

Ms Rosin: Awesome. Thank you, Doctor, for being here today. My question relates to something that was in your presentation. You mentioned that your role is primarily an advisory role except when it comes to certain orders like staying home from work or school, but then you also mentioned that you have the ability to give directives to other medical officers of health. I'm just wondering if you can clarify where that line ends. Say, in the example that a minister or a government were to say, "We're not going to blanket legislate X treatment or X examination," could you then legally still give that directive to medical officers of health despite the fact that that decision is not a ministerial one, if that makes sense? I guess my question is: where does the line between your advisory role to government begin and end, and then where does that transfer into the directives you can give to other medical officers of health?

Dr. Hinshaw: The way that I see the lines flowing: if you look at the slide that has the organizational chart, the chief medical officer of health does have the ability to provide direction to executive officers and medical officers of health as they carry out their functions under the act, but the chief medical officer of health exists within a structure of government, is appointed by the minister. Therefore, it is not the role of the chief medical officer of health to independently set policy and carry that out apart from government. The way that the position is structured is as an adviser, so the way that operationally that works with respect to the chief MOH giving direction to other MOHs and executive officers typically is with respect to government policy and to manage the emerging issues that are coming up.

I'll give you an example. Last summer there was an issue with a shortage of rabies vaccine, and we needed to move to a dose-sparing course of postexposure prevention vaccine. If somebody, for example, had exposure to a bat and they needed to have vaccine to prevent the possibility of rabies developing, we needed to use an alternate schedule for vaccine to make sure that everyone had access to vaccine because there was a national shortage at the same time as heightened awareness of issues with rabies in bats because of an unfortunate death in B.C. that was highly publicized. I gave a directive to my colleagues in Alberta Health Services to implement this new dose-sparing program, that was equally effective but allowed us to utilize our limited supply in an appropriate way.

So, for example, I have the ability to do that as a very clinical, technical decision, but if I was going to be making a policy decision that was explicitly contrary to what the minister had decided, that would be inappropriate, and at that point the minister would potentially relieve me of my role. Again, it's not meant to be separate from policy decisions. It's meant to allow clinical, technical decisions that enable a response to emerging issues, as in that case that I described from last summer, but it is not meant to be separate from my role as an appointee of the minister and therefore working within that policy environment where legislated and elected officials make the policy decisions.

Ms Rosin: And then, if I may, one more supplemental to follow up on that on the more clinical and directive side. The act itself has the words "shall subject to" or "shall submit to" treatment, examination, surgery, whatever it may be, over 30 times. I'm

wondering if those directives are some of the directives that you would have the authority to order. If so or if not, I'm also wondering if you view that there is a necessity for submittance to a treatment, just given that you already said that potentially there wasn't a need for mandatory vaccinations. I'm curious: your perspective also on mandatory treatment of whatever that may be.

Dr. Hinshaw: The framework for mandatory treatment or requiring someone to submit to an examination is a framework – in most cases where that is laid out in the act, it refers to specific diseases that are specified in regulation. That would be under a policy framework where – for example, tuberculosis; you've heard that example used already – if someone has tuberculosis or if someone, for example, is a close contact of someone who has confirmed tuberculosis and they have suspicious symptoms, then, in my opinion, if that person, after education, support, and all the other least restrictive means that are attempted, refuses to consent to an examination for the purposes of diagnosis and refuses to consent to treatment, I do believe it is necessary in the act to have provisions that allow a local medical officer of health to require that person to submit to an examination and to require them to undergo treatment because someone who has tuberculosis can be infectious for a very long period of time, can spread to many other people. We know that in the world currently there are both multidrug resistant and extensively drug resistant strains of tuberculosis that can cause significant illness if we aren't able to manage it.

While it's the measure of last resort, it is something that I believe is necessary in the act to retain. But, again, it's not used for any illness, and it's only used to protect others from that individual. It is never ever meant – and it is not structured that way in the act – to require someone to submit to any kind of examination or treatment for their own benefit. That is not part of the framework. It is only with respect to illnesses that are laid out in the regulations that are a threat to other people.

The Chair: Thank you.

Member Hoffman.

Ms Hoffman: Thanks. This question flows from the question that my colleague Member Rosin just asked and also from some examples that we saw previously, not related to COVID at all, around congenital syphilis. We know that there were situations where medical officers of health felt that their advice wasn't being accepted when they were trying to act on preventing death in congenital syphilis in particular. From what I recall from those days, probably around 2008 or 2009, there were very public departures. I'm wondering if there are other mechanisms, rather than one having to quit, whether it's a chief medical officer of health or the local medical officers of health, where folks can raise an alarm if they feel that their actions aren't being followed by those they report to, including government, as was outlined in your presentation, or if the only recourse for an individual who's within the organization is to quit.

Dr. Hinshaw: In my opinion, the role of a medical officer of health, chief medical officer of health: part of that is to raise concerns when there are issues. Obviously, as I've mentioned, it's not even discretionary in my case; it's "shall monitor" and "shall [provide] recommendations." I think that no matter what job anyone has, whether it's a chief MOH, an MOH, or anyone in any position, particularly people who are professionals, there may come a time when an opinion of that individual and their direct report is different, and there may need to be a decision to leave a position. That's not unique to the chief MOH or MOHs. I think that, for the most part, medical officers of health and chief medical officers of health work, you know, within the structures, within our reporting relationships to the best of our ability to ensure that any concerns we might have are voiced.

But I think that if the question is whether or not there should be additional measures in the act to permit, allow, or protect some kind of a reporting mechanism, again that would be part of, in some ways, going back to the framework that you mentioned about being a loyal adviser or the kind of external public reporter, because I think it is a decision of what the role of the chief medical of health – what role does government wish for the CMOH to play? As I said, there's no one perfect role. Each of them has pros and cons. That's, in my personal opinion, something that's not my decision to make. I would function within whatever that role is.

You know, again, like anyone else, if in a position you feel that you're not able to be maximally effective, you seek another position where you can be effective. That would be independent of whatever framework was set out. That would still happen.

Ms Hoffman: Thanks very much. This is a clear segue, I think, into what I didn't even have prepared. In terms of the loyal executive model, I believe that your summary is very clear and accurate, that your responsibility is that you shall raise concerns with the minister, but there is no responsibility to raise them with the public or to raise them in a way that ensures that everyone understands that the chief medical officer of health and the local medical officers of health have the ability to raise concerns in a way that is unfettered. The reporting structure, as it currently is, is directed, I think, from this legislation.

1:55

This gives us an opportunity as this committee to consider: if we want to instill greater public confidence, do we want to consider one of the other models? My question would be: of your colleagues in other jurisdictions, either within Canada or internationally, which models – and if you don't have this available today, I'm happy to receive it in writing – have the greatest level of public transparency and accountability to the public rather than to the minister and then the Premier and then Executive Council?

Dr. Hinshaw: I don't have that at my fingertips, so that'll be something I would have to take away and work with the team to get back to you. But I would just reiterate that I do think that there are advantages and disadvantages to all models. I personally feel that a chief MOH can be very effective and successful in any one of those models, and it's just a policy decision as to what the government wishes the role of the CMOH to be.

Ms Hoffman: Thank you.

The Chair: Thank you.

Member Lovely.

Ms Lovely: Thank you so much, Mr. Chair. Dr. Hinshaw, I just want to share with you that my community is so proud of the work that you're doing. You completed your undergraduate degree in Camrose at Augustana campus, and they're just so proud of you. I wanted to acknowledge that.

My question. Under section 29(2.1) of the Public Health Act, the chief medical officer of health may take whatever steps are, in your opinion, necessary in order to lessen the impact of the public health emergency. This includes the ability to prohibit someone from going to school or work. It also includes powers to quarantine or isolate an infectious person. This is obviously a really significant power. Can you walk us through the kinds of determinations that you go through to make this decision?

Dr. Hinshaw: Sure. I'm just wanting to reference the specific one. That was 29 . . .

Ms Lovely: Section 29(2.1).

Dr. Hinshaw: With respect to quarantine, I think quarantine in people's minds is often equated to a very heavy-handed tool. In fact, quarantine, in terms of public health technical language, simply refers to an individual who has been exposed to an infectious disease and therefore may be in an incubation period and about to develop that infectious disease. That person, when they're required to stay home for a certain time period, would be in quarantine.

We distinguish between – an individual who is actively infected and infectious, technically speaking, would be isolated. I'll use an example of measles. If an individual has measles, they would need to be isolated until they're no longer infectious from that particular illness. If someone is exposed to measles and not immune to it, they could come down with that illness up to three weeks after their exposure. It's quite a long period of time. Unfortunately, with measles it is possible for an individual to pass measles to others before they become sick.

With respect to what we take into account and how we decide about quarantine, quarantine is only effective for illnesses that can be passed from one person to another before symptoms start, because if someone is only infectious after they are sick, then it's quite easy to simply require them to stay home if they start getting symptoms. But for an illness like measles, unfortunately, for COVID, where it seems that it is possible for someone to pass that virus to others a day or two before symptoms start, if you don't require that person to be away from others for that period of time during which they might be incubating or the virus might be in their body but not quite have developed an illness yet, then we have lost an opportunity to prevent that person from passing it on to others.

Quarantine would only be used in conditions where there's an infectious disease, an individual has clearly been exposed to someone who was infectious with that disease, and it is a disease where a person can transmit it before symptoms start. If those three tests are met, that would be when we would consider quarantine as an intervention that would be useful in that case.

Ms Lovely: Thank you, Dr. Hinshaw.

I do have a supplemental, Chair. As a follow-up: could you expand on how a quarantine or isolation order is currently enforced under the act and if you believe those provisions are adequate?

Dr. Hinshaw: Under the act, as I mentioned earlier with respect to enforcement, a medical officer of health can write an order for quarantine or isolation, and a person is legally obliged to follow that order. If, however, they violate it, again, the escalation of enforcement would be to go to the Court of Queen's Bench to get a second order that says that not just the medical officer of health says that you have to do this, but the court also says that you have to do this. If there are continued challenges, if that person continues to not follow those orders, then prosecution could be implemented with respect to fines or any other penalties that the court might consider to be appropriate. As I mentioned in an earlier question about enforcement, I think, again, it would be something for this committee to determine. If that particular method of enforcement isn't particularly timely, it is quite challenging to enforce from that perspective, so that may be something that you want to consider in your deliberations.

The Chair: Thank you.

Member Hoffman.

Ms Hoffman: Thank you very much. I'm going to pull on some of the examples that you've given to us earlier today through your presentation and conversations that we had with AHS as well. I'd like to explore further how decisions are made and if we need to consider changes to that when it comes to future legislative amendments.

By way of context, earlier in the pandemic there was an order to lock down all of Alberta in order to bend the curve, and this action was driven by the government of Alberta and was based on the expertise, I believe, that you provided as well as AHS. Later the government of Alberta took a different approach around a distinct demographic approach. Most of Alberta opened up, with Calgary and Brooks still being locked down for a slightly longer period. Again, this was driven by the province. But as it's progressed through the pandemic, we've seen that the responsibility has been divested to the local communities, and initiatives around wearing masks have been the decisions of municipalities. As the province's chief adviser, the chief medical officer, and as we're in a pandemic, why was your advice that municipalities, without having that health expertise, be the ones that make the decisions as we move forward?

Ms Rosin: Point of order.

Ms Hoffman: Or was it your advice under the current legislation?

The Chair: I believe that I know where this point of order is going. However, I will offer it up to Ms Rosin.

Ms Rosin: Under relevance. This seems like a question related to mask policies and to the government's response to COVID, not the regulations or legislation defined under the Public Health Act.

The Chair: Ms Renaud.

Ms Renaud: Thank you, Mr. Chair. Actually, I believe this is actually very relevant. This is about lines of reporting and decision-making. I think where the question was really going is about, you know, the expertise of the medical officers of health, particularly the chief. So I don't believe that this is a point of order.

The Chair: I actually do find that in this case there would be a point of order. The reason why is because the hon. member is asking a specific question about what her advice may or may not have been, not the lines of reporting or the information flow, as was the premise of the question. The premise of the question leads to: does advice change? Or perhaps a question along the lines of: do you think that – I don't know – your advice was well taken? Or something like that. Either way I actually have trouble figuring out how it falls within the mandate of this committee, which is simply just to review the Public Health Act, not the decisions of a medical officer of health or a chief medical officer of health specifically in specific situations because that would be leaning towards more the policy decision-making side of things rather than what tools are available for future pandemics and decision-making or future public health issues.

If you could please rephrase because I don't think that that question was quite in order.

Ms Hoffman: Yeah. Fair, Mr. Chair.

Given that a few months ago there was provincial direction flowing from the legislation that health decisions were made at a provincial level and given that – where in the legislation does it allow health decision-making to be done under municipalities that may not have that expertise or school authorities that may not have that expertise, other orders of government that don't have the health

expertise? Would it be the advice of Dr. Hinshaw that that should be reconsidered as we move forward, that health decisions be made by health experts in policy?

2:05

Dr. Hinshaw: The Public Health Act isn't the only piece of legislation that enables decisions to be made for the good of populations. It's certainly beyond the scope of my expertise to comment on other pieces of legislation and the powers that those other pieces of legislation give to, for example, municipalities or local school boards.

I think what will be really important, as you as a committee review the Public Health Act and consider what changes you may wish to make and on this particular topic, whether or not there are authorities that could be contemplated for other groups. I guess it would be important, in my opinion, to look at the authorities granted to, say, municipalities, school boards, and other public actors under other pieces of legislation because the Public Health Act, again, is really about the use of particular authorities as often a means of last resort to ensure that the health of the population is protected. But I believe that still there are other tools related to health in other pieces of legislation that may be relevant to other orders.

I think I find it a bit of a challenging question to answer with respect to how all of those pieces of legislation come together and whether there are gaps that are left because, I think, from a public health perspective, as you heard earlier, we are concerned with the health of how our environment is built, clean air, clean water, you know, all sorts of things that contribute to health that are outside of the health system. There are many other pieces of legislation that deal with some of those foundational aspects of health. I think my colleague from Alberta Health Services articulated very well that public health is something that we're all in together. While there's a certain expertise that those of us who are public health physicians or executive officers have due to our training and that provision of advice, I do think it's important that collectively we see public health as something that's a result of all of our efforts together.

I guess I would just say that questions about the respective roles would be best looked at in light of how all those different pieces of legislation enable supports to health because I think that it's really important to not just have public health decisions or decisions that impact public health. To think that the Public Health Act is the only piece of legislation that enables that, I think, is more narrow than I would advise. I don't know if that's a fulsome response to your question, but again, I'm not familiar with all those pieces of legislation, and I do think they need to work together to have the best outcome of the best health of the public.

The Chair: A supplemental?

Ms Hoffman: Thanks very much. So given that, would it be possible – and again, perhaps in writing – to talk about what some of the additional pieces of legislation might be given that health is a provincial responsibility as deemed by the government of Canada? We know that it's important. I think that we have public health advice that gives local decision-makers confidence to be able to make their decisions. I know that there were examples of councillors saying that they felt like they were bearing the responsibility of decisions that they knew would have health consequences if they made the wrong decision, but they didn't have the information or the expertise to be able to do so. What would be the gaps, and how can we ensure that the provincial responsibility for health is acted on in a way that ensures that everyone has the right information and that those who are ultimately responsible are the ones who are making the decisions if it comes to wearing responsibility as we move forward? That would be helpful.

Thank you.

Dr. Hinshaw: Yeah. Yes.

The Chair: Just for clarity, that was a request for an in-writing response, correct?

Ms Hoffman: Yeah. That'd be great.

The Chair: Mr. Neudorf.

Mr. Neudorf: Thank you, Mr. Chair. Dr. Hinshaw, I just would like to thank you for your diligence, expertise, and ability to adapt. I think we've seen massive changes in the province from our first fears to our current realities. We're fortunate in Lethbridge that the number of cases is now zero. At least they have been for two or three days. I appreciate your ability to continue to evolve with the situation and change how we approach it as we learn more.

In line with that and the recent conversation, as a layperson reviewing this act, it's not unreasonable that some Albertans were concerned about sections that on the surface could appear to have a strong overreach of and into civil liberties. When it comes to powers granted under this act, again just following the recent conversation, what is the role of regulations and other acts like the FOIP Act or the Health Information Act or MGA, different things that you are aware of or not necessarily aware of every single one, that in practice can clarify or constrain the more expansive powers that are evidenced within the Public Health Act?

Dr. Hinshaw: The final section of the Public Health Act is one of paramountcy that indicates that the Public Health Act takes precedence over other pieces of legislation with the exception of the Alberta Bill of Rights, so the Health Information Act and FOIP and other pieces of legislation would be superseded by the Public Health Act.

The Public Health Act does contain extraordinary powers, and they are powers that are used in extraordinary times. As you know, this is the first time there's ever been a state of public health emergency declared. It's a good opportunity to have a look at those powers. We've already discussed a couple that I think would be reasonable to remove from the act. I think that other powers or other authorities that give some flexibility are important to retain because I do believe that we can't predict everything that's going to come at us from a public health standpoint. I think it's really important to remember that the people who have the powers in this act – the most significant powers are given to, in fact, elected officials. The most significant powers in this act under the state of public health emergency are powers given to ministers in cabinet, in whom the public has entrusted a responsibility by voting them into their office, and the powers that are given to those of us who are not elected are secondary to that governance framework I guess I would say. While there are significant abilities to do things to protect public health, they are not done lightly and they are done under that governance.

If, for example, an individual medical officer of health or executive officer overreached, there is the ability for the chief medical officer of health to intervene either directly in that decision or in a worst-case scenario to remove that person from their role. The chief medical officer of health can be removed at any time by the Minister of Health. Again, I think it's really important for people to remember that none of these powers mean that an individual can do whatever they want. It's all within governance, structure, framework and must be appropriate to the circumstances.

I think you've heard earlier from Alberta Health Services, and I will reiterate that the powers are here for the worst-case scenario that's failed all other attempts to intervene, so it's not meant to be that initial reaction to an issue. It's actually in that very small number of cases where all other attempts are not possible so that we do have the ability to protect the public's health if we need to take that step.

I think one of the other pieces of the act that I know that you're contemplating are those checks and balances. We have some of them in the act. Are they enough? Do we need more? I will leave that deliberation to you as the committee to consider what else might be required, but I would say that, for example, there've been questions about a need to make decisions very quickly outside of the typical legislative process the way that the Public Health Act allows that to happen.

It's really important to know for COVID in particular – and this could be the case with other infectious diseases – the modelling that we had, which was the hospitalization and ICU rate modelling that we did in Alberta, actually per population basis, our high projections were essentially what Ontario experienced, and our severe projections were essentially what Quebec experienced. Our hospitalization and ICU modelling actually predicted what those other provinces experienced. Thankfully, we didn't, and what we know is that if you hit a certain acceleration point in an infectious disease spread, a matter of days can make a difference, so making a decision on a Monday versus a Friday can actually make a huge difference in terms of outcomes.

It should never be taken lightly. It should not be used unless it's necessary, but again I would really ask that you consider that all of the authorities in this act are not just for what we've already experienced; they're for what we might experience in the future. Again, recognizing that there need to be checks and balances, there need to be assurances that there's not going to be use of this act in an inappropriate way, I would advocate that tools not be taken out but, rather, if additional checks and balances are needed, that those be put in.

2:15

The Chair: A supplemental.

Mr. Neudorf: Thank you, Mr. Chair. You've somewhat anticipated my second question, but I think you've hit the crux of the issue that this committee is faced with and the challenge that we have before us, the absolute unpredictability of what the next public health emergency could be. To try to foresee every eventuality is virtually impossible, so to allow for flexibility and yet the ability to respond because – as you just said, time and the speed with which to make decisions in terms of response can have a vast impact on the outcome of whatever that emergency is, and that is the exact challenge.

If you had any further thoughts. Obviously, what we're trying to balance here, and it's been brought up several times: the perspective on the balance between civil liberties and protecting those – we have many individuals within Alberta that hold those very, very true and dear to their hearts – as well as the overall obligation of government in the general sense of what government is, to protect the full public health. Any further advice? I think you have touched on it, but I would ask that you just expand once more on trying to balance those two things within the act and whatever changes we make so that we can find that balance that allows us to do a great job at protecting the public health, not overly infringing upon the civil liberties of any free and independent individual within the province of Alberta.

Dr. Hinshaw: I mean, I think we've spoken already about a couple of provisions in the act that I don't think would be needed and therefore could be taken out, and that may help people to understand that the act is meant to be a tool that helps us protect people not from themselves. I think there's also a misconception that we're trying to protect people from themselves, and that's not the intention of the act. You heard that earlier from my colleague on the question about raw milk, that it's about protecting people from others and from public activities that cause risk. I think that one of the things I might suggest is that I know we've put together a summary of the current checks and balances in the act, so perhaps if I could take that away and give a bit more thought to what additional checks and balances I might suggest – I feel I could give you a more fulsome answer if I could just spend a little bit more time thinking about it.

The Chair: Thank you very much.
Member Hoffman.

Ms Hoffman: Thank you very much, Mr. Chair.

The Chair: Cognizant of the time, we've got about three minutes.

Ms Hoffman: I will use one of them. I just want to say how helpful this has been, and I think I would wonder if it would be possible, as we want to make sure we get this right – legislation is something that has teeth. If the committee requests for you to return, is that something that you would be able to comply with, knowing how busy you are?

Dr. Hinshaw: Of course. This is a priority. If the committee requests it, I would be happy to come back.

Ms Hoffman: Thanks so much. Just a very short supplemental. With regard to the legislation today, does it allow you to consider things like transportation plans for other authorities like schools?

Dr. Hinshaw: The current Public Health Act is really focused on observing, detecting a threat based on inspection and then taking action against that threat. I don't know that the current legislation restrains where that threat might exist, but typically the legislation is for the most part relatively reactive when it comes to identification of threats. Again, there would be no limitations on where we could investigate as long as it's in a public place, but then typically it's the identification of a threat that would lead to an action to manage that threat.

The Chair: Member Dach.

Mr. Dach: Yes, quickly. I have a quick question for Dr. Hinshaw. Thank you once again for coming. You mentioned earlier in your comments that different organizational models of chief medical officers of health across Canada exist and that you could work under a different variety of existing models and that you'd be comfortable with that and that you've been respectfully listened to and that your advice has been considered, in your words. Now, I was just wondering: if indeed the chief medical officer of health actually became an independent officer of the Legislature, would that change the role of the chief medical officer of health in a way that is compatible with your current responsibilities?

Dr. Hinshaw: Again, that would be something I think I would have to spend a bit of time thinking about. Of course, I'm very familiar with the current role, so I would have to say that I would have to look more in detail about what the changes would be if I were to be an independent officer of the Legislature. I'm not sure I can provide

you with a robust answer to that question today, but if I could take that back and provide an answer in writing . . .

Mr. Dach: Please do take that and respond in writing. We'd be very pleased to receive your answer.

Dr. Hinshaw: Okay.

The Chair: A supplemental if you should so choose.

Mr. Dach: Well, I just basically, actually once again say thank you very much. I mean, we're, on all sides of the House, very respectful of the work that you do. I know that you're in tough position and know that your heart is in the right place when you're looking at the health of our province and our children in particular and our elderly as well. So thank you once again.

Dr. Hinshaw: Thank you.

The Chair: Thank you.

What we have done with previous presenters is that we've given – well, for the last three, anyways, there's been an opportunity. If you would be so kind as to perhaps take a question or two back for written responses, just knowing that we have limited time here.

If there were, say, a question from either side or both sides that you'd like to read into the record for the purposes of receiving a written response, now is your opportunity.

Mr. Rowswell: You partially answered this, and I just wanted to make sure it was written in case you wanted to expand on it. Section 52.21 relates specifically to the significant likelihood of pandemic influenza. What are the benefits to the chief medical officer of health in terms of response if the words "pandemic influenza" were amended in the act to "pandemic," and how does this change in language affect the chief medical officer of health's ability to respond to a public health emergency or a declared state of public health emergency?

Ms Hoffman: In the context of a pandemic, what's the standard for what gets elevated to elected officials? As was mentioned, the chief medical officer of health is an advisory role. What's decided by officials such as the medical officers of health? How often are issues being pushed up by the public service, by professionals like yourself to cabinet, and how often are they being pulled up from elected officials, be it the Minister of Health or Premier or the executive committee of cabinet?

Thank you.

The Chair: Thank you. That concludes the question period with regard to Dr. Hinshaw's presentation.

I want to take this opportunity as the chair of this committee to thank you for your time and for coming here and attending and helping us with regard to this review of the Public Health Act. Thank you very much.

Dr. Hinshaw: Thank you.

The Chair: Having now heard from all the presenters scheduled to meet with us today, our next item on the agenda is other business. At this point, I would like to – oh. Please go ahead, Member.

Mr. Nielsen: Thank you, Mr. Chair. I must say that the presentations were very interesting given the fact that I'm not actually a full-time sitting member on the committee. I would love to, maybe, at some point in time. Given, as you mentioned, the constraints on the time, I think it would be prudent at the very least – and I think Member Hoffman had thankfully asked this question, because I've been thinking about this for probably about the last 15 minutes. I would like to propose a motion for the committee to consider.

The Chair: It's my understanding – and correct me if I'm wrong – that prior to hearing the motion, we must first get majority approval to hear the motion itself. On the question of whether to hear . . .

Dr. Massolin: Mr. Chair, do you know what the motion is before you vote on it?

The Chair: I'm voting to hear the motion first.

Dr. Massolin: Yeah; he could put it forward, and then you could decide, right?

The Chair: Okay.

Dr. Massolin: Yeah. I mean, it's up to you.

The Chair: Read it into the record. Yeah.

Mr. Nielsen: Thank you, Mr. Chair. I would move that

> the Select Special Public Health Act Review Committee invite Dr. Hinshaw, chief medical officer of health, to reappear before the committee for one and a half hours at the call of the committee to provide additional testimony and insights as the committee considers amendments to the Public Health Act.

2:25

The Chair: Having heard the motion as proposed by the hon. Mr. Nielsen, all those in favour, please say aye. Any opposed, please say no.

That is carried.

At this point I would like to briefly update committee members on the response to our invitation for submissions. As you know, the deadline for submitting written submissions passed on August 25, 2020. I would like to report, though, that we have received over 700 submissions, all of which will be posted on the committee's website by the end of business tomorrow and may be reviewed by committee members and discussed at our next meeting if we should choose to do so. Research services, as I understand, will also prepare all of us a summary of these submissions, again, for review, potentially at our next meeting.

Is there any other business to discuss today?

Seeing none, the next meeting will be at the call of the chair.

I would look to members for the potential motion to adjourn this committee meeting.

Mr. Nielsen: So moved.

The Chair: I see Member Nielsen has moved that the August 27, 2020, meeting of the Select Special Public Health Act Review Committee be adjourned. All those in favour, please say aye. Any opposed, please say no. That is carried. We are adjourned.

Please remember, once again with regard to health and safety protocols, to make sure that you take your cups, any napkins or anything that you have used. We will, I'm sure, see each other all shortly. Thank you.

[The committee adjourned at 2:26 p.m.]

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