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Submission to the Standing Committee on Justice Policy

Respecting Bill 56:

***Emergency Management Statute
Law Amendment Act, 2006***

Ontario Hospital Association
May 2006

Ontario Hospital Association

The Ontario Hospital Association (OHA) is a voluntary organization representing approximately 159 public hospital corporations, across 225 sites, in Ontario. Among its members are all the public hospitals in Ontario as well as the province's psychiatric hospitals. Many other health-related organizations are among OHA's approximately 200 associate and affiliate members. Founded in 1924 as an independent, non-profit organization, the Association is governed by a 28-member Board of Directors comprised of hospital trustees and chief executive officers from across the province, as well as three ex-officio members of the board.

OHA is the voice of Ontario's hospitals. It is a leader in shaping the future of the health care system, fostering excellence, building linkages with the community and advocating for quality health care. It is a positive force for change in hospitals and across the health care system, advocating on behalf of its members. OHA represents hospitals' needs and views to government, other organizations and the public.

OHA is organized into five Regions, representing north, east, south-western and south-central regions, and the Greater Toronto Area. Each has its own Regional Council and elects members to the OHA Board of Directors. These Board members represent the following hospital constituencies:

- Complex Continuing Care, Mental Health and Rehabilitation;
- Community Hospitals;
- Small Hospitals; and
- Teaching and Specialty Hospitals

There are six main divisions at OHA including the President's Office, Strategic Human Resources Management, Educational Services & Operations, Policy and Public Affairs, Human Resources and Information Technology, and Finance and Administration.

OHA has formal links with over 30 professional and volunteer organizations in the health care field through its Allied Groups. This alliance enables OHA to collaborate with many health care professionals working in hospitals to improve Ontario's health care system. OHA also has a formal relationship with the Hospital Auxiliaries Association of Ontario (HAAO).

OHA is also a member of the Canadian Healthcare Association, the national federation of the provinces and territories, and the Ontario Health Providers Alliance, a group including representatives of all major health service providers in the province.

Mission Statement

The Ontario Hospital Association is an association of health care providers dedicated to the continuing improvement of health services in Ontario through leadership, advocacy, education, communications and service.

Introduction

Public attention has been focused on the adequacy of Ontario's emergency management statutes in recent years following two declared emergencies - the SARS Outbreak and the Electricity Blackout of 2003. The effectiveness and clarity of declaration and order making powers in Ontario's current *Emergency Management Act* were compared with the emergency preparedness and response statutes of other province. Following the SARS outbreak in 2003, the Standing Committee on Justice Policy conducted a review and reported on the adequacy of Ontario's emergency management legislation. A draft bill was introduced in November 2004 as Bill 138.

In drafting Bill 138, the Standing Committee consulted with interested stakeholders such as the OHA as to how to best manage provincial emergencies in a way that would balance the interests and needs of all Ontarians. While a number of changes were made to Bill 138, the introduction of Bill 56, the *Emergency Management Statute Law Amendment Act, 2006*, is an important step in ensuring that Ontario is prepared for best equipped to manage provincial emergencies.

The OHA is pleased to offer our comments on Bill 56, the *Emergency Management Statute Law Amendment Act, 2006* in the spirit of ensuring that Ontario is able to effectively respond to all types of emergencies in the future.

Systemic Coordination

Hospitals were at the forefront of the SARS outbreak, and as a result, much was learned about emergency management and what can be done to ensure that health care providers have the necessary resources and support to respond effectively in future emergencies involving the health care sector. In an emergency situation, health providers face tremendous challenges including the management of supplies; patient transportation; secure and guaranteed centralized telecommunications; and human resource management, while at the same time attempting to maintain service to the community.

It is our understanding that, as currently drafted, Bill 56 confirms the powers of the Chief Medical Officer of Health (CMOH) under the *Health Protection and Promotion Act*, except to the extent that there is conflict with an order made under section 7.0.2 of the *Emergency Management Act*. We endorse the need to retain the independent decision and order-making power of the CMOH, but would suggest that further clarification as to the role CMOH is needed, specifically in instances where there is a difference of opinion between the Premier and the CMOH (e.g., instances of potential quarantine).

The legislation provides clear authority to the Premier and the Lieutenant Governor in Council (LGIC) to declare emergencies and make orders. We believe that there is a greater need to ensure that all lines of communication remain open, and that any decisions and orders issued on a provincial level are structured in collaboration with local emergency plans. Specifically, local hospital and community involvement play a

critical role in determining whether or not to close or establish such a facility. These plans not only take into account the unique needs of local health care providers, but also provide a valuable framework on which provincial emergency plans can be prepared.

Scope of Authority

The OHA supports the identification of an overarching, centralized authority to provide for coordination of the system as a whole during a declared emergency. We therefore believe that the Premier's powers in Bill 56 as central-decision maker are necessary to ensure that there is a coordinated system approach to province-wide emergencies.

However, while the OHA endorses the need to broaden the current *Emergency Management Act* to ensure that there is sufficient authority for decision-making during an emergency, we are concerned that as currently drafted, section 7.0.2 provides the LGIC with broad order-making authority to potentially conscript health care professionals to work during a declared emergency.

Paragraph 12 of subsection 7.0.2(4) of the proposed amendments to the *Emergency Management Act* authorizes the LGIC to, amongst other things, order the "authorization of any person to render services of a type that that person, or a person of that class is reasonably qualified to provide." Subsection 7.0.2(8) provides that the employment of a person providing services pursuant to an order under paragraph 12 shall not be terminated because the person is providing those services.

We understand that this ability to "authorize" professionals to perform certain services was not intended to conscript people to work, but to allow for individuals with certain skill sets, who are not "qualified" to work in Ontario, to use these skill sets accordingly. As an example, in a declared emergency, physicians from outside the province would be "authorized" to provide their skills and expertise in Ontario despite the fact that they are not licensed in Ontario, and be immune from personal liability.

While we support such a provision that would permit these individuals to work during an emergency, we are concerned that the legislation as currently drafted, (in addition to the penalties that can be imposed for failing to abide by an order), suggests that health care professionals may be compelled to work. If this is the case, we would suggest that the legislation be amended to ensure that this type of order is made only after all voluntary efforts have been exhausted.

If the legislative intent is such that orders under paragraph 12 are to apply only to health care professionals without the jurisdictional qualifications to practice in Ontario, then subsection 7.0.2(8) is unnecessary. We would ask that these provisions be reconciled to ensure that the intent of these provisions, as articulated previously by the Minister, is clearly set out in the legislation.

Paragraph 9, 10 and 11 of Subsection 7.0.2(4) also give the LGIC the ability to make orders in respect of:

- the use of any necessary goods, services and resources;
- the procurement and distribution of necessary goods, services and resources; and,
- the fixing of prices for necessary goods, services and resources.

Given that the proposed definition of “necessary, goods, services and resources” includes medical services, we are further concerned that this definition could be interpreted to include human resources and provide the LGIC with the power to make an order accordingly.

While we appreciate the need to ensure that the LGIC retains significant powers to effectively distribute necessary resources during a declared emergency, we would ask that further clarification be provided to ensure that human resources are not caught within the scope of “medical services.”

Suspension of legislative/regulatory requirements

Any emergency legislation must clearly provide for the suspension of existing legislative and regulatory requirements, where appropriate. During the SARS emergency, it became abundantly clear that in some instances, existing legislative and regulatory requirements were an impediment to responding effectively to the challenges that arose. For example, the discharging of patients to long-term care facilities was difficult due to regulatory requirements that permitted transfers only to facilities that were on the patient’s list of preferred facilities.

Given that this issue was raised during the extensive consultations on Bill 138 by a number of stakeholders, the OHA applauds the government for recognizing this need and supports the inclusion of the provision in Bill 56, whereby emergency orders would prevail over all other statutes, rules, by-laws or orders, with the exception of the *Occupational Health and Safety Act*.

In addition to conflicting legislative and regulatory requirements, restrictive collective agreement language regarding work assignments make it challenging to redeploy Ontario’s unionized health care professions throughout an institution, or throughout the province, during large-scale emergencies. Given that health care professionals may be required to provide patient care at a moment’s notice during emergencies, temporary cessation of restrictive collective agreement language may better facilitate the redeployment of health care workers within hospitals and across the province.

Further, there are significant human resource/labour issues that arise during an emergency. The SARS experience reinforced the need to ensure that there is a process to collectively engage various partners – unions, management, government ministries and associations – to address these complex systemic and legal issues well in advance

of an emergency, in order that decisions made during an emergency may ultimately be made in a timely manner.

Deviation from Professional Standards

One of the concerns addressed during the stakeholder consultations preceding Bill 138 was the need to address possible deviations from professional standards articulated in various statutes and their related codes of conduct during a declared emergency.

Statutes such as the *Regulated Health Professions Act*, *Nursing Act* and *Medicine Act* and their various codes of conduct, set out professional standards of practice of a profession. In an emergency or in an outbreak of infectious disease, actions may be taken in the absence of any prevailing or known standard, or possibly in contravention of this standard. While it is acknowledged that such deviation may be necessary and even desirable in emergencies, there is currently no mechanism by which to provide for such contingencies.

Amendments to the *Employment Standards Act*

The OHA endorses the need for amendments to the *Employment Standards Act* (ESA) that would provide for job protection during a declared emergency. We recognize that during this time, professionals may be required to provide care or assistance to persons prescribed by the legislation. We are concerned though, that as currently drafted, the amendments that broaden the circumstances in which an employee may take unpaid leave may be somewhat at odds with the provisions found in paragraph 12 of subsection 7.0.2(4) of the *Emergency Management Act* that potentially compel health professionals to work.

Subsection 50.1(5) provides that an employee is entitled to take leave for as long as they are not performing the duties of their position because of a declared emergency and one of the additional reasons for leave applies under clauses 50.1(1)(a)-(d) (e.g. subject to an order, needed to provide care and assistance to a prescribed individual). We support this inclusion, but would ask for further specification as to the duration of the leave in instances where the duration of the declared emergency is different from the duration for leave under 50.1(1)(a)-(d). It is foreseeable that, even in instances where a declared emergency is over, an employee may be required to continue to care or assist a prescribed individual (e.g., extended quarantine).

Conclusion

As we stated above, the OHA endorses the need for an overarching, centralized authority to provide for coordination of the health system during a declared emergency. While we support such an authority, we would ask that the LGIC's order-making powers pursuant to subsection 7.0.2(4) be clarified to ensure that their intent and scope is sufficiently defined and set out in the legislation.