

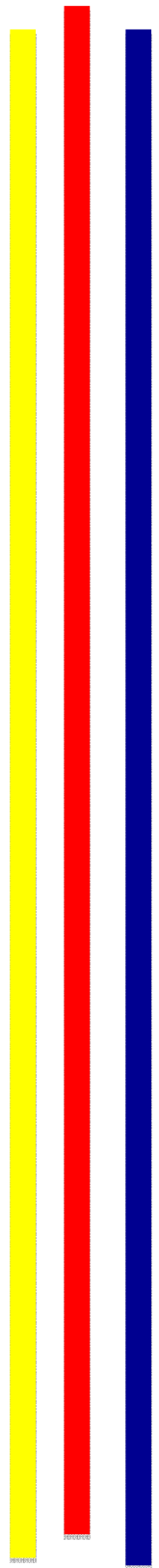
SPECIAL SERIES: THE ROLE OF FEDERALISM IN PROTECTING THE PUBLIC'S HEALTH

*Understanding the Role of Intergovernmental Relations
On Public Health Policy:
A Case Study of Emergency Preparedness and Response*

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Public Health 2008(3)



INTRODUCTION

A combination of events over recent years has led to a serious reconsideration of Canada's capacity to prepare for and respond to public health emergencies. The SARS (Severe Acute Respiratory Syndrome) outbreak in Toronto in spring 2003, and the heightened concern globally over a potential influenza pandemic, has called into question various aspects of the existing public health systems in both Ontario and across Canada. Issues such as inadequacies in outbreak management protocols; infection control and infectious disease surveillance; the linkages between public health systems and public medical services; the absence of protocols for data and information sharing between orders of government; and the lack of coordination across institutions and jurisdictions for outbreak management and emergency response have all been raised as areas requiring significant re-thinking. At the same time, the threat of international terrorism since the World Trade Center attacks of 11 September 2001, and the subsequent concerns about bio-terrorism, continues to put pressure on Canadian policymakers from all three orders of government to develop adequate and harmonious emergency response plans and capacity to deal with a host of possible crisis scenarios.

Taken together, the questioning of the existing public health infrastructure in Canada to deal with infectious outbreaks, as well as the continuing efforts to develop policies and strategies to better respond to emergencies in general, highlights the necessity of examining Canada's ongoing ability to ensure the health security of its citizens. Recent developments at the federal level such as the creation of a new department of public safety, the Public Health Agency of Canada (PHAC) and the appointment of a Canadian Chief Public Health Officer (CPHO), clearly demonstrate the centrality of this issue to present political agendas. Of particular concern in evaluating Canada's ability to ensure the health security of its citizens are the intergovernmental aspects of Canada's public health systems. As with many policy issues in Canada, the problem of constitutional jurisdiction and the respective roles and responsibilities of the three orders of government are central to the effective management of public health. The provinces and territories have primary

responsibility over most issues affecting public health as well as medical services in the case of a health emergency, whatever the cause. However, given the broad implications of ensuring health security the federal government also has some key responsibilities. These include potential authority over national emergencies, border control, intelligence networks within the country and with other nation-states, and relations with foreign governments and international organizations. In the public health sphere more specifically, Ottawa's powers are more limited. Yet these powers are integral to the overall effectiveness of Canada's public health regime, including for example, quarantine and criminal legislation affecting public health, among other responsibilities.

Together then, the need to rethink Canada's approach to emergency preparedness and response in the public health domain, and the federalism / intergovernmental backdrop against which this will take place, provide the subject matter of this case study. The principal organizing effort for the purposes of this study is the Government of Canada's announced "federal strategy" to improve Canada's public health system generally, and to better prepare for and respond to public health emergencies more specifically. Central to the federal government's plan is the newly-created PHAC and the appointment of the CPHO, a prime responsibility of both being to prepare for future public health emergencies. The third key component of this federal strategy is the creation of the Pan-Canadian Public Health Network to manage intergovernmental relations. In addition to this core strategy, the case study also touches on one other related federal initiative: the Government of Canada's broader, national security plan. *Securing an Open Society* outlined the overarching goals of the federal government in guarding the security of Canadians against external risks. Of particular interest, it reiterated the national government's commitment to create a national public health agency and announced other complementary measures designed to manage potential public health emergencies from a national perspective.

BACKGROUND

The appearance of public health emergencies as a national concern – Opening a public policy window

Between 1999 and 2003, Canada's approach to managing public health security, including for example, the tracking of infectious diseases, emergency planning and response for outbreaks, and communications and information flows during emergencies, came under intense public and political scrutiny and were found, for the most part, wanting. Three unrelated events have each led to varying degrees of change in the Canadian approach to preparing for and managing public health emergencies, particularly at the federal level.

First, in two separate reports made public in 1999 and 2002, the Auditor-General of Canada raised serious concerns regarding the effectiveness of Canada's infectious disease surveillance system and the overall national public health framework. The Auditor-General's 1999 report noted that the health surveillance system was not functioning the way it was intended with numerous deficiencies in the sharing of information between health providers and the province, and between provincial authorities and Health Canada officials. In addition, the report questioned the lack of formal agreements or protocols between the orders of government for the purposes of preventing the entry into Canada of serious infectious diseases and of dealing with disease outbreaks once they occur. In summing up his concerns, the Auditor General stated that, "... the weaknesses that we observed have clear national implications for public health. First, they compromise Health Canada's ability to detect, anticipate, prevent and control health risks associated with outbreaks of communicable diseases. Second, they compromise its ability to plan, carry out and evaluate public health programs and other programs that deal with the causes and treatment of diseases" (Auditor General of Canada 1999, 18). Of particular note in the 1999 report was the attention paid to the role of intergovernmental affairs and wider concerns that the Auditor-General had regarding the entire public health framework in Canada. Noting the effects of globalization on disease migration, the Auditor-General stated that the management of public health concerns could no longer be argued to be the reserve

of any one jurisdiction, and, they, therefore, required advanced processes and institutions to manage intergovernmental, and intra-governmental, cooperation. However, at the time, there was no specific legislation, policies, or agreements that linked the separate components of public health functions among the three orders of government. No formal agreements existed to clearly assign roles and responsibilities to deal with issues such as information sharing and ownership, privacy, and the consequences of governmental non-compliance with these terms. Instead, “there is a void; current health surveillance activities are largely carried out on an ad hoc basis” (Auditor General of Canada 1999, 11). The follow-up report three years later in 2002 recognized that “limited progress” had been made, but maintained the core of its criticisms from 1999, finding the situation still worrisome (Auditor General of Canada 2002).

A second key event was the terrorist attacks on the World Trade Center in New York City in September 2001, and the subsequent anthrax attacks in the United States throughout the fall of 2001. The fear of future attacks of this nature led to a complete rethinking of Canada’s approach to national security, preparation for possible terrorist threats and its emergency planning in the case of conventional or chemical, biological or radio-nuclear (CBRN) terrorism. In the immediate aftermath of the attacks, Health Canada quickly expanded the National Emergency Stockpile System to respond to the increased need for various pharmaceuticals (e.g., vaccines, etc...) to treat and protect Canadians from chemical agents like anthrax and from infectious diseases such as small pox (Health Canada 2002a, 32). As well, in October 2001, the federal-provincial / territorial (F/P/T) Deputy Ministers of Health created the Special Task Force on Emergency Preparedness and Response and charged it with developing recommendations on how best to prepare the country for any kind of possible health emergency. The recommendations brought forward by this intergovernmental group led to the creation of the F/P/T Network on Emergency Preparedness and Response that began the process of creating a more integrated and seamless emergency response system in Canada on health-related issues (Health Canada 2003, 100-2). At the same time, the federal government also began rethinking its national emergency response protocols and legislation given the

increased concern that Canada may become the target of new terrorist attacks. This larger effort would eventually lead to a new department and a new national security policy to better protect Canadians and better plan for future emergencies that will be described in greater detail later.

The third, and most important, event to reshape the debate in Canada on the national public health system has been the re-emergence of infectious diseases such as avian flu as a key international concern for national governments. For Canada, the immediacy of this concern was brought home in 2003 with the SARS outbreak in Toronto and the subsequent public inquiries into the management of the outbreak. SARS, a corona virus that presented as a form of atypical pneumonia, first appeared in China in the fall of 2002 and, by February 2003, had spread to Canada where the first case arrived in Toronto (Svoboda et al. 2004, 2352-61). A single Canadian, returning from a trip to Asia, eventually sparked an outbreak that affected 438 individuals and that resulted in 44 deaths and a travel advisory for the city of Toronto issued by the World Health Organization (WHO) (World Health Organization 2003). Managing the spread of SARS presented a considerable challenge to all orders of government, largely as a consequence of several unknown aspects of the pathogen including its level of infectivity, and the lack of definitive clarity as to its mode of transmission (Wenzel & Edmond. 2003, 1947-8). In Toronto, the initial management of the outbreak occurred at the hospital and local public health levels where the disease first presented. The provincial government soon became involved and declared the situation an emergency allowing it to utilize aggressive protective measures such as quarantine (Mackay 2003).¹ For its part, Ottawa provided epidemiologic and laboratory support to provincial and local officials, managed issues related to the spread of the disease at international borders and communicated information on the status of the outbreak to other provinces, international organizations and the international community (Heath Canada 2003, c. 2). As well, the federal government organized the "SARS Summit" late in the crisis in an attempt to develop a national SARS strategy and met with limited success.

Assessing Canada's public health system and emergency response

In the aftermath of the SARS crisis, it was soon obvious to both Ottawa and to Queen's Park that a serious reexamination of the public health system was called for, particularly related to emergency preparedness and response. In fact, the Ontario government had committed to a public enquiry on June 10, 2003, even before the crisis itself was officially over.² For its part, the federal government responded even more quickly with the announcement of the National Advisory Committee on SARS and Public Health on May 6, 2003. Chaired by Dr. David Naylor, Dean of Medicine at the University of Toronto, the committee was struck specifically to provide a "third party assessment of current public health efforts and lessons learned for ongoing and future infectious disease control." This committee would release the most influential of the SARS reports, *Learning from SARS: Renewal of Public Health in Canada* in the fall of 2003. This report highlighted many of the health and governance-related deficiencies that contributed to the severity of the SARS crisis in Toronto and made a series of recommendations on how to prevent another SARS outbreak. More importantly, however, and picking up on previous criticisms of the public health framework in Canada, *Learning from SARS* laid out an ambitious series of recommendations that would in many ways reinvent the public health system in Canada, particularly at the federal level.

In his report, Dr. Naylor proposed a number of innovations: the creation of a national public health agency; the appointment of a national public health officer; an advisory panel to guide the work of the agency and the CPHO that would include provincial and territorial representation; and, the development of a national public health strategy to guide the work of the agency. Taken together, these recommendations amounted to a wholesale reinvention of the Canadian public health system, with a particular emphasis placed on the question of emergency preparedness and response. Remarkably, for an investigation of what was chiefly a complicated medical crisis, a heavy emphasis had been placed on questions of jurisdiction and governance, both in terms of problems with the system and the proposed solutions, as had been the case with the reports made by the Auditor-General in 1999 and 2002. For the federal government, designing a response to

these recommendations would require a reevaluation of the federal role in public health and how it undertook that role.

While Naylor's report offered the federal government the most complete set of recommendations on public health emergencies relevant to the federal role, the multitude of other investigations into public health in Canada, and the SARS crisis in particular, served to reinforce some of the same messages on issues of governance and public health. One of the first public efforts to highlight certain inadequacies in the Canadian approach to public health as part of the overall health system was found in Senator Michael Kirby's 2002 senate investigation into health care. In it, Kirby noted the resurgence of infectious disease as a national concern and recommended that "the federal government ensure strong leadership and provide additional funding to sustain, better coordinate and integrate the public health infrastructure in Canada as well as relevant health promotion efforts" (Standing Senate Committee on Social Affairs Science and Technology 2002, 249-50).

More directly related to SARS were the reports of two Ontario government commissions launched in the aftermath of the emergency in 2003: the Expert Panel on SARS and Infectious Disease Control headed by Dr. David Walker of Queen's University and the independent Commission to Investigate the Introduction and Spread of SARS under Mr. Justice Archie Campbell of the Ontario Superior Court of Justice. Both reports concentrated heavily on the specific inadequacies of the Ontario public health system at the time of SARS, but also ventured into some of the broader implications for the country as a whole, and for the federal government in particular. In his initial report of December 2003, Walker noted the lack of dedicated resources and coordinated efforts to manage this health emergency. More specifically, he zeroed in on questions related to the failures of Ontario's legal framework during SARS and recommended "the establishment of a legislative regime that allows for a graduated system of response...[the development of which] must be done with an eye to ultimate federal / provincial / territorial harmonization of all legislation creating emergency powers" (Ontario Ministry of Health and Long-Term Care 2003, 116).³ In the second interim report of the SARS Commission, Justice Campbell laid out an exhaustive analysis of Ontario's legal framework on

public health and made a long series of specific recommendations to strengthen and clarify provincial powers in the event of another public health emergency, including significant amendments to Ontario's *Health Protection and Promotion Act* and *Emergency Management Act*. Of particular note was the report's recognition that in the era of the Charter of Rights and Freedoms, striking the right balance in designing an emergency framework would mean weighing the interests of public health against intrusion upon individual rights and freedoms (The SARS Commission 2005).

DESIGNING A NEW FEDERAL FRAMEWORK FOR PUBLIC HEALTH EMERGENCIES

Public Health Emergencies and the Constitution

Both orders of government in Canada have powers to legislate in relation to public health emergencies and emergency preparedness. For the federal government, in addition to its powers related to quarantine, First Nations and criminal law that give it some measure of legislative jurisdiction in public health matters, it potentially has the power to legislate for national emergencies under the important Peace, Order and Good Government (POGG) clause of the *Constitution Act, 1867*. Under POGG, the Parliament of Canada is authorized to enact laws "for the Peace, Order and Good Government of Canada, in relation to all Matters not coming within the Classes of Subjects by this Act assigned to the Legislatures of the Provinces." Throughout over a century of jurisprudence, POGG has been recognized to contain three "branches," or circumstances, under which it can be used as a basis for federal legislation: for "residual" matters not specifically assigned in the constitution to either order of government; for matters related to an "emergency" of national significance; and matters that are inherently "national" in character, that is, on issues that cannot be legislated for by individual provinces.⁴

In terms of thinking about public health emergencies, it has been argued that the national concern branch of the POGG clause provides the federal government with the necessary legislative power to deal with and prepare for these types of emergencies once they outstrip the capacity of any individual province to handle

(Wilson & MacLennan 2006, 3-13).⁵ This clause can be utilized for issues in which intra and extra provincial implications of the issues are linked, for when provinces are not able to regulate effectively on their own and for when failure of one province to regulate would affect the health of residents of other provinces (*Schneider v. R.* 1982. 2 S.C.R. 112 at 142 qtd. in M. Jackman 200, 96).⁶ Infectious disease outbreaks could be argued as meeting each of these three criteria, particularly at early stages of the outbreak where the nature of the disease and how it is spread is not clearly understood.

However, it is under POGG's emergency branch that the clearest jurisdiction exists for the federal government to legislate in relation to a public health emergency. The federal parliament has enacted two pieces of legislation to equip the government's preparations for and response to national emergencies when they occur, including those related to infectious disease. The *Emergency Preparedness Act* provides the statutory framework for federal departments to prepare for civil emergencies and for the Government of Canada to provide support to provinces in the event of a provincial emergency. The *Emergencies Act* is a more wide-sweeping piece of legislation and is deemed as a tool of last resort. It is intended for use during emergencies at the national level and can only be invoked after it has been determined that a critical situation cannot be effectively dealt with under any other law of Canada and that the situation is either: of such proportions as to exceed the capacity or authority of a province to deal with it; or seriously threatens the federal government's ability to preserve the sovereignty, security or territorial integrity of the country (Public Safety and Emergency Preparedness Canada 2005). The *Emergencies Act* is comprised four classes of emergency: public welfare, public order, international and war. In the first two cases, the act envisages that the provinces would be responsible for taking action; in the last two, the federal government would exercise a planning function focussing on mobilizing national resources, with support from provincial and territorial governments and the private sector. In terms of public health, under this act an infectious outbreak (disease in human beings, animals or plants) is one of several categories of emergency that would be considered as a "public welfare emergency" (others include accidents,

pollution and natural disasters). Overall, the *Emergencies Act* confers substantial powers on the federal government to respond to public health emergencies, including the regulation of travel to the affected region, evacuation of the area, possession of property and the direction of services to provide emergency care. However, the question remains as to whether this act is up to the task of meeting a 21st century public health emergency.

The Federal Strategy – new structures to manage public health emergencies

Taking the Naylor recommendations to heart, Prime Minister Paul Martin, on his first day in office on December 12, 2003, announced his government's intentions to create a new framework for the management of public health in Canada generally, and emergencies more specifically. This commitment was reiterated and expanded two months later in the government's speech from the throne: "[the federal government will] take the lead in establishing a strong and responsive public health system, starting with a new Canada Public Health Agency that will ensure that Canada is linked, both nationally and globally, in a network for disease control and emergency response. The Government will also appoint a new Chief Public Health Officer for Canada – and undertake a much-needed overhaul of federal health protection through a Canada Health Protection Act" (Government of Canada 2004). In addition to those announcements specifically related to public health, the prime minister also announced a series of changes to government to better ensure the security of Canadians more generally and to better coordinate federal responses to all types of emergency situations. Together, these two elements – new public health structures and a new security policy – would form the core of the federal response to the previous ten years of voiced concerns of Canada's public health system and its readiness for dealing with a potentially serious public health emergency.

The first element is the so-called "Federal Strategy" on public health. Led by the federal minister responsible for public health, this strategy is composed of three key components: the Public Health Agency of Canada; the Chief Public Health Officer and the development of the Pan-Canadian Public Health Network. The first two elements of the strategy were announced on September 24, 2004, after having

been given intergovernmental support at a First Ministers Meeting on health issues. In brief, PHAC was created by order-in-council, and is accountable to the Minister of Health. At its core, it is mandated to coordinate and build national readiness to respond to public health threats, promote excellence in the management of public health and oversee federal activities to promote healthy living. At the head of the agency is the Chief Public Health Officer. The CPHO has the broad responsibility to manage and lead the agency, provide advice to the minister of health on preparing for and responding to public health threats and provide leadership in interacting with public health experts within the country and internationally.

Clearly, emergency response and preparedness were the first order of business for these two elements of the strategy. As noted in Paul Martin's launch of the agency and the appointment of David Butler-Jones as Canada's first CPHO: "[PHAC] will act as a hub for health surveillance, threat identification and disease prevention and control programs to create a more effective, coordinated Canadian public health system that serves Canadians well – no matter what the health risk or where they live" (Public Health Agency of Canada 2004). More broadly, the "Public Health Agency will also work closely with other government departments and agencies on long-term strategies to confront both infectious and chronic disease and injury prevention and with Public Security and Emergency Preparedness Canada on emergency planning, preparedness, and response to national public health emergencies" (Public Health Agency of Canada 2004). PHAC and the new Chief Medical Officer are intended to coordinate federal efforts in identifying and reducing public health risks and threats and support national preparedness. They are meant to show public leadership in the event of a crisis and to work continually upon improving intergovernmental collaboration in public health emergency preparedness. At the same time, PHAC and the Chief Medical Officer will coordinate Canada's interaction with various international public health agencies and bodies such as the World Health Organization, the US Centers for Disease Control and Prevention and other agencies in Asia and Europe.

The third element of the Federal Strategy, the Pan-Canadian Public Health Network, was officially announced on April 22, 2005. The origins of this network

can be traced back to the efforts of F/P/T Ministers of Health who in 2003 agreed to work collaboratively on a number of key issues related to emergency response (e.g., clarification of roles and responsibilities, improving the surveillance and information structure, creating a national network of public health science centers, and resolving issues related to health human resources). Now a part of the Federal Strategy, the Pan-Canadian Public Health Network is meant to act as a forum for multilateral intergovernmental collaboration to improve the public health system. Among its principal roles, the network is mandated to facilitate the sharing of information and data among jurisdictions; to provide a conduit for the dissemination of best-practices in public health; and to “work with other emergency preparedness/management organizations (e.g., Public Safety and Emergency Preparedness Canada) both at the federal and provincial / territorial levels to ensure an adequate and coordinated response to the emergency” (Health Canada 2005). The network is led by a Council consisting of representatives of each province and territory and of the federal government with the CPHO and a rotating P/T member co-chairing.

Securing an Open Society – the broader context for managing public health emergencies

The second major front of the federal response is contained in the government’s national security framework and action plan, *Securing an Open Society: Canada’s National Security Policy*, tabled in Parliament on April 4, 2004.⁷ This document provides a strategic framework for building a security system that would allow the federal government to better manage and coordinate both its security policy and operations and its emergency preparations and response. Two of the six key strategic areas singled out in the policy framework include emergency response and management and public health. In terms of emergency response, the framework called for: the creation of an Integrated Threat Assessment Centre to bring together threat-related information; a Government Operations Centre to coordinate federal efforts during emergencies; a review of the *Emergency Preparedness Act*; and, the creation of a permanent FPT “high-level” forum on

emergency management. An integral part of this framework is the identification of the international migration of infectious diseases and the possibility of bio-terrorist attacks as key security threats to Canadians. In response, the policy reiterated the federal decision to create the public health agency and the appointment of the CPHO. It also called for a number of specific actions including: the creation of health emergency response teams; the replenishment of the National Emergency Services Stockpile System; enhanced laboratory capacity; enhanced public health surveillance; \$300 million to provinces and territories for the National Immunization Strategy; and, \$100 million to provinces and territories to support public health systems “at the front line.” In sum, the national security framework intends to integrate its efforts to renew the federal leadership in public health with the government’s broader action plan for emergency preparedness.

PUBLIC HEALTH IN THE INTERGOVERNMENTAL CONTEXT

Federalism and the new public health emergency regime

There is a great deal of interdependence among the three orders of government when it comes to managing public health in general, and in preparing for and responding to public health emergencies more specifically. Clearly, each order of government has certain tools to bring to the table. As well, even after a cursory look at the new public health “regime” put in place at the federal level, the basic form of intergovernmental relationship that is intended is one of collaboration. In fact, the government explicitly chose this form of intergovernmental relationship for new Federal Strategy as part of the process in creating the new structures. In recommending the need for a more robust federal role in public health, the Naylor Report considered a more-centralized model in which the federal government, through legislative mechanisms or strong conditions attached to transfers, would direct provincial or local public health activities. This course was rejected explicitly due to the perceived increased potential for intergovernmental conflict. Instead the report suggested that Canada adopt a model in which the federal government, largely through a new national public health agency, would work “collaboratively” with the provinces and regions (Health Canada 2003).

As well, the issue of what form of relationship should frame the new strategy was a central element in the work of the Working Group on a Public Health Agency for Canada. This small task group was established in December 2003 by then Minister of Health, Anne McLellan, and was charged with putting meat on the recommendations brought forward by the Naylor and Kirby reports. Specifically, the group was to work out the details on the mandate, role and form of a new public health agency and the suggestion to create a CPHO.⁸ In its report, the working group listed three “models” available to manage intergovernmental coordination: “Federal Direction,” where the federal government would use its powers for “peace, order and good government” to unilaterally oversee and direct responses to emergencies; “Joint Management,” where some form of jointly managed institution would administer the relevant responsibilities of both orders of government related to public health; and, “Strengthened Collaboration,” where all jurisdictions would work in concert to develop and implement agreed-upon national approaches. In its deliberations, the working group dismissed both the “federal direction” model and the idea of creating new national institutions that would jointly manage public health. According to the working group report, “the first of these options – unilateral federal direction over public health – is neither appropriate nor practical...[first] it is unlikely that these [provincially-delivered health care services] could be ‘unbundled’ in a way that would allow the federal government to assert unilateral control over the administration of public health ‘on the ground’ ...[second] any effort by the federal government to unilaterally assert authority over provincial and territorial jurisdiction would bring with it further intergovernmental discord.” As for the suggestion of “joint management,” it was deemed unworkable because of funding concerns, the need to obtain agreement across all the provinces, with their many legitimate variations in approach, and perhaps most importantly, the “practicality and appropriateness” of governments giving up authority over some important policy matters to an arms-length, jointly-managed agency (Health Canada 2004).

As a process of elimination then, the working group “focused its attention” on those options that would develop the third model of more effective and

collaborative intergovernmental mechanisms to manage public health and public health emergencies. These mechanisms would be based on respect for jurisdictional responsibilities, flexibility in allowing for provincial variation and accountability through meaningful and measurable outcomes. The resulting recommendation by the Working Group was the creation of the Pan-Canadian Health Network to provide a new “intergovernmental framework focused around a ‘rules-based’ approach to federal/provincial/territorial relations.” The other components of the strategy, the national agency and the CPHO, would be about “aligning federal resources and responsibilities in order to effectively exercise national leadership – in other words, getting the federal house in order” (Health Canada 2004).⁹

In their assessment of the overall federal approach, public health officials spoken to for this study, whether federal, provincial or local, all characterized the new system in Canada as collaborative, where cooperation among officials and health care workers from all three levels was the watchword. What’s more, many officials argued that there was a clear linkage between the type of collaboration that was developing and the way in which emergencies themselves develop. In their view, public health emergencies, whether from infectious disease outbreaks or stemming from natural disasters, always begin locally. And while, they can usually be contained at the local level with local resources, they can sometimes grow in threat and become either a province-wide emergency or, eventually, a national concern requiring federal action. As one representative noted: “[i]n terms of emergencies, I think we still have to stick by the same idea that the response is local first, then provincial and then national for a variety of reasons. One, in terms of recognition and immediate response...most emergencies will be local, certainly if they’re natural disasters, but public health emergencies, infectious diseases, as well will probably be local. Therefore, our role nationally would be...to assist in the ability of those other levels of government to intervene. If it became a national emergency then the responsibility to lead, coordinate, ensure collaboration, and so on and so forth is different, but I still think that the premise that one starts locally and moves from there is still the same. However, that means that we have to be involved in improving the capacity at the local level in order to respond.”

One implication from this reasoning is that the form of collaboration that is developing on public health emergencies is one that is molded to the subject matter itself, rather than to constitutional roles and responsibilities. On the issue of emergencies in particular, it appears as though the federal government is cultivating a truly collaborative approach, in recognition of the vital role played by the provinces. At the same time, moreover, it is creating the necessary federal institutions and tools to enable it to lead in setting national priorities on public health while effectively showing leadership in the exercise of those national interests. To what extent the initiatives that flow from this federal leadership within a collaborative framework will produce the necessary changes called for by Dr. Naylor and the other committees looking into SARS and public health in Canada remains to be seen.

Some questions on the new approach to managing public health emergencies: federalism and policy effectiveness

It is still very early in the process to evaluate the effectiveness of the intergovernmental relationships that are being developed in public health emergency and response. At the time of the writing of this paper, the new public health agency and CPHO are still in their infancy and the Pan-Canadian Public Health Network has only recently been launched. What's more, by the very nature of the problem at hand, it is difficult to know for certain the effectiveness of the new mechanisms that have been put in place until they have been truly tested – as they were during SARS and then found wanting. To help in thinking about the assessment then, it can be noted that the federal government has built its new public health agenda very clearly with a number of specific policy gaps in mind. Examples include the development of effective intergovernmental emergency planning and coordination; clear communications protocols during emergencies, including the appointment of lead officials; ensuring surge capacity in advance of any new public health emergency; and, the renewal of the legislative framework to ensure that the federal government has all the tools necessary to respond to public health emergencies. A preliminary assessment will be made of the impact that

intergovernmental efforts have had on each of these policy gaps to date through the efforts to design and implement the “Federal Strategy.” Following this brief overview, a more detailed analysis of the federal government’s legislative readiness will be made, specifically addressing the question of whether a public health emergency act is needed.

The Naylor report identified a number of critical intergovernmental failures, or policy gaps, which contributed to the spread of SARS in 2003, and the recommendations put forth in *Learning from SARS* were designed to address these issues specifically. As a result, in adopting many of these key aspects of Naylor’s policy proposals, the federal government has gone a long way toward creating the type of framework that should address the identified policy gaps. For the purposes of this case study, three key policy gaps were chosen to test the effectiveness of the “Federal Strategy” as a framework to deal with the problems Naylor identified with Canada’s emergency preparedness and response regime in public health. The issues covered include: emergency planning and coordination among the three orders of government; coordination of communications during emergencies and the selection of a chief spokesperson; and, effectiveness of the legislative framework. On the whole, participants recognized and supported the current intergovernmental approach of collaboration on each of the above-mentioned policy gaps. Officials interviewed for this study indicated either that harmonious relationships were developing between the orders of government that respected the different orders of government’s constitutional responsibilities or that they were not certain because of a lack of clear understanding of where the jurisdictional lines were in the first place. Most respondents seemed to equate the collaborative approach with respect for jurisdiction. For example, one participant noted in response to a question on sovereignty that “everyone realizes that we are in this together [preparing for public health emergencies], and I’m not the least bit concerned that sovereignty isn’t being respected.” Another participant stated plainly that “we are very, very acutely aware of the federal, provincial and local jurisdiction, and so those are taken into account.” That said however, most were still hesitant to call victory in actually closing the

gaps themselves. The irony here seems to be that, everyone supports the approach, but nobody is certain that it is working.

Emergency Planning and Coordination

As noted earlier, the need to develop an effective F/P/T emergency planning and coordination framework, including the question of public communication and data-sharing, has been reiterated on numerous occasions and predates the watershed event of SARS. And, prior to the announcement of the Federal Strategy, efforts had been made to address this policy gap. For example, in 2000, Health Canada created the Centre for Emergency Preparedness and Response to be “Canada’s central coordinating point for public health security issues” (Health Canada 2002b, 4). In 2004, under the auspices of the F/P/T Network on Emergency Preparedness and Response, a collaborative effort produced the draft “National Framework for Health Emergency Management – A Guideline for Program Development.”¹⁰ It is within this context that the latest efforts have been undertaken.

The question of emergency planning and communication goes to the heart of the issue. Most officials interviewed were supportive of the overall approach taken to date to develop the type of intergovernmental cooperation needed to put in place an effective emergency planning regime. As one noted, “I think we’re bringing form and clarity to what needs to be done, and I think it’s going to stimulate the kind of thinking and depth of planning [that is needed].” The official went on to note what he considered to be progress on the issue: “what we had before was the beginning of a plan, but...people hadn’t thought about how it would work and how people would work together. And I think the depth of the plan...posed more questions that it answered, and I think there is a recognition now that the plans have to be much more detailed, and you have to have solutions to some of these things, and have thought through to a much greater depth. So I think that’s what we’re seeing happening, and I think it’s affecting everything down to local areas and local plans.”

Another policy expert underscored the fact that the new strategy, particularly the Pan-Canadian Public Health Network, was bringing a new clarity to the efforts that have been ongoing since at least fall 2001. The vast majority of the work of this network, which as noted is comprised of senior representatives from federal and provincial / territorial governments, is executed by a series of “expert groups,” including the pre-existing Expert Group (formerly F/P/T Network) on Emergency Preparedness and Response. This group, which had been charged with developing a national framework, now has an F/P/T body dedicated to public health and made up largely of public health professionals to which it reports and takes direction on an ongoing basis. As was noted, “this expert group occupies the full spectrum of professional streams that need to be consulted and engaged when developing public health policy for managing...public health emergencies.”

While the majority of opinion certainly favoured the intergovernmental *approach* that had been chosen to put in place to build the new public health emergencies framework called for by Naylor and others, a few voices raised concerns about the actual *effectiveness* of the measures taken thus far to close the policy gap. Here the argument is reasonably simple and driven in large part by the relatively early days of the new F/P/T process that has been put in place under federal leadership. Some felt it was too early to assume that the collaborative efforts currently underway – and it is important to point out that even here the approach was not questioned, just the results – would necessarily lead to a well-coordinated, emergency response framework capable of meeting the next pandemic. As one official cautioned, “I’m an avid believer in that these [collaborative efforts] are the right ways to go, but they just have not been implemented yet in an effective way and it will take some time. I think there is some new openness that we’re seeing particularly with aspects of the Public Health Agency in the form of the Centre for Emergency Preparedness and Response, but I still think there are some hang-ups and there are some ways of doing things that revert to the old ways. There’s a lot more room for improvement yet, and it may take a generational change shift in mindset to get that.”

Communications Management

On the question of communications, the SARS crisis made readily apparent the utter lack of coordination across the three levels of government in terms of their interaction with the media and the wider public. This fact was presented on numerous occasions in testimonials in front of the various commissions struck to investigate the response to the outbreak and, not surprisingly, was highlighted as one of the critical intergovernmental failures in need of significant overhaul. For this case study, public health officials clearly supported the federal government's decision to appoint a clear spokesperson on public health issues in the form of the CPHO. As well, there was more or less agreement on the fact that the new Federal Strategy should pave the way toward more smooth public communications on the one hand, and better information-sharing between jurisdictions on the other. However, it was clear that among the public health representatives interviewed there was only a vague understanding, or perhaps expectation, as to how communications would actually be managed. Some felt that the CPHO would be the "lead" spokesperson in the event of an emergency, while others stated that the CPHO would be the "lead" federal spokesperson and provinces and local authorities would have their own "leads." What's more, it was unclear how lead officials would interact to address the types of concerns raised by Dr. Naylor as to public confusion during SARS as a result of numerous sources of communications from governments. One interviewee spoke of the "ideal," but seemed to recognize that no clear protocol was yet in place: "In my ideal during a crisis, you'd have the lead official from each level of government actually working...together. If we're talking to the media, which is a major communications issue, you actually have the Chief Medical Officer [CPHO], the lead [provincial] official, which will most likely be the Chief Medical Officer of Health at the provincial level, plus a local authority...[They would have] joint press conferences, having the same messages, having the same information at the same time, and coordinating the messages as they get them internally...."

Legislative Framework

In the myriad of reports that have emerged post-SARS, a recurring theme has been the need to review and evaluate the current legislative framework as it relates to emergencies in general and public health emergencies in particular.¹¹ Dr. Naylor argued that while efforts had been underway since 2001 to “upgrade” emergency legislation, there had been no evidence of clear success in terms of assuring “comparability and interoperability.” As a result, he called for a general intergovernmental review to harmonize F/P/T public health legislation with special attention paid to “public health emergencies within extant emergency legislation.” What’s more, following up on a suggestion from the Canadian Medical Association, Naylor even suggested that consideration should be given to creating special federal public health emergencies legislation (Health Canada 2003, 7).¹²

Despite announced intentions by the federal government to act upon the Naylor recommendations, the proposed federal legislation apparently remains on the drawing board.¹³ Perhaps reflecting the fact that no new legislation has in fact been passed, the perspective of almost all the participants in this case study was that the renewal of the legislative framework was important, but other than highlighting the types of things that needed to be addressed, they could not really comment on whether the current approach was going to be successful or not in closing the policy gap. For the most part, those interviewed were aware that the process was underway, but offered little by way of detailed opinions of what should be done. On the suggestion of a specific federal public health emergency act there was little enthusiasm. A couple of representatives voiced their support, although they offered only a cursory explanation as to why. Most felt that not only would the existing framework adequately enable the federal government to meet its obligations, they also argued that emergency legislation of any sort was not really the answer to the problem. One official went on at length: “First of all declaring a national emergency is something that you don’t want to do because the message that you’re sending out is... that you have lost control and you are in a crisis mode...declaring a national emergency is sometimes like using a 2X4 to swat a

fly...you don't necessarily want to use legislative powers when you don't need to where other instruments would not only be more efficient, but less distracting from a public point of view." Even more pointed was another participant's comment: "I don't know if there's a need [for a federal public health emergencies act]. There is a definite need for clarifying federal powers, but also clarifying federal roles and responsibilities...What is [the federal government's] job?...[there were] many occasions where people at the federal level were telling...the local level [what to do] with this individual patient, and I don't think that's appropriate...Their job [federal government] is to manage with the other provinces, communications and the WHO, in my mind, and that needs to be instilled in detail. Who's going to do what and at what point?"

The question of what the federal government should do to renew its legislative framework and, in particular, whether it should adopt specific public health emergency legislation deserves particular consideration given its centrality to the debate around the country's ability to respond effectively to pandemic threats and the issue of federalism and intergovernmental relations in the public health field.¹⁴ As already discussed, the federal government's current emergency response to public health threats is framed primarily by two pieces of related legislation: the *Emergencies Act* and the *Emergency Preparedness Act*. Of these, it is the *Emergencies Act* that actually provides for specific statutory powers to be employed in the event of a real emergency.¹⁵ However, the outstanding question that remains is whether this statute, as it is currently formulated, provides the federal government with the most appropriate mechanism to respond quickly and effectively to all types and levels of public health emergencies.

One concern has to do with the potential stigma attached to the use of this act. Since its adoption the new act has never been invoked, including during the SARS crisis. As can be seen from some of the comments above from public health officials, it was believed that the mere mention of using national emergency legislation was somehow an admission that the government had "lost control." Much of this stigma likely is derived from the bill's origins. In 1985, the *Emergencies Act* replaced the much-maligned *War Measures Act*, a statute that had been the

government's principal organ to deal with all manner of national emergency since the First World War. The government had used this act extensively during the Second World War to deal with numerous aspects of Canada's management of the war emergency at home, but came under tremendous criticism for the quite apparent abuse of civil liberties associated with many of the government's actions. Included here was the uprooting of Japanese-Canadians from the west coast, the curtailment of certain union activities and the internment of members of some religious and political groups. More recently, the act was invoked to deal with the October Crisis in Quebec in 1970, which created another controversy around the act's use to suspend civil liberties. In the post-Charter period, the decision in 1985 to modernize and replace the act was explicitly motivated in part by the need to soften some of the previous legislation's more egregious elements that had enabled the curtailment of civil liberties.¹⁶ Moreover, the government now clearly views this legislation as an "instrument of last resort" not to be invoked unless no other law is available to deal with the emergency (Public Safety and Emergency Preparedness Canada 2006).

Another important concern has to do with the formulation of the act, particularly from a public health perspective. According to the act, there is a requirement that at least two provinces must be affected before the federal government has the authority to invoke its powers under the act. Otherwise, the federal government must be invited to intervene in a single province's jurisdiction. Nevertheless, this requirement appears to be at odds with the nature of the threat when looking at infectious disease outbreaks. As was the case with SARS, this virus was present in numerous countries and in one Canadian province – very clearly it had the potential to spread to other provinces, either from cases in Toronto or from another international carrier arriving in a second Canadian province.

This problem is all the more relevant given the World Health Assembly's recent revision of the "International Health Regulations" (IHR) in May 2005 and the new demands that will be placed on national governments to take leadership in the event of an infectious outbreak with international implications. Following SARS and the renewed fears of avian flu, the international health community recognized the

need to rethink and revamp these regulations, which had been drafted originally in 1951 and had not been revised significantly since 1969. The new regulations are designed to broaden the scope of activities for both WHO and its member states to "prevent, protect against, control and provide a public health response to the international spread of disease" and to "develop, strengthen and maintain core surveillance and response capacities to detect, assess, notify and report public health events to WHO and respond to public health risks and public health emergencies." This broadening in scope of the International Health Regulations is of particular importance to federal states like Canada given the increased demands placed on the national level of government to report in detail on any emerging infectious disease of "international concern," as defined by the regulations themselves. In the case of Canada, the federal government's inability to access data related to the SARS outbreak has been underlined as a major contributing factor in the poor response to the crisis on the part of both the federal and Ontario governments. However more recently, some authors have noted that this problem not only affects the federal government's capacity to respond to public health threats at home, it also jeopardizes its ability to meet its international obligations under the new International Health Regulations.¹⁷ According to Kumanan Wilson and Harvey Lazar, there is a strong possibility that "the federal government may not be able to meet its reporting requirements because of a lack of intergovernmental cooperation within Canada. While the WHO would have mechanisms to obtain this data from nongovernmental sources, if the WHO had to resort to such measures to monitor the outbreak, its confidence in Canada's ability to manage the outbreak would most certainly be undermined (Wilson and Lazar 2005, 15)."

In sum, the current legislative framework creates a type of paradox for the federal government. The *Emergencies Act* offers everything and more than is required for almost all public health emergencies, and, therefore, the federal government remains quite reluctant to actually invoke it. At the same time, for anything less than a "national emergency," the government's legislative tools remain limited, and the government's ability to provide direct leadership is somewhat compromised, particularly in light of the new requirements being asked of national

governments under the International Health Regulations. At one point, the Martin government appeared to recognize this problem with its intended comprehensive overhaul of federal public health legislation into a single, integrated public health act, but in the end it remained an unmet priority, and it was never clear if specific changes were in the offing in regards to the government's emergency powers. What is clear is that the federal government needs some type of in-between legislation to allow it a greater role in the event of a serious public health emergency – but one which may not necessarily constitute a national crisis. Whether this is a separate public health emergencies act or special emergency powers as part of a greater federal public health act, the government needs to more clearly identify its role in the event of another SARS and equip itself accordingly to undertake that role. At a minimum, this would mean legislating the power to demand complete data transfer regarding the infectious outbreak for the purposes of meeting Canada's international obligations and the ability to ensure that the outbreak does not spread either beyond Canada's national borders or over provincial boundaries.

CONCLUSION

So what can be said about the influence of intergovernmental relations upon the most recent initiatives to build a better public health emergency response system in Canada? First, there can be little doubt that the question of intergovernmental *approach* was foremost in the mind of the federal government in designing the "Federal Strategy." It was no accident that the collaborative model was actually an explicit policy goal. The Naylor report called for greater, and for that matter, better, intergovernmental cooperation and harmony, and the Health Canada working group led by Andrew Noseworthy reviewed the possible models and explicitly rejected both federal unilateralism and joint management. Furthermore, the new federal leadership was designed to firstly get the "federal house in order" on public health and to build upon an existing collaborative framework with the provinces and territories from there. Another thing that can be said is that the overwhelming sentiment among officials and academics seems to be that the collaborative approach is the correct one for the purposes of creating a

modern public health emergency preparedness and response regime for Canada. Among the participants in this study, no voices were raised against a significant federal role in and around public health on the part of provincial officials.

Jurisdictional interdependence seemed to be recognized by all of the participants – something that they felt was known among public health officials for a long time. Collaboration seemed to be the only logical option.

This, however, leads to at least one troubling reflection. If collaboration is the best and most efficient intergovernmental approach to responding to public health emergencies, and this has been the basic framework at least since 2001, why did it fail during SARS? Dr. Naylor and others have offered a litany of where the collaboration went off the rails, but did not really question the approach itself. In reviewing the “federal strategy,” some public health officials have allowed for the fact that it was too early to cry victory regarding the closing of policy gaps, but all were confident that the proposed approach would eventually get it right. However, truly testing this hypothesis is obviously quite problematic in that it requires a real-life emergency – not exactly the time when you want to discover that the regime put in place didn’t meet expectations. As the review of the legislative framework demonstrated, because of the potential gravity of “getting it wrong,” it may be necessary to consider possible backstops in case the preferred approach proves wanting. This may lead to the conclusion that a more robust federal emergencies legislation is needed to allow for a more unilateral approach by the federal government to ensure the security of Canadians. Preparing for emergencies clearly implies the need to plan for a long list of risks. SARS has shown that the effectiveness of intergovernmental collaboration should be considered one of those risks.

Table 1 Overview of Government Approach

<i>Federal Strategy</i>	<i>National Security Framework</i>
<p>Key Elements:</p> <ol style="list-style-type: none"> 1. National Public Health Agency - responsible for coordinating and building national readiness to respond to public health threats, promote excellence in the management of public health and oversee federal activities to promote healthy living. 2. Chief Public Health Officer - manage and lead PHAC, provide advice to the minister of health on preparing for and responding to public health threats and provide leadership in interacting with public health experts within the country and internationally. 3. Pan-Canadian Public Health Network - facilitate the sharing of information and data among jurisdictions; provide a conduit for the dissemination of best-practices in public health; and work with other emergency management organizations to coordinate emergency response 	<p>Key Elements:</p> <p><i>General</i></p> <ol style="list-style-type: none"> 1. Integrated Threat Assessment Centre - responsible for collecting and evaluating threat-related information. 2. Government Operations Centre - responsible for the coordination of federal efforts during emergencies. 3. Review of the <i>Emergency Preparedness Act</i> - to identify potential amendments to address policy gaps 4. Permanent FPT Forum on Emergencies - to allow for regular strategic discussion of emergency management issues among key national players <p><i>Public Health Specific</i></p> <ol style="list-style-type: none"> 1. Establish health emergency response teams 2. Replenish the National Emergency Services Stockpile System 3. Enhance laboratory capacity 4. Enhance public health surveillance 5. Provide \$300 million to provinces and territories for the National Immunization Strategy 6. Provide \$100 million to provinces and territories to relieve stress on National public health systems at the front line

Table 2 Overview of Respondents' Views on the Federal Government's "Federal Strategy"

<i>Issue</i>	<i>Respondents' views on intergovernmental aspects</i>	<i>Respondent's views on policy effectiveness</i>
1. Emergency Planning and Coordination	<ul style="list-style-type: none"> - clear support for the collaborative approach contained in the federal strategy - belief that strategy represents progress on sorting out FPT roles and responsibilities 	<ul style="list-style-type: none"> - general support that collaborative approach would produce policy results - some skepticism as to effectiveness given that the new system had not yet been tested
2. Communications Management	<ul style="list-style-type: none"> - support for the creation of the PHAC and CPHO and belief that this would improve intergovernmental collaboration - consensus that collaborative approaches to communications management worked best 	<ul style="list-style-type: none"> - agreement that federal strategy would lead to more effective communications during emergencies - no clear consensus or understanding as to how inter-governmental aspects of communications would be handled during an emergency
3. Legislative Framework	<ul style="list-style-type: none"> - support for general suggestion to modernize legislative framework, but limited understanding of details - most disagreed with suggestion that separate federal public health emergency legislation was needed 	<ul style="list-style-type: none"> - general agreement that governments already had adequate legislative tools at their disposal - belief that specific federal public health emergency legislation would not increase effectiveness of national emergency response

Table 3 Allocation of Roles and Responsibilities in Emergency Preparedness and Response

Activities	Federal	Provincial/ Territorial	Local	Supranational
Agenda/standard setting	X	X	X	X
Legislative authority	X	X		
Regulation and/or safety assessment	X	X	varies	
Funding responsibilities	X	X	varies	
Inspection and enforcement	X	X	X	
Promotion and related funding	X	X	X	
Information provision	X	X	X	

Table 4 Nature of the Intergovernmental Relationship in Emergency Preparedness and Response

	Hierarchical	Interdependent	<i>Form of Relationship</i>
Federal-provincial	No	Yes	Collaborative
Federal-local	No	Yes	Collaborative
Provincial-local	Varies	Varies	Varies

Endnotes

¹ Ontario declared that SARS was a communicable and virulent disease. This allowed the medical officer of health, under the Health Protection and Promotion Act, to “by a written order...require a person to take or to refrain from taking any action that is specified in the order in respect of a communicable disease.” Such orders include “requiring any person that the order states has or may have a communicable disease or is or may be infected with an agent of a communicable disease to isolate himself or herself and remain in isolation from other persons”. Health Protection and Promotion Act R.S.O. 1990, Chapter H.7

² The SARS Commission was created by Order-in-Council of the government of Ontario on June 10, 2003 with Ontario Justice Archie Campbell appointed as chair. The goals of the commission were to examine the introduction, spread and management of SARS in Ontario and to make recommendations. See <http://www.sarscommission.ca> for details on the terms of reference and mandate of the commission.

³ The recommendations in this report were added to in April 2004 with the panel’s final report, which concentrated on the recommendation for an Ontario health promotion and protection agency.

⁴ More recently, arguments have been advanced of a fourth branch related to issues of an “inter-provincial” nature, but there is less consensus on this point in the legal community, see Patrick Monahan. 2002. *Constitutional Law*, 2nd ed. Toronto: Irwin Law Inc.: 273-278. On POGG more generally, see Monahan, *Constitutional Law* and Peter W. Hogg. 1997. *Constitutional Law of Canada*, 4th ed. Toronto: Thomson Canada Ltd.: 443-473. For a more expansive view of federal jurisdiction under POGG, see Sujit Choudhry.

2002. "Recasting Social Canada: A Reconsideration of Federal Jurisdiction over Social Policy," *University of Toronto Law Journal* (50):163-252.

⁵ See also Choudhry, S. 2002. "Recasting Social Canada: A Reconsideration of Federal Jurisdiction Over Social Policy." *University of Toronto Law Journal* 52(3):163-252.

⁶ See also Peter W. Hogg. 2004. *Constitutional Law of Canada* (Student Edition 2004) Scarborough: Thompson Canada Ltd.: 446, where he notes: "It seems, therefore, that the most important element of national concern is a need for one national law which cannot realistically be satisfied by cooperative provincial action because the failure of one province to cooperate would carry with it adverse consequences for the residents of other provinces."

⁷ Available at http://www.pco-bcp.gc.ca/default.asp?Page=docs/Publications&Language=E&doc=/NatSecurnat/natsecurnat_e.htm.pdf

⁸ See Health Canada. 2004. *Report: A Public Health Agency for Canada: Working Group on a Public Health Agency for Canada*. <http://www.phac-aspc.gc.ca/publicat/phawg-aspgtaspcgt-noseworthy/index.html>.

⁹ While the origins of the Pan-Canadian Public Health Network can be found prior to the striking of this working group, it appears as though this report was the one to link this effort to the federal government's overall strategy on public health, particularly in terms of the form or model of intergovernmental relationship it wished to forge with the provinces.

¹⁰ See F/P/T Network on Emergency Preparedness and Response. 2004. *National Framework for Health Emergency Management: A Guideline for Program Development*.

¹¹ For example see, Health Canada, 2003. *Learning from SARS: Renewal of Public Health in Canada, A Report of the National Advisory Committee on SARS and Public Health*. <http://www.phac-aspc.gc.ca/publicat/sars-sras/pdf/sars-e.pdf>: 7, and Ontario Expert Panel on SARS and Infectious Disease Control. 2003. *For the Public's Health: Initial Report of the Ontario Expert Panel on SARS and Infectious Disease Control*. Ontario Ministry of Health and Long-Term Care: 24.

¹² Echoing these types of recommendations, David Walker, Chair of the Ontario Expert Panel on SARS and Infectious Disease Control, called on Ontario's government to harmonize Ontario's and the federal government's emergency legislation in *For the Public's Health*. See Ontario Expert Panel on SARS and Infectious Disease Control. 2003. *For the Public's Health: Initial Report of the Ontario Expert Panel on SARS and Infectious Disease Control*. Ontario Ministry of Health and Long-Term Care: 24.

¹³ The Martin government had announced its intention to introduce a comprehensive "Canadian Health Protection Act" in the February 2, 2004 Speech from the Throne. This act would have brought together the various elements of the federal government's public health legislation (e.g., quarantine) into a single piece of legislation. However, it retreated from this ambitious agenda and scaled down expectations, as witnessed in the October 5 Speech from the Throne that spoke more vaguely of "proceeding with new health protection legislation." The second major federal thrust on this front concerns the commitment made in the 2004 national security policy document, *Securing an Open Society*, to review the *Emergency Preparedness Act* – one of the key pieces of federal emergencies legislation. However, legislation to modernize the emergency act died on the order paper with the call of the 2006 federal election *Speech from the Throne*,

February 2, 2004, 7 and *Speech from the Throne*, October 5, 2004, 8. See also

Government of Canada. 2005. *Securing an Open Society: One Year Later. Progress Report on the Implementation of Canada's National Security Policy*: 19-20.

¹⁴ See Kumanan Wilson and Harvey Lazar. 2005. "Planning for the Next Pandemic Threat: Defining the Federal Role in Public Health Emergencies," *Policy Matters* 6 (5).

¹⁵ *Emergencies Act* (R.S. 1985, c. 22 (4th Supp.)).

¹⁶ On the government's use and the public's response to the *War Measures Act* see Christopher MacLennan. 2003. *Toward the Charter: Canadians and the Demand for a National Bill of Rights, 1929-1960*. Montreal: MQUP.

¹⁷ See Kumanan Wilson and Harvey Lazar. 2005. "Planning for the Next Pandemic Threat: Defining the Federal Role in Public Health Emergencies," *Policy Matters* 6 (5).

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