November 28, 2023

Haste Makes Waste: Amending the *Public Health Act*

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Bill Commented On: Bill 6, *Public Health Amendment Act, 2023*, 1st Sess, 31st Leg, Alberta, 2021 (first reading 2 November 2023)

If there is one point of consensus on public health decisions made in Alberta during the COVID-19 pandemic, it is probably that the *Public Health Act*, RSA 2000, c P-37 failed to provide a proper framework for general lawmaking by executive order. The enactment of COVID-19 public health orders that applied restrictions to the general public did not adhere to basic matters of democratic governance such as organization and clarity, predictability and consistency, transparency and justification, and accountability to the elected assembly. The Act contains no provisions to ensure these lawmaking attributes are followed in making public health orders. Indeed, just weeks after the onset of the pandemic in 2020 it was readily apparent the Act was wholly inadequate in this regard (see here and here). Instead of addressing these fundamental issues, the UCP government has been fixated on amendments that score political points. For example, in April 2021, Alberta made a number of relatively inconsequential amendments to the Act (which we discuss here), but still found space to repeal Cabinet powers to compel vaccination in a public health emergency. In this post we explain why Bill 6, *Public Health Amendment Act, 2023* is more of the same.

On November 2, the Minister of Justice introduced Bill 6 to ". . . clarify the roles and ensure accountability of both cabinet and medical officers of health, including the chief medical officer of health, during states of public health emergencies." These amendments would "align with how decisions were made during the COVID-19 pandemic and how they should be made." (Alberta Hansard 1st Sess, 31st Leg, at 90) The timing of Bill 6 is quite puzzling, given that just 13 days after its introduction, the Report of the Public Health Emergencies Governance Review Panel (chaired by former politician Preston Manning and hereinafter referred to as the Manning Report) was released to the public and makes recommendations specific to allocating decision-making authority during a public health emergency. In addition to its bizarre timing, Bill 6 is also a woefully inadequate response to serious shortcomings in the Act when it comes to governing during a public health emergency.

Overview and Context for Bill 6

Since the onset of the COVID-19 pandemic, there have been numerous debates about whether public health experts or elected officials ought to have the power to make public health decisions with general application to the public. While ignited by disagreement over the substance of the restrictions in public health orders, these debates are also fueled by the fact that governing public health legislation in most of the provinces and territories was never intended to provide the general lawmaking power that public health officials exercised to contain the spread of COVID-19. Most

of these enactments have specific provisions that empower public health experts to address specific and targeted public health issues, but the statutory authority for their decisions with general application to the public (e.g. the COVID-19 public health orders that imposed restrictions on access to public places) is found only in a 'catch all' provision; perhaps suitable in a pinch, but hardly a sound basis for general lawmaking over a longer term (see our discussion of this early in the pandemic here and here).

The current version of Alberta's *Public Health Act* is an example of this problematic structure. Section 29(2.1) of the Act gives a medical officer of health, which includes the Chief Medical Officer of Health (CMOH), power to "take whatever steps the medical officer of health considers necessary" to address a communicable disease or lessen the impact of a public health emergency. This section authorized the COVID-19 public health orders that bore the signature of Alberta's former CMOH, Dr. Deena Hinshaw. Strangely however, Dr. Hinshaw repeatedly asserted that she was merely an advisor to Cabinet and not a decision-maker.

We now know that while she was misstating the law, she was accurately describing what was occurring in Alberta. While Cabinet took Dr. Hinshaw's advice into account, ultimately it determined the contents of some (perhaps all) of the public health orders that she signed. Two decisions by the Alberta Court of King's Bench ruled that this was an unlawful delegation of legal authority from the CMOH to Cabinet. In *CM v Alberta*, 2022 ABKB 716 (CanLII) (which we discuss here), parents argued that an order compelling masking in schools was prematurely rescinded, while in *Ingram v Alberta (Chief Medical Officer of Health)*, 2023 ABKB 453 (CanLII) (discussed here), claimants argued that various public health restrictions violated their *Charter* rights. As a result of public health orders being found *ultra vires* in these two cases, individuals who had been charged under the Act have since been acquitted.

Bill 6 purports to respond to these judicial decisions by explicitly shifting some decision-making power under the Act to Cabinet in the context of a public health emergency. However, that is all it does. It is nothing more than a knee-jerk reaction by the UCP government to these judicial decisions, and a seemingly superficial response to placate those who blame the CMOH for pandemic restrictions. While it might satisfy a desire for revenge politics, Bill 6 fails to properly address the real governance problems in the Act. The debate about whether public health experts or elected officials ought to have the power to make public health decisions with general application is a serious issue in the midst of a pandemic, and most certainly is not resolved by simply shifting decision-making power from experts to politicians. This shift on its own does nothing to ensure public health orders will follow norms of predictability, consistency, transparency, justification, and accountability to the elected assembly.

If anything, shifting decision-making power to Cabinet will only exacerbate these shortcomings because of the principle of cabinet confidentiality. We have already seen how this will play out in the next public health emergency. During the COVID-19 pandemic, the CMOH asserted that her recommendations could not be made public due to the privilege that protects advice provided to Cabinet (see here and here). Moreover, lawmaking by the executive branch in our system of government is inherently non-transparent. We discuss this in a recent publication (see "Executive Lawmaking and COVID-19 Public Health Orders in Canada" (2020-2021) 25:2 Rev Const Stud 145 – a prepublication version of which is available on SSRN).

In its rush to appear decisive and responsive, the government has also failed to conduct a more fulsome evaluation of how effectively the Act functioned during COVID-19, which is essential to ensuring that we are prepared for the next public health emergency. On this point, the Manning Report also misses the mark. Chapters 2 and 4 of the Report, which speak to the structure of decision-making during the COVID-19 pandemic, support a broader examination of transparency in public health decision-making by recommending, for example, that a motion to confirm the declaration of an emergency be immediately submitted to the assembly for debate, that orders and regulations pertaining to an emergency be adequately communicated to the public, and that legislative duties be created to disclose plans, decisions, and regulations in an emergency. However, the basis and analysis for these proposals is set out in very brief terms and the proposals are lost in the midst of the other chapters in the Report which appear to be attempts to relitigate COVID-19 restrictions, such as school closures (see chapter 5).

So what exactly does Bill 6 seek to change in the Public Health Act?

Removing CMOH Powers During a Public Health Emergency

Under Bill 6, the powers of the CMOH will remain unchanged outside of a public health emergency declared by Cabinet under section 52.1 of the Act. For example, the CMOH could order someone with a communicable disease to isolate or order the closure of a commercial kitchen to contain the spread of a communicable disease. Under section 29(2)(b)(ii), outside of a declared public health emergency, the CMOH can also issue orders that prohibit classes of persons (rather than just individuals) from attending school, engaging in their occupations, or having contact with any persons or classes of persons.

Bill 6 shifts the power to make public health orders of general application to Cabinet once a public health emergency is declared by Cabinet under section 52.1 of the Act. It strikes us as odd that Bill 6 structures the allocation of powers between Cabinet and the CMOH on the basis of an emergency declaration because many of the COVID-19 public health orders remained in force outside of a declared public health emergency in Alberta. A public health emergency declaration is limited to a duration of no more than 30 days unless extended by resolution of the Legislature (at section 52.8). The three Cabinet declarations of a public health emergency were issued in March 2020, and then in November 2020, and finally again in September 2021. The UCP government seemingly used the declaration power (badly) for political purposes, and this was perhaps most obvious when COVID-19 restrictions were removed for the Open for Summer 2021 plan (resulting in a fourth wave of COVID-19), followed by the public health emergency declaration in September 2021 and the very controversial vaccine passport rules.

One of the fundamental problems with the Act, which is not addressed in Bill 6, is that the phrase "public health emergency" is used throughout the Act without an explicit tethering to the declaration in section 52.1. The Act makes reference to a distinction between the "existence of a public health emergency" and a declared "state of public health emergency" in section 12.1(2), and section 1 defines "public health emergency" without any reference to section 52.1. This creates ambiguity and suggests there are two kinds of public health emergency under the Act: an

emergency that exists based on the definition in section 1 (i.e., an illness that creates a significant risk to public health) and an emergency that is declared by Cabinet under section 52.1.

There is a strong argument to be made that all of the general lawmaking powers set out in the Act – powers which allow for the exercise of executive (and largely non-democratic) legislative authority with general application to the public – should be explicitly tethered to a declaration of a public health emergency under section 52.1. The Act currently fails to make this connection. Indeed, the current version of the Act correlates a public health emergency declaration with powers under section 52.6, which relate to the seizure of property or delivery of services during a public health emergency.

Under Bill 6, legislative authority to make public health orders with respect to classes of persons will shift from the CMOH to Cabinet upon the declaration of a public health emergency under section 52.1 of the Act. In other words, the CMOH will lose their power to make laws of general application under section 29(2.1). Specifically, Bill 6 states that the CMOH "must cease acting under subsection (2.1) with respect to classes of persons in respect of a declared public health emergency" (Bill 6 at section 2(a)). Instead, the CMOH will be limited to orders respecting "a specific person or persons or specific public place related to the nature of the public health emergency" (Bill 6 at section 2(a)). For example, if a public health emergency were declared in respect of a novel virus, the CMOH could order particular people who had travelled to the region where the virus originated to quarantine but could not make a similar order in respect of all persons re-entering the province after international travel.

Under the proposed amendments, Cabinet would assume the power to issue class-related orders with the advice of the CMOH, as actually occurred in Alberta during the COVID-19 pandemic. Specifically, section 2(a) of Bill 6 gives Cabinet three powers "in respect of all persons or a class of persons, including a class of individuals, bodies corporate, associations, non-profit or for-profit organizations."

First, Cabinet would have a general power to "take whatever steps are necessary in order to lessen the impact of the public health emergency" (a power that currently rests with medical officers of health). Second, Cabinet would have the same powers as a medical officer of health to make orders addressing a communicable disease but, unlike medical officers of health, would have those powers in relation to classes of persons. And third, Cabinet would have the power to reverse or vary any order issued by a medical officer of health related to the public health emergency, whether that order was issued before or during the declared state of public health emergency.

In addition to the power to overturn or vary medical officer of health orders relating to a public health emergency, section 3 of Bill 6 gives Cabinet the very broad power to "reverse or vary any decision of any decision-maker made under this Act." The threat of having one's decisions overturned on a political whim, along with the past scapegoating of the CMOH by the government, may make it difficult to recruit qualified individuals to this role.

Transparency and CMOH Independence

A primary concern with Alberta's pandemic response was the extent to which public health decisions appeared to be politically motivated. As it turns out, this appearance reflected exactly what was going on, as the authority to make COVID-19 public health orders was unlawfully delegated to (or taken by) Cabinet. This concern with the politicization of public health has only deepened with the current UCP government, which has summarily dismissed public health officials and adopted a very authoritarian tone on public health governance and health care more generally.

The underlying issue here is a lack of transparency in decision-making, which Bill 6 does nothing to change. In our recent paper (referenced above), we conducted a cross-Canadian comparative analysis of public health legislation. One of the most notable findings in that study was that most provincial and territorial public health statutes have few (if any) requirements relating to transparency or accountability for general lawmaking in public health orders. For example, in relation to the most basic of transparency requirements — the dissemination of public health orders — a surprising number of provinces and territories give full discretion to decision-makers on how to publish these orders. This was particularly problematic during COVID-19, given that the public health orders were not obscure and narrow rule changes that applied to a small subset of people at some future date. Instead, they were typically immediately effective rules, often involving sweeping changes, that individuals and businesses required timely access to in order to properly understand their obligations and avoid fines.

Ontario's Long-Term Care COVID-19 Commission Report (Ontario Commission) commented on the problems with a lack of transparency in public health decision-making and proposed greater independence for that province's CMOH. Ontario's expert advisory body and CMOH had recommended a threshold of 40 cases per 100,000 per week for public health restrictions to come into effect, which the government ignored in favour of a threshold of 100 cases per 100,000 per week. Ontario's CMOH said that he believed "confidentiality restrictions" constrained him from speaking out "since he gave this advice to Cabinet" (an argument also raised by Dr. Hinshaw in response to requests for her recommendations). In response, the Ontario Commission said that "in a health emergency, the public has the right to know the advice given on such an important matter, directly from their chief medical officer" (at 230).

If Cabinet is going to make public health decisions, then they ought to counterbalance the risk of increased politicization with greater independence for the CMOH by facilitating greater transparency of their recommendations. This way, the public can make more informed health-related decisions and hold the government's feet to the fire if they choose not to follow CMOH recommendations. For example, members of the Official Opposition who sat on Alberta's Select Special Public Health Act Review Committee recommended that the role of CMOH be made an Independent Officer of the Legislature (at 28). In Ontario, where the CMOH already reports annually to the Legislative Assembly, the Ontario Commission recommended that the CMOH "should be required to report directly to the public where he or she believes it would be in the public interest to do so" (at 230-1).

Conclusion

The problem of extensive discretionary power held by executive officials in emergency times is one of the most difficult governance issues to solve for those who seek to explain how such powers are properly exercised in a system of government that adheres to the rule of law. The COVID-19 pandemic is an exceptional opportunity to explore this conundrum. Bill 6 and the Manning Report are thoroughly underwhelming in this regard.

Our research on public health legislation across Canada confirmed that there are several different structures of accountability and transparency in public health decision-making across the country. The provinces and territories are generally split 50/50 on whether general lawmaking power is held by public health experts or politicians. The legislation in all jurisdictions is woefully inadequate in relation to having accountability and transparency measures in relation to the exercise of these powers during an emergency. Alberta's *Public Health Act* is, however, amongst the worst of the bunch. Bill 6 does nothing to change this. It represents a missed opportunity to resolve fundamental issues in the Act and to address important debates in public health governance, such as the independence of the CMOH to make their recommendations public. Bill 6, which is currently at second reading, ought to be withdrawn in favour of a broader conversation around the COVID-19 pandemic, as is occurring in Manitoba, with the new government's campaign commitment to a 1.6 million, 4-year inquiry into the pandemic. These more fulsome analyses are necessary in order to be adequately prepared for the next public health emergency.

This post may be cited as: Lorian Hardcastle and Shaun Fluker, "Haste Makes Waste: Amending the Public Health Act" (28 November 2023), online: ABlawg, http://ablawg.ca/wp-content/uploads/2023/11/Blog_LH_SF_Bill_6_Public_Health.pdf