Long-Term Care COVID-19 Commission Meeting

Dr. Réka Gustafson and Dr. Perry Kendall
on Wednesday, February 17, 2021

neesons
A VERITEXT COMPANY

77 King Street West, Suite 2020
Toronto, Ontario M5K 1A1

neesonsreporting.com | 416.413.7755

MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom Videoconferencing, with all participants attending remotely, on the 17th day of February, 2021, 11:00 a.m. to 1:00 p.m.

BEFORE:

The Honourable Frank N. Marrocco, Commission Chair
Angela Coke, Commissioner
Dr. Jack Kitts, Commissioner

PRESENTERS:

BC CENTRE FOR DISEASE CONTROL, PROVINCIAL HEALTH SERVICES AUTHORITY:
Dr. Réka Gustafson, Vice President, Public Health and Wellness, Provincial Health Services Authority, and Deputy Provincial Health Officer
Dr. Perry Kendall, Public Health Consultant, Past BC Provincial Health Officer (1999-2018)

PARTICIPANTS:

John Callaghan, Co-Lead Commission Counsel, Gowling WLG
Lynn Mahoney, Counsel, Gowling WLG
Michael Finley, Counsel, Gowling WLG
Jennifer King, Counsel, Gowling WLG
Alison Drummond, Assistant Deputy Minister,

Long-Term Care Commission Secretariat

Rose Bianchini, Senior Policy Analyst, Long-Term Care Commission Secretariat

Adriana Diaz Choconta, Senior Policy Analyst, Long-Term Care Commission Secretariat

ALSO PRESENT:

Deana Santedicola, Stenographer/Transcriptionist

-- Upon commencing at 11:00 a.m.

COMMISSION CHAIR FRANK MARROCCO:

Let me start. I am Frank Marrocco. This is Dr. Jack Kitts and Commissioner Angela Coke. We are the Commissioners on this inquiry.

I want to thank you both for agreeing to meet with us, and I think we'll benefit considerably from your experience. And, of course, Dr. Kendall, you have one foot that was formerly in Toronto, anyway, before you made the mistake of leaving Toronto and going to another part of Canada, but in any event, welcome.

We do have a reporter here, Deana. We create a transcript, and we will post the transcript on the website so that people can understand what we are hearing and what we are doing.

Because we have an April 30th deadline, we have had to follow a somewhat less traditional approach to this. We have had to expedite the hearing of information, and we have used this interview format to do that.

With your permission, if we have questions, we'll just interrupt and ask them rather

than wait until you are finished, if that is all right with the two of you.

And with that, Ms. King, go ahead.

JENNIFER KING: Thank you, Commissioner Marrocco. Good morning, everyone. I am Jennifer King. I'm a lawyer assisting the Commission. And I wanted to thank you, Drs. Kendall and Gustafson, for meeting with the Commission this morning.

And, Commissioners, Dr. Kendall and Dr. Gustafson will be talking with you about the Public Health response to COVID-19 in British Columbia and, where they can, talk about the differences between the Public Health systems in BC and Ontario and how these differences may have impacted the province's responses to the pandemic.

The Doctors do not have a PowerPoint presentation for you this morning, but I have a series of questions for them to assist in guiding the discussion, and, Commissioners, if you have any questions for either of the Doctors, of course, please interject.

Just by way of brief introduction, Dr. Kendall, I am going to tell the Commissioners something about your background. You are a Public Health physician, yes, and you served as BC's first

Provincial Health Officer from 1999 to 2018?

DR. PERRY KENDALL: Technically not correct. I wasn't the first Provincial Health Officer. They have had Provincial Health Officers since the 1940s. I was the second Provincial Health Officer under a Public Health Act that gave the Provincial Health Officer an independent voice and a role in monitoring the health of the population.

JENNIFER KING: Thank you.

And you served in that role until 2018, and you were replaced by the current BC Provincial Health Officer, Dr. Bonnie Henry?

DR. PERRY KENDALL: Correct.

JENNIFER KING: And Dr. Henry was your former Deputy Provincial Health Officer?

DR. PERRY KENDALL: Yes, she was.

JENNIFER KING: And public health issues that arose during your tenure as Provincial Health Officer in BC included your declaration of a public health emergency of overdose deaths in 2016?

DR. PERRY KENDALL: Correct.

JENNIFER KING: Yes, and H1N1 in 2009?

DR. PERRY KENDALL: Correct.

JENNIFER KING: And the establishment

of Insite, the needle exchange program and Canada's first safe injection site in Vancouver of 2003?

DR. PERRY KENDALL: That's correct. We also had the avian influenza outbreak in the Lower Mainland, and SARS, and the response to Ebola in Africa. Those were considerable issues.

JENNIFER KING: Right, and you served in that role for 20 years?

DR. PERRY KENDALL: Almost 20 years, yes.

JENNIFER KING: Almost 20 years. And before you had that role in BC, you had experience in the Ontario public health system where you were the City of Toronto's Medical Officer of Health from 1989 to 1995?

DR. PERRY KENDALL: That's correct, and during that time, I was one year on secondment to the Deputy Minister of Health in the -- to the ADM in long-term care.

JENNIFER KING: And you also were the President of the Addiction Research Foundation of Ontario?

DR. PERRY KENDALL: That's correct, for three years.

JENNIFER KING: Great. And I see that

you were awarded the Order of British Columbia in 2005, and you were appointed to the Order of Canada in 2019 in honour of your leadership in public health in BC and nationally?

DR. PERRY KENDALL: I had that honour, yes.

JENNIFER KING: Great. Thank you, Dr. Kendall. And I will introduce Dr. Gustafson because I think most of the questions that you'll be addressing will probably be addressed by both of you as we go through.

So, Dr. Gustafson, you are also a medical doctor specializing in Public Health?

DR. RÉKA GUSTAFSON: Correct.

JENNIFER KING: Yes, and since February of 2020, you have had the role of Deputy Provincial Health Officer at the BC Provincial Health Services Authority?

DR. RÉKA GUSTAFSON: Deputy Provincial Health Officer and Vice President of Public Health and Wellness at the Provincial Health Services Authority, yes.

JENNIFER KING: And in these roles, you lead the integration of population and public health promotion, planning and prevention across

the Provincial Health Services Authority's clinical programs?

DR. RÉKA GUSTAFSON: Right.

JENNIFER KING: And you also are responsible for the delegated functions of the BC Centre for Disease Control under the Public Health Act?

DR. RÉKA GUSTAFSON: That's correct.

JENNIFER KING: So you have been right in the thick of BC's response to COVID-19 during your time at the Provincial Health Services Authority.

DR. RÉKA GUSTAFSON: That's right.

JENNIFER KING: Yes. So thank you so much for taking time out of your busy schedule to speak with the Commission.

I think it is also relevant for the Commissioners to know that, before your current position, you practised public health as the Deputy Chief Medical Health Officer and Medical Health Officer in Vancouver Coastal Health for over 15 years?

DR. RÉKA GUSTAFSON: That's right.

JENNIFER KING: And you are currently a Clinical Associate Professor at the School of

Population and Public Health at UBC?

DR. RÉKA GUSTAFSON: That's right.

JENNIFER KING: Great. Is there anything else you would like to add about your background or experience for the Commissioners' benefit?

DR. RÉKA GUSTAFSON: Just that the focus of my practice was for many years communicable disease control, so that would have been outbreak detection and outbreak management, participated in a number of large outbreaks, such as the outbreak of pneumococcal disease in the Downtown East Side, H1N1, and a measles outbreak right after the Olympics.

JENNIFER KING: Thank you so much for coming and speaking with us this morning.

Perhaps we can start, Dr. Kendall, and we'll get right into it. If you could provide an overview, a brief overview of the structure of Public Health in British Columbia and the roles and relationships between the various participants.

DR. PERRY KENDALL: Certainly. So prior to 2002, essentially most of Public Health in British Columbia was performed by physicians, nurses, Environmental Health Officers, et cetera,

who were employees of the BC Ministry of Health and they were directly linked with the municipalities. There were 18 organizations.

And outside of Vancouver and Victoria and a couple of Health Authorities in the Lower Mainland which were municipal and their public health folk were employees of the municipality, although the funding came largely from the province.

In 2002, there was a major re-organization of health services in British Columbia so that hospitals and long-term care facilities, certain community care organizations and Public Health were reorganized into five geographical health authorities under the Health Authorities Act.

So we had the Northern Health Authority, the Interior Health Authority, the Fraser Health Authority, Vancouver Coastal Health Authority, and Vancouver Island Health Authority, and a Provincial Health Services Authority which gathered together province-wide functions such as the responsibilities for transplant, BC Women and Children's Hospital and the BC Cancer Agency and the BC Centres for Disease Control.

So this brought Public Health integrated into the health services delivery. Pieces that were outside of the Regional Health Authorities were the primary care -- most primary care physicians and the pharmaceutical component, which was not actually run -- other than drugs for cancer control and HIV, the pharmaceutical area was outside of the ambit of the Regional Health Authorities.

If we look just at Public Health, the Act, the Health Act in 2002 was amended to give the Provincial Health Officer a role to advise government on the health of the population and to report publicly on progress to achieving British Columbia's health goals and also gave the Provincial Health Officer the responsibility for setting standards for the Medical Officers of Health in the Health Authorities.

We also reorganized the Public Health system, at least as far as the Medical Health Officers were concerned, so that each Regional Health Authority had a Chief Medical Health Officer and a number of Associate Medical Health Officers.

So de facto each Regional Health Authority had the equivalent of an obstetrics and

gynaecology surgical ward or cancer specialty, and the Chief Medical Health Officers had a dual reporting role under the Public Health Act. They reported -- they were responsible to the Provincial Health Officer for their duties and authorities in regards to health hazards, communicable diseases, and reporting on the health of the public, and then administratively they were responsible to the CEO of the Regional Health Authority, who in turn was responsible to the Chair of the Board of the Health Authority, who in turn was responsible to the Minister of Health.

The other component Act which is relevant is the Long-Term Care and Assisted Living Act. In the 1970s, the late 1970s in British Columbia, the non-institutional components of community care, which was home nursing care, assisted living, et cetera, were brought into the Regional Health Authorities and became part of the -- well, brought into the Public Health system at that time and then in 2002 became part of the Regional Health Authorities' mandate. The Regional Health Authorities were also given the responsibility under the Community Care and Assisted Living Act to manage the funding, the

public funding of long-term care facilities.

And under the long-term care and assisted living act -- the Community Care and Assisted Living Act, there is a Chief Licensing Officer who can direct the Health Authorities to provide reports.

And under the CCALA, the Chief Medical Health Officer or the Medical Health Officer has the responsibility for issuing licences, dealing with complaints, adding conditions to licences, responding to every complaint and publishing those reports on a public basis essentially.

And at the Ministry of Health, the Chief Public Health Officer has a close relationship with the Chief Licensing Officer as it pertains to residential care standards and the responsibilities of Medical Health Officers, who kind of in a way have a bifurcated relationship both to the PHO and to the Chief Licensing Officer, and maybe it is trifurcated because they also have a responsibility to oversee long-term care residences that might be actually owned and run by the Health Authority.

And when you get into some detail, long-term care in BC is -- we have got 27,000 beds.

About one-third of them are publicly not-for-profit owned and funded, one-third are for-profit, and one-third are run by the Regional Health Authorities directly.

So that is in essence the sort of structure with the three components, the Regional Health Authorities, Public Health Act, the Regional Health Authorities Act, and Community Care and Assisted Living Act.

Under the Public Health Act, Medical Health Officers and the Chief, the PHO, have a responsibility to report publicly on the health of the public. The PHO has a responsibility to report annually to the legislature on the health of the public. He or she also has a responsibility to provide reports and advice on any matter pertaining to public health and to ensure that those reports are publicized or made public in however the Chief Public Health Officer determines is the most appropriate way of doing it.

And the Provincial Health Officer has a direct reporting line to the Minister of Health, but also administratively, in the Ministry of Health, to the Deputy Minister of Health and --

JENNIFER KING: Dr. Kendall, sorry for

interrupting you, but I think I saw that Commissioner Kitts had a question.

DR. PERRY KENDALL: Of course.

COMMISSION CHAIR FRANK MARROCCO: He is gone.

JENNIFER KING: Oh, he is gone.

COMMISSION CHAIR FRANK MARROCCO: He'll be back.

DR. PERRY KENDALL: Shall I continue?

JENNIFER KING: Should we continue, or should we wait for --

COMMISSION CHAIR FRANK MARROCCO: Well, why don't we just wait a few seconds and see if he logs back on. Usually what happens to me is the phone rings, and it is a variety of telephone providers or the air duct people. I don't know if you have had the pleasure of dealing with them in BC, but they are forever interrupting these. In fact, I think what I will do is I'll get rid of this while we are waiting for Dr. Kitts.

COMMISSIONER ANGELA COKE: He did mention that he was having some wi-fi issues.

DR. PERRY KENDALL: That is the curse of Zoom, I think.

JENNIFER KING: But we have the convenience of being able to meet with people in British Columbia, so there is trade-offs, Commissioner.

COMMISSION CHAIR FRANK MARROCCO:

Well, Ms. Drummond, could you give him a call and see if he is going to join us presently?

ALISON DRUMMOND: Yes, I will.

COMMISSION CHAIR FRANK MARROCCO:

If he isn't, we'll just proceed because there is a transcript, but we'll just give him another minute or so.

ALISON DRUMMOND: Dr. Kitts asked that people go ahead. There seems to be problems with a fiber optic cable in the neighbourhood.

COMMISSION CHAIR FRANK MARROCCO:

Okay. Well, then, Ms. King, why don't we carry on with the doctors.

JENNIFER KING: Okay. So, Dr. Kendall, I had interrupted you, but I think that you -- if you can proceed.

COMMISSION CHAIR FRANK MARROCCO:

With the interruption.

JENNIFER KING: Yes.

DR. PERRY KENDALL: It couldn't have

been the air duct people anyway. The fiber optic duct people -- anyway, excuse me.

So I was just going to say, I think, that -- I was going to talk a little bit about the Public Health Act which arose out of the BC Health Act, preceded the Public Health Act, and was basically a complicated Act that was first written in 1945 and had substantial changes and alterations over 20, 30, 40, 60 years. So it was sort of an archaeological trove of what people had thought Public Health and Health Authorities should be.

And it was substantially revised in the early 2000s and promulgated in 2008 to be a more public -- a more modern Public Health Act that outlined the powers and the independence of Medical Health Officers and the Provincial Health Officer, and also gave them powers in the case of an emergency, which could either be a local emergency which could be declared by the Local Medical Health Officer or a regional or a provincial public health emergency. And the standard for declaring an emergency was a threat to the health of the public, primarily deemed to be a communicable disease, but not necessarily. It could be other issues. And for communicable diseases and actually for

radiation, the Medical Health Officer was deemed to be the person in charge and the person most responsible for guiding the responses.

And under the powers when an emergency was declared, certain regulatory processes could be speeded up. Written orders could be delivered verbally. The ability to contest such an order was basically put in place. You could still contest the order, but the order stood in place while the hearing was being heard. And rather than having to write individual orders for quarantine on individuals, it could be applied to groups of people or individuals. So the powers became a lot more effective and a lot more rapid and gave Medical Health Officers and the Provincial Health Officer sort of considerable authority once an emergency had been declared.

And that I think was a very helpful tool to have when you are dealing with, say, an outbreak of measles in a religious community that involved several hundred people, and that could be dealt with as a group.

And that, I think -- unless there is any questions, hopefully that at least gives a little bit of an outline of the sort of

relationships between the Provincial Health Officer and the Ministry of Health, the long-term care, the community area of long-term care, the home care, et cetera, and the Public Health in the field.

In the field, Public Health is integrated into service delivery. Most of the Executive Committees in the Regional Health Authorities have the Chief Public Health Officer -- have the Chief Medical Health Officer as part of their organizational structure. Not all of them and that isn't mandated, so the structures do differ somewhat. And each Regional Health Authority has a Chief Medical Health Officer and four or five Associate Medical Health Officers with them.

The funding for Public Health is roughly about 3.5 percent of the total global budget. It isn't ring-fenced. And it has had its ups and downs. It has been invested in, and it has also been diminished. And I would say, going into COVID, we were in a situation where I think my successor, Dr. Bonnie Henry, shared my concerns about the level of funding that was available at the community level and the capabilities of the BC CDC in terms of budget and particularly in terms of

the Public Health Act, which were also associated with the BC Centres for Disease Control and fell under the Provincial Health Services Agency.

COMMISSION CHAIR FRANK MARROCCO:

Doctor, if I could interrupt for a minute, I am trying to -- in this COVID outbreak, then you or your successor is the decision-maker? My question is related to leadership in the end, but I am trying to understand the structure in terms of decision-making power.

DR. PERRY KENDALL: The Local Chief Medical Health Officer has the ability to declare a local emergency. He or she would do that in consultation with the Provincial Health Officer. The Provincial Health Officer has the ability to declare a public health emergency. I declared the first public health emergency under the Public Health Act in 2016 and that was in respect of the opioid overdose crisis which has its epicentre in British Columbia. I did that actually in consultation with the Minister of Health, who agreed that that was a rational thing to do, and I did it with the support and at the request of Local Medical Officers of Health and others.

The power technically was within my

rights to declare it even if the Minister of Health had not agreed, but fortunately, we had a long history of working quite closely with Ministers of Health who respected the independence of the Public Health Officer and the Medical Health Officer's expertise, just as we respected the fact that they had been elected and we had only been appointed.

COMMISSION CHAIR FRANK MARROCCO:

Did --

DR. PERRY KENDALL: I don't know if that answers your question, but --

COMMISSION CHAIR FRANK MARROCCO:

Well, it does in a way. One of the other issues is timeliness of decision-making. You know, in long-term care, for example, masking or not, these decisions have to be made it seems promptly, and I was just curious what your views were on ensuring timely decision-making.

DR. PERRY KENDALL: Well, if it comes to masking, I would say that probably North America or English speaking had a different take on masking than, say, the Asian continents. There was almost a global divide in the degree to which people accepted the efficacy or the efficiency of masking.

So I don't think it was central to our

considerations around disease control back at the beginning of 2020.

I don't know, Réka, would you have a comment on that?

DR. RÉKA GUSTAFSON: Yes. So I think the importance of masking notwithstanding, the response -- the timeliness of the response to the first outbreak in a long-term care facility was important, and that was done -- that is under the authority of the Local Medical Health Officer.

So our first outbreak in a long-term care facility happened to occur in Vancouver Coastal Health, and the Medical Health Officer was actually immediately there. They physically went to the long-term care facility. They tested all the staff -- or tested those who needed to be tested and immediately implemented infection control recommendations. That did not need to wait to go up a chain of command to a provincial setting.

So that is a relationship -- that is an existing relationship, an existing authority. And in that particular case, as we found out in many other outbreaks before we had the level of surveillance that we do now, is that it probably

was in the facility for a little while before it was detected. But as soon as it was detected, the Local Medical Health Officer has both the authority but the relationships to respond to that outbreak, so that is just to answer your timeliness question.

DR. PERRY KENDALL: Yes, and that relationship has existed for years, ever since long-term care facilities and community care were brought into the public health system in the late '70s.

And when we go back to masking, I should say there is a big difference between masking in the community, which is where North America and Canada did not see much evidence for the protective effect of that, versus masking in health care facilities where it has long been the standard for personal protective equipment. The degree to which masks should be used and when has often been a bone of contention between some health professionals and other people in infection control.

JENNIFER KING: Dr. Gustafson, you were talking about I guess it was Dr. Daly, who is the Medical Health Officer in Vancouver, and her role with the first outbreak. And can you tell the

Commissioners a little bit more about the existing relationship between the Regional Health Authority and long-term care homes.

DR. RÉKA GUSTAFSON: Absolutely. So as Dr. Kendall mentioned, there is a role of the local medical -- or the Chief Medical Health Officers via the Community and Assisted Living Act that names the Medical Health Officer as the licenser for long-term care facilities.

How that has actually manifested in practice is that the Local Medical Health Officer issues the licence but also has a set of licensing officers. These licensing officers carry out the duties of licensing on behalf of the Local Medical Health Officer. And that relationship I think consists of sort of a number of things. One, some understanding of administrative law, so clear understanding of what the role actually is; expertise, expertise in surveillance, outbreak detection and management, as well as an infection control.

A really big part of that is resourcing. You have to be resourced by the Regional Health Authority to actually carry out those duties.

And then really the long-standing relationships, these long-standing relationships that are established through the management of outbreaks that occur on a regular basis in long-term care facilities. So the most common ones are norovirus and influenza, and these are annual occurrences that happen in long-term care facilities with some predictability. And so that relationship is really maintained through the fact that there is a common body of work that happens between Public Health and the long-term care facilities.

So, to me, I think that is probably one of the most important things to have at your disposal when an emergency is declared, is that you are not meeting for the first time, that you have an established relationship and, in particular, protocols in place, protocols that you renew, that you communicate every year.

We have respiratory illness outbreak protocols that exist and get updated, and you work with long-term care facilities to make sure that they are implemented. We have swabs to collect. Samples for influenza are sent to the long-term care facilities every fall. There is a pathway for

those swabs to the lab to be identified as outbreak swabs. There is a reporting mechanism for outbreaks for long-term care facilities.

So really all the components of the response are actually in existence and are exercised every year. The packaging changed quite profoundly, though.

COMMISSION CHAIR FRANK MARROCCO:

Are they required to have a pandemic plan? What kind of plans are they required to have, if they are --

DR. RÉKA GUSTAFSON: There are regional pandemic plans, and there is also a provincial pandemic plan, and so yes, they do exist. I worked on them quite a lot.

One of the challenges with pandemic plans, however, is that people tend to plan for the last pandemic or the last event they had rather than the next one. So I have long held that a pandemic plan is probably something that should be renewed. It should actually be a flexible version of the existing outbreak plans that should probably be reviewed every year after your influenza season to see what you would want to change rather than sort of a plan that exists in isolation for an

event that may take years and years to come.

So yes, there is a pandemic plan, but I think what is more important is that there is a living document, which is the Outbreak Response Plan, that is actually used for the outbreaks that we experience on a regular and predictable basis.

COMMISSION CHAIR FRANK MARROCCO:

Do you think maybe -- oh, go ahead, Commissioner Coke.

COMMISSIONER ANGELA COKE: No, if you are following on, it is okay.

COMMISSION CHAIR FRANK MARROCCO:

Well, no, I was just asking if you had any views on how you maintain that sense of vigilance. It seemed here that after SARS people were vigilant for a short period of time, two or three, four years, and then gradually -- because pandemics don't occur -- or because infectious disease outbreaks of significance don't occur that regularly, that there was kind of a fall-off. They let it go. The supplies of PPE expired and weren't replaced. And this created a problem in long-term care.

So how do you maintain that sense? Do you have any views on how you maintain that sense

of vigilance?

DR. RÉKA GUSTAFSON: So my personal view - and Dr. Kendall may feel differently about it - I think that natural falling off of interest is entirely predictable and expected.

And so from my perspective, what you want to do is to really do an excellent job of managing the events that do occur, and maybe with some regularity apply what you would know to a potential larger outbreak or event.

I think that decline in interest was a result of the fact that pandemic planning almost turned into a self-perpetuating industry, and it was not always related to your primary work, to the thing that you actually had to do every day.

So for me, if you can connect the activities that you are doing, that you need to do, to exercising something more extraordinary rather than a separate division of your organization or an administrative requirement for accreditation, then I think it remains alive and exercised, and keeping in mind that this pandemic planning has to occur in the context of very busy Health Authorities that have the urgent needs of the everyday to tend to.

So from my perspective, the key to a

pandemic plan would be for it to be very simple, very conceptual, not focussed on the last pathogen that you had, not necessarily telling you what to think but how to think and be exercised in the context of regular outbreaks.

I don't know what Perry thinks about that.

DR. PERRY KENDALL: Yes, I agree that on the front line that is what you need to do.

I have also observed, though, over the nearly 20 years that I was in the job that no matter how much planning is being done, you have to take advantage of a crisis when it occurs.

So with avian influenza, the focus was on adequate respiratory equipment, personal protective equipment, to protect people from the possibility of getting avian flus.

In 2003, the SARS outbreak brought a lot of attention to personal protective equipment and everybody -- we were at first -- well, no, we were at first kind of surprised by that, but that gave a whole new level of awareness certainly on the front lines around PPE and the necessity to have that equipment.

But as things drift off and away, you

lose administrative focus on this, and you get more focussed on the next urgent issue in health care, which is invariably a shortage of beds or a shortage of cardiac surgery or a shortage of cancer therapies, and the attention drifts away until the next crisis comes along, and then you realize that your stocks of equipment have been forgotten. The training that you were supposed to put in place for PPE has gone out of the window. And everybody is panicked all over again.

And then you think about building a centre at, say, a particular hospital that will have the responsibility for maintaining stocks and training people, and then you discover that the budget that was put aside for that after three years has gone into general revenue because of cost pressures in another area.

So we see this cyclical interest response fading away and loss of attention, and then the next crisis comes in and we go back into reactive mode.

Hopefully we'll learn from it, but I kind of think it is a human condition that you can't maintain a state of readiness all the time because there is always something else that will

detract from that focus.

COMMISSION CHAIR FRANK MARROCCO:

Commissioner Coke, I am monopolizing the --

COMMISSIONER ANGELA COKE: No, no, this was just going back to a comment you had made about the Local Medical Officer issues the licence for the long-term care homes. I am just trying to understand, are they responsible for the inspection regime as well?

DR. RÉKA GUSTAFSON: Yes. So there is an inspection -- so under the licensing, the Community and Assisted Living Act, yes, they do regular inspections. There is a set of criteria by which they inspect long-term care facilities. It is quite wide-ranging. It includes the physical layout. It can include the processes in place for TB testing.

And so, yes, they inspect all licensed facilities on a periodic basis.

COMMISSIONER ANGELA COKE: Okay.

DR. RÉKA GUSTAFSON: Not the Medical Health Officer, but their licensing officers.

COMMISSIONER ANGELA COKE: Okay.

COMMISSION CHAIR FRANK MARROCCO:

So go ahead, Ms. King.

JENNIFER KING: We have been touching on a number of different topics, and I just wanted to bring you back to -- we have talked about the different players in the Public Health system in BC.

And before I ask you about the actual response to COVID-19 in BC, I just wanted to ask you, Dr. Gustafson, you currently have a role leading the BC CDC, and I am wondering if you could talk about the BC CDC's role in the Public Health system and if you can say anything about comparing it to the equivalent in Ontario, which is Public Health Ontario.

DR. RÉKA GUSTAFSON: So I will actually invite Dr. Kendall to speak to this as well, because the BC CDC, he has been more familiar with it for more years than I have. I actually started on February the 3rd, 2020, at the BC Centre for Disease Control, not the ideal timing.

So the BC Centre for Disease Control didn't exist within the Public Health Act, as far as I know, until the renewal of the Public Health Act that Dr. Kendall spoke to.

It is a body under the Provincial

Health Services Authority. It is a provincial body. It carries out -- my role is that of -- as a Deputy Provincial Health Officer, the primary role is to collect reportable disease information, collect and analyze, so really perform those surveillance functions that enable the Provincial Health Officer to monitor the health of the population.

Over the last several years, I would say that mandate has evolved and developed. It includes a number of other functions. We do carry out the provincial management of one communicable disease, which is tuberculosis, in collaboration with the Regional Health Authorities who do contact tracing for tuberculosis. We also have a provincial sexually transmitted infection clinic that is primarily responsible for the management of syphilis. That is sort of the sole responsibility for the BC CDC. And we are co-located with the provincial laboratory, and that does allow us to combine epidemiology with the laboratory to monitor things like testing rates, for example.

So that is actually an advantage that we have, that for certain pathogens we can also monitor not just the numerator, which is how many

positive tests we have had, but also the denominator of how many negative tests we have had.

Over the last little while, the BC Centre for Disease Control also is -- and it is something I will build on, is expanding its role in population health management.

The role of BC CDC in the management of outbreaks in long-term care facilities has actually been quite minimal. So the majority -- the role really is with the provincial laboratory. And that is I think an important thing to note. But by and large, outbreaks in long-term care facilities are managed by the Regional Health Authorities under the auspices of the Chief Medical Health Officer.

And other than reporting on the number of outbreaks -- so influenza outbreaks and norovirus outbreaks are reported to the BC Centre for Disease Control and form the part of our, say, biweekly or weekly influenza surveillance report.

The actual management of those outbreaks the BC CDC does not participate in, by and large.

COMMISSION CHAIR FRANK MARROCCO:

And so the management of the outbreak is really local -- the decision-making is

anticipated will be driven down and be local?

DR. RÉKA GUSTAFSON: Yes.

COMMISSION CHAIR FRANK MARROCCO: Okay.

DR. RÉKA GUSTAFSON: And certainly in non-emergent times, the management of outbreaks in long-term care facilities is entirely a local public health activity.

COMMISSION CHAIR FRANK MARROCCO: No, but in a pandemic, in our situation here.

DR. RÉKA GUSTAFSON: So in the pandemic, again, the day-to-day decision-making around what to do around the outbreak was still made locally, but there was more involvement than is in peacetime.

So there would have been -- there would certainly have been a discussion with the Provincial Health Officer. There would be a discussion with the BC Centre for Disease Control as well. There would certainly be sort of a joint consideration of, you know, what this means for us now in British Columbia.

But sort of in my experience, the Provincial Health Officer didn't direct the

response within a long-term care facility. There is a -- what did happen and I think this -- and Dr. Kendall can comment on this. I think we benefit in British Columbia being relatively small, and so from fairly early on, the Public Health community consisting of all the Chief Medical Health Officers, the Provincial Health Officer, as well as the Provincial Health Officers' Deputies, started meeting on a three-times-a-week basis to essentially form a community of practice to discuss practice issues because they were evolving in real time.

And the role of BC CDC in that was to make sure that those discussions get consolidated into guidelines, guidelines on how to detect and manage outbreaks in long-term care facilities fairly rapidly, in collaboration with an organization called PICN, which is the Provincial Infection Control Network. And while Health Authorities with a lot of capacity would have written their own guidelines probably in real time, in relatively short order the BC Centre for Disease Control made sure that those guidelines were consolidated into something provincial.

So that is something that we did

discuss provincially and its implementation is done locally.

I don't know, Dr. Kendall, if you agree with that assessment.

DR. PERRY KENDALL: Yes, and the only thing I would add to that is that it built on a long past history of the BC Centres for Disease Control working on communicable disease control with the Regional Medical Health Officers, and not every Public Health area within every Regional Health Authority is equipped to the same extent that, say, Vancouver Coastal and the Lower Mainland might be, but there has been a long-standing BC communicable disease policy control organization with Public Health physicians from the Regional Health Authorities and BC CDC working together to try and establish the best practices in communicable disease management and outbreak control.

The BC CDC had a particular role when more than one Health Authority is involved or when you have a provincial outbreak that needs coordination. So the BC CDC had that coordination role and collecting data from the whole of the province to put the epidemiological picture

forward.

And also I think their role nationally, connecting nationally with the Public Health Agency of Canada and hence through internationally when you were dealing with issues that spanned continents, like Ebola, like SARS, like MERS, and like COVID-19.

DR. RÉKA GUSTAFSON: Thank you, and now you are bringing me things to my mind.

The other thing I think that the BC Centre for Disease Control has a significant role in is things like evidence reviews to inform the management.

So as Dr. Kendall mentioned, there is significant differences in the capacity of Health Authorities. We have some parts of our province, of course, like everywhere else, which are densely populated and there is significant expertise and just concentration or number of people who can do the work, and there are other parts that are quite geographically distributed and just a lot fewer human resources to do the work.

So there is direct support for outbreaks from the BC Centre for Disease Control for the regions that have less capacity. There is

an evidence synthesis component. I think the other part that BC CDC played a part in is that our physicians in the laboratory are actually part of the BC Centre for Disease Control, and we in British Columbia had a test very, very early. We had a test that the -- I believe the genetic code of the virus was published on January 10th, a local test was developed by the 13th, and the first person was diagnosed by the 26th of February.

And what that meant -- and yes, this laboratory and our physicians went through the approval process with the National Microbiology Lab, and for some time samples were being sent to the National Microbiology Lab, but we didn't wait for that process to occur before we acted on results. So that was actually a very significant role that the BC Centre for Disease Control played.

So now you are making me think about things that I hadn't thought of before.

The other area that was very important is whole genome sequencing. Whole genome sequencing within BC CDC actually allowed us to distinguish between multiple introductions of a virus within a long-term care facility as opposed to ongoing transmission to be able to actually

identify what we can attribute to the long-term care facility and what we cannot.

There is also a sero-survey that was done to try and understand the extent of transmission, undetected transmission in the population that we may not be able to understand. And right now, one of the roles of the BC Centre for Disease Control, which we are going to hear about at 11:30, is an assessment of the vaccine effectiveness in long-term care facilities.

So yes, I think I understated the role a little bit, but -- so there is -- that would be the historical role, and I think a really important part of the role of BC CDC, for example, is an annual assessment of vaccine effectiveness of the influenza vaccine, as well as whole genome sequencing for other outbreaks, such as norovirus.

JENNIFER KING: Dr. Gustafson, can you talk about the independence of BC CDC? Like does the BC CDC report directly to the public? Are their recommendations and advice public?

DR. RÉKA GUSTAFSON: So that is an excellent question. And what is interesting is that there is a Memorandum of Understanding between the Provincial Health Officer and the BC Centre for

Disease Control, which at the moment, I believe, is expired, so it is not at the moment signed.

So that I, as a Deputy Provincial Health Officer, am responsible to the Provincial Health Officer for the activities that are outlined in the Public Health Act, but I would not say that the independence of BC CDC one year after this is entirely clear to me. I don't think it is particularly well articulated, and so -- and the mandate is probably something that I would think needs some clarification, just so that I could answer that question very, very clearly.

The BC Centre for Disease Control, in an ideal state, I believe it is able to put out a report that is an independent assessment of the health of the population. That is something that certainly -- in the terms of routine surveillance, BC CDC puts out information that isn't vetted, but I don't believe that that independence is clearly articulated in any legislation.

DR. PERRY KENDALL: I could perhaps add to that. When the BC Centre for Disease Control -- the BC Centre for Disease Control does its analytics and its data collection on behalf of the Provincial Health Officer, so that is a delegated

function.

The BC Centre for Disease Control is part of the organization which is the Provincial Health Services Authority, but in order to try and establish the independence of the agency and be clear about its responsibilities, there was a Memorandum of Understanding developed, that Dr. Gustafson has referred to, which I think is under revision currently. It was signed. It was in existence. It was fairly clear.

The other piece that we were concerned about when I was the PHO and the BC CDC and was incorporated into the Provincial Health Services Authority was that Regional Health Authorities have their own legal advisors. The Provincial Health Officer has his or her own legal advisor within the Ministry of the Attorney General. And we wanted to be sure that the BC CDC had advantage of that legal advice so that we were not getting competing legal advisories from the PHSA legal services and the PHO legal services.

So it is really clear in the BC CDC mandate that the BC CDC, when it comes to issues of health hazards or communicable diseases, shares the legal advice of the Ministry of the Attorney

General legal advisor who gives advice to the Provincial Health Officer.

The other thing that we put in place a few years ago to ensure that independence was previously the Executive Director or Executive Medical Director of the BC CDC was not officially an Order in Council Medical Health Officer. We made that a requirement that the Executive Director of the BC CDC should be eligible to be a Deputy Provincial Health Officer and hold an OIC appointment, which gives the holder of that appointment all of the authorities of a Provincial Health Officer and can speak on behalf of and independently on public health issues.

That was to give the Director of the BC CDC the ability to raise concerns of budget cuts which otherwise might have been imposed upon the BC CDC with adverse public health consequences.

JENNIFER KING: Thank you. So I think why don't we get into -- we have already talked about -- you have already talked to us about the response in BC, but can you talk -- I think just to both of you, comment on what has worked in BC in terms of the pandemic response, specifically with respect to the response of long-term care homes,

and if you can, talk about -- if you have information about it, compare it to Ontario and Ontario's response.

DR. PERRY KENDALL: I'll just start off by saying I think that the organizational structure and the regulatory structures, which had been in place for over a decade, really make responses to emergencies a lot more coordinated and integrated in British Columbia. Admittedly, we have a smaller population, but the regionalization of the Health Authorities, the clear authority that Public Health has in respect to long-term care and the relationship with the Regional Health Authorities and the relationship with the Ministry mean that with one telephone call, within an hour the Deputy Minister can have the CEOs of each Health Authority on the line to plan something together in real time, and the Chief Public Health Officer and the Provincial Health Officer can do the same with the Chief Medical Health Officers in the region.

And so the organizational structure is there for a really rapid, integrated response, both clinically or with the continuing care of a long-term care area.

So over to you, Réka.

DR. RÉKA GUSTAFSON: Well, I would second that.

So just some examples of that. As Dr. Kendall mentioned, we had the Long Standing Communicable Disease Advisory Committee, as well as we have something called a Leadership Council where the CEOs of each Health Authority meet with the Deputy Minister, and I believe they meet on a weekly basis or even during not a pandemic and much more frequently now.

So that is a level of provincial coordination and familiarity which I think is absolutely critical in an emergency. I think the -- for me, I don't think we can underestimate the value of knowing who your partners in an emergency are and having worked with them and having them on your speed dial and knowing who you are going to call.

I think that is actually really key.

Then the other part that I think makes a really big difference is, within the Regional Health Authority structure, as Dr. Kendall mentioned, the Chief Medical Health Officer by and large sits I think in just about every Health Authority now on the executive team, which means

that within the hospital setting or within the Health Authority setting those are individuals that they meet with and work with to address daily crises or larger crises on a regular basis.

So they not only have the authority, but they have an associated credibility. And as a result, I would say that their guidance -- the legislation enables -- is an enabling legislation. It is not something you have to call upon and is unfamiliar to the people who need to act on your advice or only act on your advice because they are directed to do so by legislation. You have a long-standing practice of having supported them in responding to a hospital-wide norovirus outbreak or a community outbreak of whooping cough or whatever it might be that has existed, or MRSA or C. difficile or whatever it is that you are supporting them with, and that has been happening over many years.

And I think then a really important thing that doesn't necessarily exist in every Regional Health Authority is that, upon your direction or advice, the Health Authorities will actually deploy resources. And again, I think that varies by Health Authority, Health Authority by

Health Authority, the extent to which that will actually happen, but I think it says a lot that then when there were a number of outbreaks, then the Regional Health Authority actually deployed resources to go to contracted health care facilities that came from acute care.

And some Health Authorities did that and others followed suit, and I think that is not -- I don't think that would be the consequence of just the legislative authority. I think it is the ongoing practice that is nurtured over time.

And the legislative authority is a really, really strong enabling tool, but it is not the motivation.

COMMISSION CHAIR FRANK MARROCCO:

Can I just follow up. It is one thing to have the authority, the legal authority, but it is another thing to have what it takes to exercise it. And I'm wondering how you address -- or what your views are and how you address the question of leadership. Like, I mean, saying that you need effective leadership doesn't say much. Very few people would say that you need ineffective leadership.

But is there a way of addressing that

that we might find helpful?

DR. PERRY KENDALL: I think it does help if you have the mandate and can point to it. There are independent agencies, Auditors General, Seniors Advocate, and the Representative for Children and Youth, who very clearly are independent of government and report to government.

Public Health, in BC at least, has the mandate to report independently and give advice but not to the same degree of freedom that, say, the Auditor General has or the Privacy Commissioner has.

So you have to build up on that through relationship-building, through professional training in leadership, and there are leadership courses that are available. I think having good communication skills is essential. I think the ability personally to take a certain amount of risk and the ability to speak effectively to power is an important issue and to be able to communicate what might be unpopular at the time but do so in such a way that doesn't get you disrespected.

And I think it is important to understand the difference between people who were appointed to a position and people who were elected

to a position, and those -- the opinions don't necessarily always gel. Politicians make policies which are not always -- or not frequently enough, shall I say, sort of supportive of general public health across the field, but the ability to be able to make a point and provide advice that is unbiased and non-political and has some grounding is important.

But I think it is also important to relate it -- an effective Public Health Officer tries to make a difference rather than necessarily making a point. So choosing your issues - and there are always many issues - choosing your issues is important. Choosing when to push an issue is important, and having a measure of trust behind you is really critical as well.

So every time there is a new elected leader, it is important to build on whatever legacy of trust you have and try and develop a relationship, even if you do hold opposing political philosophies.

Réka, you could add to that, I am sure.

DR. RÉKA GUSTAFSON: So I very strongly agree with that. A strong Public Health Act that clearly outlines your mandate is actually critical.

It is really, really important.

I think the point I was probably making is that by itself it doesn't get you there. And I think your question, Commissioner, about the courage to exercise your power or exercise your authority, I think that, again, comes with practice.

And one of the things that I have seen, for example, not necessarily in long-term care facilities but in others, where there has been a differential courage to shut something down where there is an outbreak, to actually exercise your power to -- your authority to put an intervention in place.

And I think there is a number of things that can contribute to that. Again, practice is one of them. The other is that because you are functioning within Regional Health Authorities, the Regional Health Authority can over time either increase or decrease your power within that organization.

And one of the -- and I don't know if, Perry, this is an explicit role of the Provincial Health Officer, but in the 20 years that Dr. Kendall was the Provincial Health Officer, in that

time, if I needed backup, if I needed support from the Provincial Health Officer and I demonstrated - this is in my role as a Regional Medical Health Officer - and I demonstrated the public health merits or necessity of taking a step that may or may not have been popular, I could reach out to my Provincial Health Officer and get that support.

And that support was actually really, really important because there is both a legal authority and a gravitas that goes with the role of the Provincial Health Officer. And if you are about to exercise your authority, there is actually a procedural step whereby, if you issue an order, the Provincial Health Officer approves that order. But it is more than a procedural step. It is also -- it also actually ensures that you go through the process of having considered the pros and the cons of taking that step and that you are actually exercising your authority with discretion.

And so I think that's, again, sort of a -- part of our day-to-day life, that whether you are going to issue an order over a drinking water operator or actually restricting the rights of another human being, you do have that exercise of both requiring the Provincial Health Officer's

approval, but then actually having their support.

So I would say that those are really important parts of the overall practice, but again, I do think that if the only time you were to exercise your authority is during an emergency, that is a dangerous place to be.

One of the things I tend to see in emergency responses is that it tends to draw in a lot of players who may not actually have the greatest amount of experience and that isn't always to the benefit of the response.

Sometimes it is great, it is fresh troops, but we also have to be careful to make sure that people who are making the difficult decisions have the experience to do so.

COMMISSION CHAIR FRANK MARROCCO:

Well, the different players bring different perspectives, and what they think is important and what the Medical Officer of Health thinks is important might not be the same.

DR. RÉKA GUSTAFSON: Right.

COMMISSION CHAIR FRANK MARROCCO:

All right.

JENNIFER KING: Dr. Kendall and Dr. Gustafson, you talked about having a strong

Public Health Act that sets out the mandate. Is there anything else in the legislation that you think is necessary to ensure that you get the right kind of leader, the kind of leader that you have described, Dr. Kendall, in the role of the top Public Health official in the province?

DR. PERRY KENDALL: I can't think of anything that could be written into the legislation that would make that choice inevitable.

I think BC has fortunately had a good history of carefully vetting who moves into the position. They certainly have to have the appropriate technical and educational capabilities, and I would like to think that the people who made the ultimate decisions made good decisions. Obviously, I would like to think that.

But I don't know, Réka, if you could think of anything else?

DR. RÉKA GUSTAFSON: Well, I have actually been thinking about it, and I don't know if necessarily the Provincial Health Officer, but these leadership roles that a number of us are in, I have some thoughts about it.

I actually think being deeply rooted in practice is important to a certain degree and -- or

a certain period of your practice has to be in actually practising in the area of public health, so I think that is really important.

The other that I am starting to think about is that I think an opportunity to rotate in those positions. The way we set up our positions, all of our Public Health positions in British Columbia is they are sort of lifetime appointments, and I think they should be -- like I think there should be an option to renew.

But I also think there should be an option to not renew without it being a dismissal. And the reason that I think about that is that I think these types of positions benefit into a rotation back into practice and think about them a little bit -- not the Provincial Health Officer but the other, because that is such a position so deeply rooted in legislation, but sort of leadership positions in Public Health, to recognize that Public Health is ultimately, you know, rooted in local practice and then coordinated through provincial practice and supported with a provincial or national evidence review.

But I do find that there is an artificial hierarchy that is set up that isn't

necessarily commensurate with depth of experience, and so one of the things that I sometimes wonder about is it is a form of medical practice and sometimes the conversation at the national level that I am privy to reflects the disconnect from practice that I find concerning.

So to me, that is one of the things that I think we need to just be thoughtful about, about whether or not is it really a hierarchy or is it practising at different levels.

And that may just be because I come from a communist country and, therefore, I am just -- I don't believe in hierarchies, but I just think the leadership -- I think the leadership has to be humble. I think it has to be more rooted in responsibility than authority. And I think it has to be a leader that can consult in a meaningful way.

And I will bring back, again, H1N1, Dr. Kendall, when there was an issue that came up around vaccine and potentially the effect of a previous vaccine, and you formed a solace that I need my wise counsellors to answer this question. And I think that -- I still remember that, that was 11 years ago, and I think that is what a Provincial

Health Officer needs to do because you can't, as a single practitioner, have the depth of knowledge about every single area in every single moment, but you have the judgment and the ability to synthesize that information into a decision.

I don't know what you think about that, Perry, but I think those are the qualities that I would want.

DR. PERRY KENDALL: I think it is extraordinarily helpful to be able to do that and have that body of expertise to consult, because you are right, no one individual can possibly know enough about everything to make sensible decisions or wise decisions.

JENNIFER KING: So, Dr. Kendall and Dr. Gustafson, I know we have talked about how it works in BC, and, Dr. Kendall, you have experience in Ontario. I know it was some time ago. Can you comment on -- specifically compare the BC Public Health response to Ontario's and perhaps what about the successes in BC are translatable to Ontario?

DR. PERRY KENDALL: Thank you.

JENNIFER KING: You have talked about the size -- the difference in size, but what is translatable to our context.

DR. PERRY KENDALL: If I was to make recommendations, it would be to aggregate health care delivery in Ontario. I think it is the only province that hasn't really moved to a regionalized system, for whatever reason.

I think Public Health -- there are pros and cons to integrating Public Health with a regional health service delivery system. Certainly for British Columbia, I have seen benefits, and I have seen downsides of integrating the Public Health into part of a global budget.

If I was going to make a strong recommendation, it would be that the Public Health should be adequately resourced to manage issues, and nationally, for at least two decades, we recommended roughly 6 percent of the Health Authority budget should be engaged in the Public Health piece.

Many Public Health functions could be carried out in community health centres where you had populations who were enrolled and had health care teams, which could include Public Health for the health promotion components.

I think integrating the long-term care oversight into Public Health was really critical to

British Columbia's success. Having separate organizations who do the inspections and the infection control and take it out of the ambit of the health care delivery system and Public Health piece is not an ideal situation when you want to coordinate a swift, effective response.

So some of those organizational and regulatory principles I think would benefit Ontario if they could move to put them in place. I don't know if the Commissioners were aware, but the February Canadian Medical Association Journal published a review around COVID-19 in long-term care homes in Ontario and British Columbia, which is looking at the first few months of the response, and it is a very coherent review, and the recommendations basically reflect that those were some of the key differences that made a difference.

The political aspect of it in Ontario is BC has had a very consistent public face to the response, which in the past has been really important, and I think in this particular aspect has been really important in keeping the public informed on what was going on with transparency and a single voice, or if it is not a single voice, at least the voices are basically conveying the same

message, which I think has been more effective than the Ontario response. At times it was less than clear who was on first and what the message was.

And, Réka, would you have anything to add to that?

DR. RÉKA GUSTAFSON: I think -- and I may not be as familiar with the Ontario system, but the one thing I would add to that is I think we may have, based on our Public Health Act, struck a slightly better balance between distributed versus centralized authority and responsibility.

One of the things that I understand about the Ontario system is that there is one Medical Officer of Health for each jurisdiction, and then the Associate Medical Health Officers, as far as I know, do not have orders in council, whereas in British Columbia every Medical Health Officer has an Order in Council and that carries with it a depth of responsibility that builds also a depth of experience over time.

Similarly, our Environmental Health Officers also have independent powers under the Public Health Act, and that also -- and again, I don't know if that is different from Ontario.

But one of the -- as a result of which,

in the areas where that is well established, there is a workforce of Environmental Health Officers who have the experience of public health practice that we can call upon, and we can call upon at times that are really, really important, such as during an emergency.

So one of the things that that allows us to do is actually create a surge capacity with a depth of public health practitioner experience that I think is less likely to develop if your systems are set up more likely that there is one ultimate decision-maker and then everyone else follows a protocol.

So I think that is a really important one. We have also been moving over the last while in a number of our Public Health activities to be really focussing on risk-based rather than protocol-based practice, both in environmental health and in communicable disease control, and I think those are really, really important ways of, again, building sort of depth of practice that you can call upon when something new is emerging and you actually have to assess it in real time and you don't have a protocol to fall back on.

So I think those are important aspects

of how we set things up.

And as Dr. Kendall mentioned, there is advantages and disadvantages of Public Health being in Health Authorities, but overall, I would say, certainly in an emergency like this, it is an advantage. It is actually a very, very large advantage because you are integrated with a health care system. Medical Health Officers are regular communicators to primary care physicians. The Provincial Health Officers are regular communicators to primary care physicians. If a letter comes from Public Health about an outbreak, you know it is happening and you know it is relevant to you.

And the hospitals and primary care physicians follow that advice. They know that that is their directive and that that is also their best advice available to them.

And again, I think, especially in an emergency where we are fighting the cacophony of media voices about what you should do or what you shouldn't do and how many masks you should be wearing, the fact that you have a body of people who have communicated to you about Ebola and about H1N1 and about measles and, you know, the newest

meningitis vaccine, that is your source of information for Public Heath, then you know where that information is going to come from.

When we talk to our primary care providers, often they told us that it is that regular newsletter that comes from Public Health that tells you what is happening in your community is the thing they don't shred, and so I think those are really -- those would be for me the important parts of that relationship with the clinical practice community.

And we still have the responsibility to advise local government on policies, so that relationship exists, and it needs to be nurtured more actively than when you are within a municipal government. But I think being within a Regional Health Authority overall is a benefit.

DR. PERRY KENDALL: And if I could add something a little bit -- I agree with everything Dr. Gustafson says. I also think, looking specifically at long-term care facilities and the experience during COVID, what it has shown very, very clearly is that the importance we have put into continuing care for seniors and the long-term care housing and the way we have structured the

funding and the staffing of that has been, I would say, less than ideal. Older facilities, multi-room facilities, poorly paid staff, no benefits, lack of sick pay, the requirement that in order to make a living, we have to have people working casually between several institutions, including potentially hospitals, has certainly contributed to the very poor outcomes we saw and the high morbidity and mortality among people who are extraordinarily vulnerable.

So if I could make one recommendation to health care in Canada, it would be it is way past time to start investing in care -- in community care for people with chronic and multiple conditions and frailty, both to keep them independent in the home where we can and out of facilities, and then, when they are in a facility, be sure that facility is adequately built, adequately staffed and provides decent, humane care.

I honestly think, having been involved in long-term care and community care for many, many years, both in BC and in Ontario, I think we have gone backwards over the last three decades, to be honest.

COMMISSION CHAIR FRANK MARROCCO:

Do you agree with the idea that if people stay in their homes longer, then the people who go into long-term care residences are going to be older and sicker, and so therefore the staffing that you need needs to be more sophisticated, not less sophisticated?

DR. PERRY KENDALL: Absolutely. Yes, I do. And BC also has the assisted living. I mean, it is a Community Care and Assisted Living Act, so it is the licensed facilities, and then it is facilities that are registered have to meet certain standards but actually fall outside the long-term care provisions. They are less tightly regulated. So there is a gradation, and the idea that you can age in place I think is an important idea.

But I do agree -- and there are multiple studies over decades -- that seniors would rather live independently in the community, and if you can provide the services, whether it is assistance in daily living, shopping, bathing, dressing, et cetera, many seniors function very well in the community and do not need to go into the long-term care facility, and their morbidity can be reduced. Their dependence on emergency

rooms and hospitals can be reduced. And you have a smaller group who are more chronically ill and do require more sophisticated care, and we are not providing necessarily that level of care to those individuals under the current system.

DR. RÉKA GUSTAFSON: And in British Columbia, we are there in terms of the level of care people require once they go to long-term care facilities. The median life expectancy in long-term care facilities in BC is 18 months, so people do not go there.

So the people who are there already need that level of sophisticated care, and there is a great variation whether they are receiving it, and I would very much agree with that, that I suspect this is going to be the biggest thing that every jurisdiction, including British Columbia, will take away from this, is that the staffing levels need to be adequate and that the physical space needs to be adequate, the level of care that people need today.

So, Commissioner, I was sort of referring to the fact that I don't think that is a projection to the future, and we already have people needing very complex care in long-term care

facilities.

COMMISSIONER ANGELA COKE: I just have a question about, before the pandemic, would your long-term care homes have had a better capacity and skill in terms of their IPAC practices just because of the nature of the relationship you have in terms of how you work with them, but I am just curious as to how they were pre-pandemic and during the pandemic in terms of their IPAC knowledge and expertise and practices.

DR. RÉKA GUSTAFSON: So I can bring some of my experience to that.

The long-term care facilities that are owned and operated by the Health Authority have the benefit of infection prevention and control support from the Health Authority, from the hospital Health Authorities, so they are a different -- they are in a different category. So they have the -- again, they have the benefit of that. But frequently, again, resources are limited and focus tends to be on acute care, but I would say that, in my experience, owned and operated long-term care facilities receive very good infection and prevention support from their acute care colleagues, especially during outbreaks.

In the contracted facilities, it really varies depending on the investment that is made in that practice. So Public Health by and large has the ability to provide guidance, to provide guidance documents, education every year about influenza vaccination. Our licensing officers provide a lot of shoulder-to-shoulder training and education, but it is not a requirement, per se, and I would say that I have seen great variation in long-term care facilities on how much they invest or are able to invest depending on their funding on actual infection and prevention control knowledge.

And in keeping in mind that, you know, the level of education of the staff will also vary in that area.

So certainly I wouldn't say that is consistently where we would want it to be.

COMMISSION CHAIR FRANK MARROCCO:

The staffing issues, from what we have been able to determine, have been long-standing, and I am just curious if you have a view -- perhaps this is more directed to Dr. Kendall, but not really, if you have a view on why the staffing issues would be outstanding for so long and not be -- what the barrier is or has been to addressing

the issue.

And I was just wondering if you have a view on why that is?

DR. PERRY KENDALL: Yes, I do. I think the centrality of -- I mean, a couple of things.

Health care funding is expensive. It is the largest proportion of provincial and territorial budgets eating -- you know, using about 50 percent of the budget.

The sort of rate of inflation and increased funding has been high year over year over year.

The focus on the media and on the politicians is always on the acute care side and access to care and beds, and the answer is always to add more to the acute care and more diagnostics.

As the population ages, there is also more acuity of care and more care is provided, and so the central focus is always on the acute and the urgent. And over the last couple of decades, as politicians have sought to rein in expenditures and control the budgets, exert control over the budgets of the health care system, the priority has nearly always been the number of operations you can do, the number of cardiac surgeries you can do, the

number of MRIs that you have, et cetera, et cetera, et cetera.

And as Health Authorities run over-budget, all of the areas that haven't run over-budget tend to be tithed to make up the deficit because one of the key areas in the mandate letter to the CEO of a Health Authority is manage within your budget.

And there has not been a very large outcry or demand for the community care services or the long-term care services. This minority of patients don't have much of a voice. They don't have a lot of political clout. And so they have become neglected, and that has become an area which has become un-unionized and has become a pink and often English-second-language ghetto for lower paid casual workers. It goes against the evidence of where and how you should invest in care for aging populations.

One example of what I think is cognitive dissonance is that our primary care system operated on fee for service, was designed for a younger population with acute illnesses or accidents who were treated and got better. What we are seeing is a growing population of people with

multiple morbidities, who have chronic conditions which are, quite frankly, really ill-served by a fee-for-service system which functions on volume.

And so the decades' worth of recommendations for building primary care systems which reach out into the community using health care expanders or physician expanders and nurse educators, nurse practitioners, et cetera, has actually been largely ignored in favour of a focus on institutionalization in the acute care system and the primary fee for service, which does no justice to what are the health needs of an aging population.

Yes, we need acute care and fee for service for the younger individuals and for some services, something that is performance-driven, you know, independent performance-driven, like having access to good prenatal care, for example, and certain obstetrical services, but for people of my generation who have a number of chronic, ongoing conditions, the primary care service or fee for service is just not the best model to do it, and it leaves people needing care who don't have it, and it provides sub-optimal chronic care, and it underfunds the community support services, and it

underfunds the long-term care and residential needs of individuals.

Sorry, that was a bit of an exposition, my hobby horse when it comes to --

COMMISSION CHAIR FRANK MARROCCO:

Well, I was hoping to get an exposition, so that is why I'm asking the questions. So thank you for the answer.

Ms. King, are we -- well, actually, let me change topics, if you don't mind, for one second.

One of the debates here is whether for-profit homes should exist or not and because the performance of the for-profit homes seems to have been -- in terms of preserving the lives of the people under their care, seems to have been not as good as the not-for-profit. There has been a view expressed quite a few times that we should get rid of for-profit homes.

And I was wondering -- I noticed you said there is for-profit homes in British Columbia. Do you have a view on the role of for-profit and not-for-profit?

DR. PERRY KENDALL: Yes. Isobel Mackenzie, who is the Seniors Advocate in British

Columbia, has done a lot of work looking at the levels of service provided for the amounts of money that are provided by government to the for-profits. She has found that on average for-profit homes provide less care for the dollar that is given to them than do not-for-profits who often provide more care than is actually paid for by the state.

So I think if you are going to have for-profits -- and I think that politically it is probably infeasible not to have them just because of the politics of the issue and the strength of the lobby groups, that they should be really carefully and closely regulated so that they are not diverting funds that are meant for care into profit and that there are levels of investment that are actually required, so that what we see in for-profit homes, that there are more of them have multi-room -- multi-bedroom facilities as opposed to the single-room facilities. And I think that Isobel Mackenzie, her work shows, at least in BC, on average you get better care and better outcomes in the not-for-profit homes than you do in those that are profit-driven because you have to take a percentage of the margin out for your shareholders.

COMMISSION CHAIR FRANK MARROCCO:

Well, I don't know if you remember from your time in Toronto or if it was the same, but what we were told sometime ago was that the municipality contributes over and above the provincial contribution to maintain its long-term care homes, and at the same time, we read about for-profits declaring substantial dividends even in a pandemic.

So it is hard to know how, on the one hand, you have to contribute money to make it work, and on the other hand, you are able to pay dividends. I don't know if it was the same when you were here or not.

DR. PERRY KENDALL: Well, one of the differences between Public Health in BC and Ontario is that, as Medical Health Officer for Toronto, I had absolutely no relationship with the continuing care community until I spent a year on secondment to the Deputy Minister when the government - the then government, and Ruth Grier was the Minister - was trying to reform the continuing care component, which in British Columbia a couple of decades before had been brought into the Public Health, and rather than having independent agencies like the Victoria Order of Nurses competing for contracts to

provide community care, the nurses became employees of the Regional Health Authority or the Public Health Services, basically Ministry employees, now Regional Health Authority employees.

So I was completely distanced as a Public Health official from the long-term care and continuing care services, let alone the long-term care residences. We had no contact with them at all.

DR. RÉKA GUSTAFSON: And if I may just add to that, whereas sort of from my experience as a Medical Health Officer, it is a substantial part of our body of work, and I have seen Medical Health Officers not only sort of carry out their duties under the Licensing Act and managing outbreaks and surveillance, but also advocating for long-term care facilities, so advocating for better resources or better physical space, so things like that.

I do think that -- just in terms of the profit versus non-profit question, I think it is also -- that may be one variable that is very easy to measure. I think it would be really important to look at staff-to-resident ratio, whether or not there is an infection prevention and control individual actually assigned, as I say, per bed,

how many infection control nurses you would need per bed, what are the actual resources that you can put in place, but also then indicators that you measure, just as you measure hips and knees, as a performance measure for long-term care facilities.

And the profit/non-profit difference may not be the variable most important. I don't know that. But I think there are other indicators that need to be measured as to assess quality of care.

COMMISSION CHAIR FRANK MARROCCO:

Thank you.

JENNIFER KING: So I only really have one follow-up question for Dr. Kendall and, unless the Commissioners have any other questions, I think that will be all my questions.

Dr. Kendall, you talked a little bit, and Dr. Gustafson, you talked about the qualities of a leader, of a Provincial Health Officer that are required.

Is there anything, Dr. Kendall, that you can talk about, what is accountability or independence, and how in BC the Public Health Act ensures both the independence and accountability of your Provincial Health Officer and perhaps compare

that to Ontario's Chief Medical Officer of Health?

DR. PERRY KENDALL: I mean, I think it has been really very, very, very, very helpful to have the mandate for independence and speaking independently and having had predecessors who used that and exercised that mandate to the full, so at least -- I mean, I did not come into a job where I was the first person to be independent and say things that were unpopular or put forward policies that were not exactly current with what government thinking was.

So that was important, and I think I see more of that in BC than I do in other provinces. I won't, you know, necessarily single out Ontario, but other provinces where the Medical Health Officers do not have that reporting relationship to the Minister or that public access to the press or have developed that ability and that history of speaking out or working with government even when they are not necessarily, you know, in accord with the policies.

So I think it is important to do that, but there are other provinces where Medical Health Officers report to Assistant Deputy Ministers and are buried somewhere deep in the bowels of the

bureaucracy, and we have seen Medical Health Officers being dismissed for putting reports out on oil sands development in smaller jurisdictions which the government didn't like, and they lost their job.

One of the issues with being a Public Health physician, I think, is that you ought to be prepared to resign if your advice is not being taken, or you ought to have written into your contract that if you are dismissed, you have at least a cushion to enable you to be able to speak independently without fear of finding yourself on the street without an income. And we have seen that happen in recent -- in the last five years to Medical Health Officers in various jurisdictions across the country.

And we had one Medical Health Officer whose Deputy Minister -- no, whose Minister of Health mused quite publicly about whether or not it would be worth the trouble of firing the Chief Public Health Officer because of his comments around the alcohol programs and controls and policies that were being put in by the present government as opposed to what the Provincial Health Officer was saying would be a sensible regime.

JENNIFER KING: Are there protections in the Public Health Act in BC to protect the Public Health -- or the Provincial Health Officers' employment if they do speak out to the public?

DR. PERRY KENDALL: Not in the Act itself. The Order in Council and the fact that it is clear that that is your authority to do that and then the individual's contract with the government and labour law would be a protection against that.

In Ontario, the protection against dismissal from the Medical Health Officer by the local Board of Health does exist because you have to have the approval of the Provincial Health Officer or the Chief Medical Health Officer, as you do in British Columbia. So Medical Officers can be dismissed for cause, but it has to be in consultation with the Provincial Health Officer who could say that there was no cause for doing this or there was cause and then it goes to labour law.

JENNIFER KING: Thank you. Unless the Commissioners have any additional questions, those are all of the questions that I wanted to take you through today.

Is there anything else?

COMMISSION CHAIR FRANK MARROCCO:

Nothing. Commissioner Coke, do you have any questions?

COMMISSIONER ANGELA COKE: No, that is fine. Thank you.

COMMISSION CHAIR FRANK MARROCCO:

No, I think we asked them as we went along, and so if that concludes, then let me say thank you for a very informative presentation and really an opportunity to get a candid response to a number of issues that have been bobbing up and down before our Commission.

And so thank you both very much.

DR. RÉKA GUSTAFSON: Thank you.

COMMISSION CHAIR FRANK MARROCCO:

And thank you, Dr. Gustafson. I know that -- I read the newspapers, and I understand BC has some issues to deal with, just like us, so --

DR. RÉKA GUSTAFSON: Oh, yes.

COMMISSION CHAIR FRANK MARROCCO:

So thank you for taking the time.

DR. RÉKA GUSTAFSON: My pleasure.

COMMISSION CHAIR FRANK MARROCCO:

And, Dr. Kendall, thank you for the benefit of your experience and meeting with us.

DR. PERRY: Thank you.

COMMISSION CHAIR FRANK MARROCCO: It is much appreciated.

COMMISSIONER ANGELA COKE: Thank you very much.

JENNIFER KING: Thank you very much.

-- Adjourned at 12:45 p.m.

REPORTER'S CERTIFICATE

I, DEANA SANTEDICOLA, RPR, CRR, CSR, Certified Shorthand Reporter, certify:

That the foregoing proceedings were taken before me at the time and place therein set forth;

That all remarks made at the time were recorded stenographically by me and were thereafter transcribed;

That the foregoing is a true and correct transcript of my shorthand notes so taken.

Dated this 17th day of February, 2021.

NEESONS, A VERITEXT COMPANY

PER: DEANA SANTEDICOLA, RPR, CRR, CSR

C L A R I F I C A T I O N S

Page 21, line 1: "Public health lab" not "Public Health Act"

Page 21, line 3: "Provincial Health Services Authority" not "Provincial Health Services Agency"

Page 25, line 8: "is the licenser" not "as the licenser"

Page 37, line 18: "PICNet" not "PICN"

Page 43, lines 12-13: "BC CDC was incorporated" not "BC CDC and was incorporated"

Page 45, line 18: Strike "and the Chief Public Health Officer"

Page 56, line 22: "called a teleconference" not "formed a solace"

WORD INDEX