

**Bill C-12: An Act to prevent the introduction
and spread of communicable disease**

CMA's Submission to the House of Commons
Standing Committee on Health

November 23, 2004

Albert J. Schumacher, MD
President



A healthy population...a vibrant medical profession
Une population en santé...une profession médicale dynamique

The Canadian Medical Association (CMA) is the national voice of Canadian physicians. Founded in 1867, CMA's mission is to serve and unite the physicians of Canada and be the national advocate, in partnership with the people of Canada, for the highest standards of health and health care.

On behalf of its more than 58,000 members and the Canadian public, CMA performs a wide variety of functions, such as advocating health promotion and disease/injury prevention policies and strategies, advocating for access to quality health care, facilitating change within the medical profession, and providing leadership and guidance to physicians to help them influence, manage and adapt to changes in health care delivery.

The CMA is a voluntary professional organization representing the majority of Canada's physicians and comprising 12 provincial and territorial divisions and 43 affiliated medical organizations.

ASSOCIATION
MÉDICALE
CANADIENNE



CANADIAN
MEDICAL
ASSOCIATION

ASSOCIATION
MÉDICALE
CANADIENNE



CANADIAN
MEDICAL
ASSOCIATION

The Canadian Medical Association (CMA) appreciates the opportunity to appear before the House of Commons Standing Committee on Health to provide our observations concerning Bill C-12, *an Act to prevent the introduction and spread of communicable disease*, which will repeal and replace the current *Quarantine Act*.

Since our founding in 1867, the CMA has had a long tradition in the field of public health and infectious diseases. For example, in 1885 we worked with the federal government to prevent an outbreak of cholera in Canada, while in 1891 we began a long campaign to encourage governments to deal with tuberculosis. And fast forward to 2003 and SARS, CMA worked along with many levels of government to deal with this public health crisis.

While the CMA is particularly interested in how the proposed legislation will impact the practices of our more than 58,000 members across the country, we have reviewed this legislation through the lens of what is in the best interest of patients and the public.

1) Comprehensive Approach to Public Health

Our comments call for and are embedded in the broader context of a comprehensive approach to public health. They are also based on previous recommendations CMA has made to the federal government including:

- a) Response to the Health Protection Legislative Renewal initiative carried out by Health Canada (2004). In this submission, CMA identified the *Quarantine Act* as a piece of legislation the CMA believed merited urgent updating;
- b) Review of the World Health Organizations' draft revised International Health Regulations (IHR), (2004);
- c) Submission to the Naylor Advisory Committee on SARS and Public Health (2003);
- d) Submission to the Senate Standing Committee on Social Affairs, Science and Technology during its study of public health issues (2003); and
- e) Pre-budget submission to the House of Commons Standing Committee on Finance following September 11, 2001.

These submissions are all available on request, or at www.cma.ca.

The CMA is pleased that Parliament has identified revision of the *Quarantine Act* as a priority. The *Act* is more than a century old and the medical community and others have long called for it to be updated. Bill C-12 is an excellent start to modernizing the previous *Act*; however, we believe the proposed legislation does not go far enough in remedying its deficiencies.

In this submission we present eight key recommendations for your consideration, along with questions about particulars in the implementation process, which we suggest Parliament address in subsequent review of the *Act* and its regulations.

2) Recommendations for Consideration in Review of Bill C-12

Recommendation 1: The Act should be part of a larger, comprehensive Emergency Health Measures Plan.

In our brief to the Naylor Advisory Committee, CMA recommended the enactment of a comprehensive *Emergency Health Measures Act*, administered by the Chief Public Health Officer of Canada. This Act would consolidate and enhance existing legislation, allowing for a more rapid national response to health emergencies, in cooperation with the provinces and territories, based on a graduated, systematic approach. We also recommended that the *Emergency Health Measures Act* be part of a strong commitment, by all levels of government, to a public health strategy that also included a 5-year capacity enhancement program, development of research and surveillance capability; and funding for a communications initiative to improve technical capacity for real-time communication with front-line health providers during public health emergencies.

Recommendation 2: The Chief Public Health Officer of Canada must have authority to enforce the Act

The proposed legislation designates the Minister of Health as the person with ultimate responsibility for enforcing the *Act*; it grants the Minister sweeping powers including the power to overrule a health official's quarantine. As medical professionals we believe that public health decisions should be made primarily on the basis of the best available medical and scientific evidence, and should be independent to the greatest extent possible of other considerations.

Therefore we believe that responsibility for the implementation of the *Act* should rest with the Public Health Agency of Canada, and with the Chief Public Health Officer of Canada, not with the Minister of Health. In the provinces and territories, Medical Officers of Health do not require approvals from their Ministers to exercise their functions as health professionals; the same should hold true at the federal level.

We understand that responsibility has been placed with the Minister of Health due to a lack of existing legislation setting out the mandate, roles, responsibilities and powers of the recently created Public Health Agency of Canada, and the newly appointed Chief Public Health Officer of Canada. We are also aware that enabling legislation is currently being prepared; we urge that this legislation be enacted as soon as possible. On enactment of this enabling legislation, the powers now vested in the Minister should be ceded to the Chief Public Health Officer.

Locating responsibility for administration of the *Act* within the Public Health Agency of Canada will also combine enforcement with other needed functions of surveillance, monitoring and linkage with international monitoring agencies. As we stressed in our previous recommendation, these must all be part of a comprehensive Canadian emergency response strategy.

Recommendation 3: The Act must address interprovincial as well as international traffic.

We are happy that the provisions of Bill C-12 apply to goods and travellers leaving as well as entering Canada. This was a deficiency identified in the previous *Quarantine Act*. However, the *Act* must also expressly address goods and travellers crossing provincial or territorial boundaries.

Currently, there is tremendous variation in public health system capacity among provinces and territories and, more particularly, among municipalities and local authorities. Inconsistencies in provincial approaches to public health matters have resulted in significant weaknesses in the “emergency shield” between and across provinces. Unless the potential consequences of these disparities are remedied through federal legislation they must, as a priority, be remedied through federal/provincial/territorial agreements.

The role of the Public Health Agency of Canada in facilitating, equalizing and monitoring the management of public health emergencies nationwide must be enshrined in the legislation that establishes the Agency. CMA also hopes that the development of a pan-Canadian Public Health Network, acknowledged in the 2004 Throne Speech, will facilitate the nationwide collaboration essential for adequate and appropriate response to health emergencies.

The CMA supports those provisions in Bill C-12 that give the Minister (preferably the Chief Public Health Officer of Canada) the power to establish quarantine centres anywhere in the country. In times of threat to national health security, such bold leadership would be both warranted and expected.

Recommendation 4: “Public Health Emergency” must be adequately defined.

Bill C-12 contains no definition of “public health emergency” or “public health emergency of international concern.” We believe these should be defined.¹

Bill C-12 includes a schedule of specific communicable diseases to which its provisions would apply. We are concerned that this Schedule may limit Canada’s capacity to respond to emergencies. The next public health emergency may be a disease we have not heard of yet; or it may be a bio-terrorist attack, or a chemical or nuclear event. The *Act* must enable Canada to respond to new and emerging, as well as existing, threats to health.

¹ A public health emergency has been defined by the US Model State Emergency Powers Act (<http://www.publichealthlaw.net> accessed July 7, 2003) as an occurrence or imminent threat of an illness or health condition of a temporary nature that is believed to be caused by:

- the appearance of a novel or previously controlled or eradicated infectious agent or biological toxin;
- a bioterrorist event;
- a natural disaster
- a chemical event or accidental release; or
- a nuclear event or accident

and that poses a high probability of any of the following harms:

- a large number of deaths in the affected population;
- a large number of serious or long-term disabilities in the affected population; or
- widespread exposure to an infectious or toxic agent that poses a significant risk of substantial future harm to a large number of people in the affected population.

The World Health Organizations' draft International Health Regulations (IHR) has proposed a set of criteria for assessing emergencies; these include:

- Is the event serious?
- Is the event unexpected?
- Is there a significant risk of international spread?

The CMA urges the Canadian government to consider a hybrid approach incorporating both known disease states and criteria such as the ones used by the IHR, for assessing new diseases or other public health emergencies.

Recommendation 5: The Act, or its regulations, must clarify the roles, responsibilities and training requirements of emergency response personnel.

Some provisions of Bill C-12 have raised questions in our minds about the scope of practice of personnel involved in disease screening, and we would appreciate clarification on these points. For example:

Screening officers, the first point of contact for travelers entering or leaving Canada, are customs officers and others designated by the Minister. Their primary role under Section 14 of the *Act* is to use “non-invasive” screening technology to detect travelers entering and exiting Canada with communicable disease vectors, etc. According to Section 15 (3) screening officers, who are not health professionals, will have the power to “order any reasonable measure to prevent spread of a communicable disease”. Of what might these “reasonable measures” consist?

Quarantine officers, by definition in Section 5(2) are medical practitioners or other health professionals or anyone else in this “class of persons”. Since the quarantine officer’s job description includes physical assessment of travellers to determine whether they should be detained – a function that requires the expertise of a health professional - we would appreciate clarification of the phrase “in this class”. Similarly, under Section 26, the quarantine officer has the power to order the traveler “to comply with treatment”. Which officer—screening/quarantine or medical—might actually prescribe the course of treatment? This function must be specifically delegated to medical officers.

Bill C-12 gives authorities the powers to restrict personal movement and temporarily impound or seize property. The CMA believes that the government should also provide adequate resources and powers to allow for tracking down apparently well people who cross borders and are subsequently diagnosed with infectious diseases.

The *Act* or its regulations should also address factors that hinder deployment of qualified health professionals, such as portability of licensure and coverage for malpractice and disability insurance. CMA has previously called for the establishment of a Canadian Public Health Emergency Response Service that would maintain a “reserve” of public health professionals who could be deployed to areas of need during times of crisis, and which would co-ordinate the logistics of the issues above mentioned. This would improve the capacity of health professionals to be deployed quickly in times of health emergency, to locations where they are most needed.

Finally, CMA suggests that the Act or its regulations provide greater detail on training requirements for screening officers, to guarantee that they are appropriately trained.

Recommendation 6: Privacy and confidentiality must be respected and safeguarded.

Bill C-12 grants quarantine officers and the Minister some sweeping powers to arrest and detain people without warrants, including people who have refused to comply with testing. Though on rare occasions such measures may be required to protect the public, it is recognized that potential for their abuse may exist.

In addition, Bill C-12 raises questions about the degree to which personal health information might be exposed to scrutiny. We note that Section 51 authorizes a quarantine officer to “order any person to provide any information or record...the officer might reasonably require.” This provision could include patient medical records in a doctor’s office, particularly if the Bill guarantees travellers the right to request a “second opinion” which we assume could be obtained from any practicing physician in Canada. Similarly, Sections 55 and 56 appear to give the Minister authority to “collect medical information in order to carry out the purposes of this Act” and to “disclose personal information obtained under the Act” to a host of entities.

The CMA believes that the power to obtain and disclose information should be explicitly constrained and circumstances under which this power could be exercised must be outlined in the Act.

Recommendation 7: The role of physicians and other health care workers must be respected.

The health professional sector is on the front lines of response to health emergencies, as they were during the SARS outbreak. Therefore as a first principle the new *Act* should recognize the importance of health professionals having the power, subject to appropriate constraints, to make vital decisions in response to health emergencies. This is a legitimate delegation of power, because of the competencies of health professionals.

During the SARS outbreak of 2003, physicians and other health care providers were not only partners in containing infection; many became ill or died as well. Since health care workers expose themselves to infection as they respond to health emergencies, protocols should ensure that care and attention is paid to their safety, through measures such as ensuring ready availability of proper masks

The *Act* or regulations should address precautions required to protect quarantine officers and other health care workers from transmission of disease or the effects of becoming ill. For example, it should address compensation for quarantine officers who lose work because they become infected in the course of their duty.

We would be remiss in our review of this act if we did not pursue with this Committee the issue of compensation and indemnification programs for physicians and trainees requiring quarantine because of exposure to a communicable disease while providing medical service, or who are required to close their offices for other public health reasons, or who cannot practice in hospitals because of closure of hospitals for public health reasons.

Indeed, delegates to our annual general council meeting called on the CMA to do so. A number of these physicians were caught in such situations during the turmoil of the SARS outbreak.

Recommendation 8: Decision-making should be evidence-based.

At times, public perception and political considerations may widely influence the assessment and management of risk. While this is probably unavoidable, CMA believes that public policy should be founded first and foremost on the highest possible quality of scientific evidence. The *Act* should provide the requisite mechanisms to ensure that reviews of risk are independent and unbiased. We acknowledge, however, that this principle should not be rigidly applied; “we’re waiting for the evidence” must not be used as an excuse for inaction when action is urgently required.

3) Additional Comments

In addition to the above recommendations, additional concerns remain regarding implementation of the *Act*. In particular we note that many crucial components, such as how physical examinations are to be carried out (section 62(1), medical practitioner’s review process (section 62(d), and the protection of personal information (62(g) are left to regulations. These regulations must be developed as soon as possible.

We understand that the current *Act* constitutes “Phase I” of a longer-term strategy to enhance Canada’s capacity to respond to public health emergencies. Though we believe that the *Quarantine Act* merits attention at this time, we also believe that it should be looked at with a longer-term view. For instance, as we have already recommended, it should be incorporated into the broader legislative renewal of public health in Canada, with a view to enhancing this country’s ability to respond swiftly and effectively to public health emergencies, locally and nationwide.

Above all, Canada must ensure a sustained and substantial commitment of resources to its public health emergency response program. Without this, the best-written laws will be inadequate.

The Canadian Medical Association commends the Government of Canada for bringing this bill forward, and looks forward to working with the Government, and the Public Health Agency of Canada, to help keep Canadians safe in the event of a public health emergency.