May 31, 2022

Open letter regarding New Brunswick's Bill 104 (*An Act to Amend the Public Health Act*)

We, the Board of the Public Health Association of New Brunswick and PEI, are writing to express our questions and concerns related to the recently tabled Bill 104 (*An Act to Amend the Public Health Act*) which had its first reading on May 10, 2022.

This Bill proposes to increase the powers of those designated in the *Public Health Act* to direct individuals and groups during an emergency of public health concern, in order to avoid the prolonged use of the powers under the *Emergency Measures Act* for a sustained public health emergency. This increased power under the *Public Health Act* is welcomed and necessary; however, we wish to express our concerns regarding *who* is provided those powers, and what this means for Medical Officer of Health (MOH) scope of practice, including the Chief Medical Officer of Health (CMOH).

Bill 104 extends previous powers of the medical officer of health to issue an order respecting notifiable disease from individuals to directing actions of premises and at activities/events but restricts this latter level of intervention to the CMOH. When further measures are required for a class of persons (the Bill refers to actions such as closure of public places, prohibiting gatherings, and restricting travel on a provincial scale) the issuance of orders is restricted exclusively to the Minister of Health.

The Minister had indicated publicly that when such sweeping measures are required, elected officials are more appropriate and constitutionally accountable to the public for restrictions which may violate Charter rights. We challenge this view. This type of action is clearly within the scope of practice of public health and preventive medicine specialty trained physicians. It is one of several tools in the MOH medical bag akin to a clinical order or prescription. It requires specialized training and expertise.

According to A Set of Minimum Competencies for Medical Officers of Health in Canada (phpc-mspc.ca)

Public Health and Preventive Medicine physicians are defined as physicians "whose training, practice and world view are based in large part on a *population focus rather than individual practice*, that is, on assuring the availability of essential public health services to a population." (emphasis added)

They then go on to point out that

- Public health physicians must often make decisions, despite unsettling and irresolvable uncertainties when there is a demand for action in the presence of insufficient or conflicting data when there can be life or death implications.
- Physicians are often a trusted and effective voice to address health problems occurring in the community. The public finds them to be credible experts with the most comprehensive backgrounds in health and disease prevention.
- A physician's leadership role is vital in times of emergency when there is an urgent need to explain risks, contend with fear, and galvanize groups to contend with the emergency.

"It is this combination of a deep understanding of human health and illness, with advanced problem analysis and solving abilities, blended with public health knowledge and skills, that enables public health physicians to integrate multiple sources of information and *make and be accountable for the necessary decisions to promote and protect the public*." (emphasis added)

In addition, MOHs are comprehensively trained in public health ethical principles such as least restrictive means, proportionality, reciprocity, and equity*. One of the core frameworks embedded in public health and preventative medicine training and practice is active consideration of the determinants of health, which are defined as the broad range of personal, social, economic and environmental factors that determine individual and population health**. Therefore, any decision made related to protecting the health of the public by a public health physician takes these broader multidimensional factors into account.

Also of concern is that, although the Minister has publicly stated that the CMOH would be involved in decisions related to the issuing of an order by the Minister, there is nothing in the wording of Bill 104 that formalizes this, it simply states that "the Minister may make an order if the Minister has reasonable grounds" and the order "may provide for any action that the Minister considers necessary to prevent, decrease or eliminate the risk to health". It is thus unclear how much weight would be given to the expert analysis and recommendations of the CMOH to control a notifiable disease versus others.

We would also like to point out that greater CMOH independence was recommended by the Expert Panel on SARS and Infectious Disease Control, headed by Dr. David Walker, and Justice Archie Campbell's interim report on the SARS crisis in 2003. At that time Health and Long-Term Care Minister George Smitherman stated "We will have an independent Chief Medical Officer of Health who can act quickly and speak freely on any public health issue without any political interference. The CMOH will be able to put the health and safety of Ontarians first and can speak to the people directly on any important public health issue." Ontario Newsroom

Thank you for considering this important issue.

Appendix:

Please see the notes below on specific sections:

33.1 (1) states the CMOH can require the owner of an activity or event to take action in respect to notifiable disease in a health region (considered the geographic area that MOHs as a group have authority in per section 59). Why would this not be a power of all MOHs rather than just the CMOH? Section 33 and section 33.1 would need to align if they are both instituted. Under section 59, the CMOH would be considered a MOH where MOHs are granted the authority to act in any health region of the province.

33.2 (1) states that the Minister may make an order regarding a Group 1 notifiable disease in the province. Making orders under the current Public Heath Act is a MOH responsibility and akin to a medical act. If provincial in nature why would this role not then be the purview of the CMOH? There is no wording that explicitly states that the CMOH or any MOH needs to be consulted, recommend this action or otherwise be involved. Why would this not be an action taken by the CMOH, with the Minister being advised of any such action rather than the Minister being the one taking it?

33.2 (4) Actions like closing public places and restricting gatherings are disease control measures under MOH authority and well within their scope of practice, which according to section 59 are people who are "duly qualified medical practitioners". However, Bill 104, 33.2(4) allows the Minister the same authority.

35.1 (why would this not be under section 36, 35 is Effect of order and 36 is Order to detain) under which the Minister can decide to detain an individual with a Group 1 notifiable disease - the concept of location of detention not being a hospital facility (36 (2)) is necessary given not all detainments will require hospital level treatment, but why is this the role of the Minister? Previously everything in sections 36 and 41/42 refers to the powers of the MOH and these measures would typically be individual in scope.

61.2 General authority of MOHs – when does this section get used, it was added with the 2018 amendments to increase ability for MOHs to protect the public from notifiable diseases – "a MOH may take any reasonable action that is necessary to protect the health and well being of the population of NB" – if the proposed specificity is added through other sections it will need to be clear when this section is used. Of note, in this section the MOH is obligated to advise the Minister of any action taken under this subsection.

***Examples of Public Health ethical principles**

Least restrictive means - Intrusion into people's lives should be the minimum possible, while the policy aim can still be achieved

Proportionality- Any public health intervention should be proportionate to the threat faced, and that measures taken should not exceed those necessary to address the actual risk. This includes demonstrating that the intervention should be effective in achieving the desired aim. In making judgements of proportionality, stronger actions require stronger evidence, and in the absence of evidence, interventions should include an evidence-gathering mechanism.

Reciprocity - Every means possible should be sought to aid the individual in complying with the requests and impositions. In addition, complying with the public health program may impose sacrifices and burdens and in whatever way possible these should be compensated by the program or the agency.

Equity - All people (individuals, groups and communities) have a fair chance to reach their full health potential and are not disadvantaged by social, economic and environmental conditions

**** The determinants of health** include (Social determinants of health and health inequalities - Canada.ca):

1. Income and social status
2. Employment and working conditions
3. Education and literacy
4. Childhood experiences
5. Physical environments
6. Social supports and coping skills
7. Healthy behaviours
8. Access to health services
9. Biology and genetic endowment
10. Genetics
11. CultureRace / Racism

Board of Directors PHA NBPEI

(Note 2 members abstained due to conflict of interest and temporary leave of absence)

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