



News Release

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Auditor General Special Report: Ontario's COVID-19 Response Faced Systemic Issues and Delays

(TORONTO) Ontario's Auditor General Bonnie Lysyk says the province's response to COVID-19 in the winter and spring of 2020 was slower and more reactive relative to other provinces.

The audit looked at three areas: emergency management and pandemic response; outbreak planning and decision-making; and laboratory testing, case management and contact tracing.

It found a number of contributing factors leading to this slower pandemic response, including outdated provincial emergency plans, insufficient staff and significant changeover in leadership at Ontario's Provincial Emergency Management Office (EMO), as well as systemic issues such as the lack of lab surge capacity and outdated IT systems. A new governance structure to respond to the pandemic was not presented until a month after the state of emergency was called.

The Auditor General says much of this was avoidable as Ontario failed to act on key lessons identified after the 2003 SARS outbreak that had not been implemented.

"For example, the SARS Commission's final report identified taking preventative measures to protect the public's health even in the absence of complete information and scientific certainty as the most important lesson of SARS," stated Lysyk. "Following this principle means taking informed decisive action early. This is not what the audit found; instead, we found systemic issues and delays in decision-making."

Even after the state of emergency was declared, the audit observed a command structure that was overly cumbersome, having expanded from 21 people to 500 members at the time of this report being drafted. As well, the command structure was not led by public health expertise, and Public Health Ontario played a diminished role in the province's pandemic response.

In addition, the Chief Medical Officer of Health and other public health officials did not lead Ontario's response to COVID-19. Auditors concluded the Chief Medical Officer of Health did not fully exercise his powers under the *Health Protection and Promotion Act* to respond to COVID-19. For instance, it was the province, not the Chief Medical Officer, that finally issued an emergency order in early October 2020 to require masking for the general public.

The audit also concluded Ontario's COVID response was often disorganized and inconsistent because of variations in management and operations among public health units. Public health reform recommended about 15 years ago by the SARS Commission had not been fully acted on. In May 2020, Ontario's 34 local public health units jointly issued a document stating that there needed to be more direction and regional consistency. As of the writing of this report, these 34 public health units were still operating independently, and best practices were still often not being shared.

The report also points out that the Ministry of the Solicitor General did not implement Auditor General recommendations to the previous government from three years ago to regularly update and finalize its emergency response plans. As well, the Ministry of Health had not acted on recommendations in the 2003, 2007, 2014 and 2017 audits to address weaknesses in public health lab and information systems. Had these recommendations been addressed, Ontario would have been much better positioned to respond to COVID-19.

Auditors were also concerned that laboratory testing, case management and contact tracing for COVID-19 were still not all being performed in Ontario in a timely enough manner to contain the spread of the virus. These are the three critical things needed to control a virus according to international best practices, and success is dependent on having effective integrated information systems that can quickly capture and communicate information. This, along with clear case management and contact tracing guidance, were lacking in Ontario.

“For example, between January and August, all but one public health unit could not meet the target of reporting lab test results within a day of specimens being collected 60% of the time. We also found public health units in Toronto, Ottawa, Peel Region and York Region were failing to contact people in a timely manner after testing revealed they were COVID positive between March and August 2020,” stated Lysyk. “This may have led to further exposure and spreading of the virus.”

The need for properly resourced public health labs in Ontario and better information systems had been pointed out years ago by experts and others, including our Office, with little to no action taken until the onset of the COVID-19 pandemic. If these long-standing concerns had been addressed earlier, the Ministry would have better information to enable it to adjust testing eligibility criteria to the highest-risk Ontarians and probable cases, and Ontario could have responded to COVID-19 more quickly, more effectively and more efficiently.

“Our discussions during our audit indicate that decision-makers are willing to learn from the past and recognize that improvements continue to be required, and we hope that our reports will prove useful in this regard,” says Lysyk.

The Office of the Auditor General is now working on a second Special Report on Ontario’s response to COVID-19. It will look at: management of health-related COVID-19 expenditures; personal protective equipment; and long-term-care issues.

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Read the report at www.auditor.on.ca

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Detailed Findings:

- Ontario’s command structure evolved to become overly cumbersome, and it was not dominated by public health expertise. The Chief Medical Officer of Health and other public health officials did not lead Ontario’s response to COVID-19. Ontario’s COVID-19 response structure included a Health Command Table that took on an increasingly complex structure during the pandemic and had grown from 21 members to 83 participants by August. For months, all communications were by teleconference, which created confusion. It was not until July 14 that meetings began to be held by videoconference, meetings were not held in person, and there is no fulsome documentation of the discussions that took place. In total, more than 500 people are now involved in the Health Command Table.
- Given the significant changeover in leadership in Ontario’s Provincial Emergency Management Office (EMO), outdated emergency plans and the lack of sufficient staff, the province was not in a good position to implement the provincial response structure in its provincial emergency response plan when the province declared an emergency on March 17, 2020. It responded by hiring an external consultant to create a new governance structure, based on the belief that there was a need to create a whole-of-government approach. This approach took time, with a Central Co-ordination Table being established that held its first meeting almost a month into the emergency, on April 11, 2020. In contrast to Ontario, other provinces activated their existing response structures and emergency plans. As well, we found that when we completed our work, the EMO had still not undertaken detailed planning or worked with municipalities to plan for subsequent waves of the pandemic.
- We found that key lessons identified in the aftermath of the Severe Acute Respiratory Syndrome (SARS) outbreak in 2003 had not been implemented by the time COVID-19 hit Ontario, and were not followed during Ontario’s COVID-19 response. For example, the SARS Commission’s final report identified the precautionary principle—taking preventative measures to protect the public’s health even in the absence of complete information and scientific certainty—as the most important lesson of SARS. Following this principle means taking decisive action early. This is not what we saw in our audit work; instead, we saw delays and confusion in decision-making.
- The Chief Medical Officer of Health did not fully exercise his powers under the Health Protection and Promotion Act to respond to COVID-19. He did not issue directives to local Medical Officers of Health to ensure public health units responded consistently to the COVID-19 pandemic, nor did he issue directives on their behalf. In May 2020, 34 local Medical Officers of Health jointly prepared and signed a document stating there needed to be more direction and regional consistency. For instance, it was the province, not the Chief Medical Officer, that finally issued an emergency order in early October 2020 to require masking for the general public.
- Public Health Ontario played a diminished role in the overall provincial response, and even regional response structures were generally not led by public health experts. Some tasks that typically would have been Public Health Ontario’s responsibility were done by Ontario Health instead, such as reporting provincial surveillance data to the Health Command Table and co-ordinating provincial laboratory testing for COVID-19. Local Medical Officers of Health informed us that they were confused by provincial politicians delivering critical public health advice in place of the Chief Medical Officer of Health.
- Variations in management and operations among public health units contributed to fragmentation and inconsistencies across Ontario. Public health in other jurisdictions, such as British Columbia, Alberta and Quebec, is more simply organized. Public health reform recommended about 15 years ago by the SARS Commission had not been fully acted on. As of the writing of this report, Ontario’s 34 public health units were still operating independently, and best practices were still often not being shared.

- The Ministry of the Solicitor General did not implement our recommendations from three years ago to regularly update and finalize its emergency response plans. As well, the Ministry of Health had not acted on recommendations in our 2003, 2007, 2014 and 2017 audits to address the weaknesses in public health lab and information systems. This had negatively impacted the work of public health units during COVID-19. Information systems now in use have limited functionality for case management and contact tracing. Also, the Ministry of Health did not make the improvements needed in its fragmented management of the laboratory sector. Laboratory testing still follows a substantially manual, paper-based process, and the laboratory information system is not integrated with the public health information system.
- Ontario did not contact all travellers entering the province due to a lack of dedicated resources and the inability to receive accurate, complete and timely information from the federal government. Between April and August 2020, about 2.5 million international travellers entered Ontario. Approximately 9%, or 233,000, of them were reported to Ontario.