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# Reflections

The year 2020 will always be remembered as the year of the COVID-19 pandemic. No one could have predicted the toll this would take, and continues to take, on our lives and on the economy in Canada.

With the co-operation of Public Health Ontario, Ontario Health, the Secretary of Cabinet, Ontario's various public health units, the Ministry of Health and the Ministry of the Solicitor General, we were able to conduct our audit work during COVID-19 and produce this special report of three chapters, with recommendations for the relevant entities, and with information for the Legislative Assembly and the public. These chapters identify situations where Ontario could have done better in responding to the pandemic and capture lessons learned going forward. Our discussions during our audit indicate that decision-makers are willing to learn from the past and want to make improvements, as they continue to respond to COVID-19 and will then need to work on post-COVID-19 recovery.

This Special Report on Ontario's initial response to COVID-19 contains the following three chapters:

- Chapter 1: Emergency Management in Ontario—Pandemic Response
- Chapter 2: Outbreak Planning and Decision-Making
- Chapter 3: Laboratory Testing, Case Management and Contact Tracing

Overall, from our work in Chapters 1 and 2, we found that Ontario's response to COVID-19 in the

winter and spring of 2020 was slower and more reactive relative to most other provinces and many other international jurisdictions. We believe that there were several contributing factors:

1. 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 grew from 21 members to 90 participants. 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.
2. Given the significant changeover in leadership in Ontario's Provincial Emergency Management Office (EMO), outdated emergency plans and the lack of sufficient staff, the province was not in a good position to implement the provincial response structure in its provincial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.

3. 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 conflicts and confusion in decision-making.
  4. 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.
5. 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.
  6. 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.
  7. 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 and 2014 audits to address the weaknesses in public health 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.

International best practices indicate that there are three critical things that must be done to control the virus—timely testing, managing positive cases, and contact tracing. In Chapter 3, we noted 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.

More specifically, the three critical activities are: collecting and testing specimens from individuals to identify if they have COVID-19 (laboratory testing); contacting individuals who test positive to advise them regarding their condition and self-isolating, and to determine how they contracted COVID-19 (case management); and identifying and contacting the close contacts of individuals who have tested positive to advise them regarding testing and self-isolating (contact tracing). *The Lancet* medical journal reported in July 2020 that when there are no delays in completing these activities, an infected person's potential to transmit COVID-19 to others can be reduced by 80%. The success of this process is significantly dependent on having effective integrated information systems that can quickly capture and communicate information. Information systems of this caliber, along with clear case management and contact tracing guidance, were lacking in Ontario and delayed data collection, case management and contact tracing.

In addition, in most cases, the Ministry's targets for laboratory testing, case management and contact tracing were not being met. For example, the Ministry of Health had a target of laboratory tests being completed within 24 hours of a specimen being collected 60% of the time; yet an average of only 45% of laboratory tests, or less than half of the tests, were being completed within 24 hours.

For case management, the Ministry had a target of public health units contacting 90% of individuals who have tested positive within 24 hours of the public health unit receiving the test result. As of August 2020, in the province as a whole, an average of only about 80% of individuals who tested positive had been contacted that quickly. While public health units in all other areas of the province either met or exceeded the 90% notification target, the province's failure to meet the target was due mainly to the public health units in Toronto, Ottawa, Peel Region and York Region taking more than a day to contact infected individuals.

For contact tracing, in May 2020, the Ministry started to track public health units' performance in contacting 90% of close contacts of COVID-19 cases within one day of the public health unit being notified. As of August 2020, 92% of the close contacts of cases had been contacted within one day.

Since urban and densely populated regions in Ontario (such as Toronto, Peel Region, Ottawa and York Region) had more COVID-19 cases, these regions had a higher demand for laboratory testing, more cases to manage and more contacts to trace. The regional differences can be significant and are concerning when the most populated cities and regions with the highest demand for testing have capacity issues leading to delays and backlogs.

Between March and August 2020, it took a longer-than-average time for these regions to test specimens and start case management. The average in other regions was 2.75 days from the time the specimen was collected, but Ottawa's average time was 3.25 days and Toronto's average time was 5.75 days. In September 2020, the average times were two days from specimen collection to reporting a positive result and 1.75 days from reporting the positive test result to starting case management. In October 2020, the average time to report a positive result had increased to 2.25 days, while the average time to starting case management had decreased to one day (so an average cumulative time of 3.25 days). However, the average times in urban areas were generally longer: Ottawa's

average time to complete these activities between September and October 2020 was 4.5 days, York Region's was 2.25 days, Peel Region's was 3.25 days and Toronto's was four days. Overall, the province did not meet the case management performance target in September 2020 and October 2020, with an average of only about 75% of individuals who tested positive for COVID-19 being contacted within 24 hours (the target was 90%).

The need for properly resourced public health labs 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.

Clearly there are many lessons that can be learned from the first eight months of COVID-19. In the near future, we plan to issue a second Special

Report on Ontario's response to COVID-19 that will contain the following three chapters:

- Chapter 4: Management of Health-Related COVID-19 Expenditures
- Chapter 5: Personal Protective Equipment
- Chapter 6: Long-Term Care Issues

We recognize that decision-makers, the health-care system and the public made every effort so that Ontario's health system would not be overrun in the first wave. As well, through government communications and extensive media reporting, members of the public have been given the information they need to protect themselves against acquiring COVID-19. As we continue into this second wave, it is still not too late to make positive changes to help further control and reduce the spread of COVID-19.

Sincerely,



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