PUBLIC HEALTH EMERGENCIES GOVERNANCE REVIEW PANEL

APPENDICES

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Appendices

Disclaimer

Please note that the papers and memoranda obtained from third parties and included in these appendices represent the views of the sources and authors identified, not those of the Panel, although the Panel has drawn extensively upon them.

APPENDIX 1

Terms of Reference of the Public Health Emergencies Governance Review Panel

MINISTERIAL ORDER No. 01/2023

DEPARTMENT OF EXECUTIVE COUNCIL PROVINCE OF ALBERTA

Government Organization Act (s. 7)

PUBLIC HEALTH EMERGENCIES GOVERNANCE REVIEW PANEL

I, Danielle Smith, President of Executive Council, make the following Order:

Establishment, Appointments and Designation

1. The Public Health Emergencies Governance Review Panel (the "Panel") is established.

2. The following are appointed as members of the Panel:

    (a) Preston Manning.

3. Preston Manning is designated as the Chair of the Panel.

4. The President of Executive Council may appoint additional members to the Panel from time to time by amendment to this Order. The Chair may recommend additional members to the President of Executive Council who may consider such names in further appointments under this Order.

5. The President of Executive Council is designated as the head of this public body for the purposes of the *Freedom of Information and Protection of Privacy Act.*

Mandate and Authorities

6. The mandate and deliverables of the Panel are as set out in the Terms of Reference attached as Appendix A to this Order.

7. Subject to the terms of this Order, including the Terms of Reference, the Panel is authorized to make rules governing the calling of its meetings, the procedure to be used at its meetings, and the conduct of business at its meetings.

Additional Support

8. The work of the Panel will be supported by the Government of Alberta through resources contracted by such departments or the personnel of such departments as determined by the Deputy Minister of Executive Council.

9. Resources contracted by the Government of Alberta at the request of or in support of the Panel will be limited to a maximum budget of $2,000,000, subject to further adjustment by the Deputy Minister of Executive Council.

Remuneration and Expenses

10. Members of the Panel will be entitled to remuneration for their work and time spent in relation to the business of the Panel, as follows:

    (a) Chair – Total remuneration of $253,000 to November 30th, 2023, payable in monthly installments, in accordance with and subject to a contract to be entered into between the Chair and the Government of Alberta;

    (b) Other Panel members – Remuneration in accordance with Schedule 1, Part A of the *Committee Remuneration Order* (O.C. 466/2007).

11. Members serving on the Panel will be entitled to reimbursement of their reasonable expenses on the same basis as if they were employees of the Government of Alberta and subject to the *Travel, Meal and Hospitality Expenses Directive,* being Treasury Board Directive 05/2020, including any amendments thereto.

Disestablishment

12. The Panel is disestablished on November 30, 2023.

DATED this 19th day of January 2023.

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Danielle Smith
President of Executive Council

Appendix "A"

Terms of Reference – Public Health Emergencies Governance Review Panel

Objective

The Panel's objective is to review the legislation and governance practices typically used by the Government of Alberta during the management of public health emergencies and other emergencies to recommend changes which, in the view of the Panel, are necessary to improve the Government of Alberta's response to future emergencies.

Scope of Review

The Panel will, in relation to its objective, consider and appropriately balance the following factors in the overall context of a public health emergency:

- General public health and health information;
- Mental health and wellness;
- Child and student health, mental health and education
- Health professionals' practice standards;
- Effective implementation of emergency measures;
- Protection of rights and freedoms;
- Economic and financial effects;
- Employment standards.

The Panel will review, in relation to its objective, relevant Alberta legislation, including applicable regulations, orders in council and ministerial orders made under the legislation.

The Panel will also:

- Review any governance practices the Panel determines advisable to review in relation to its objective;
- Consider submissions made by members of the public and stakeholders;
- Undertake or provide any additional analysis or recommendations, as may be requested by the President of Executive Council, in relation to the Panel's objective.

Deliverables and Reporting

The Panel must deliver:

- An interim written report and recommendations (the "Interim Report") to the President of Executive Council on or before June 30, 2023;
- A final written report and recommendations (the "Final Report") to the President of Executive Council on or before November 15, 2023;

- A verbal presentation to the President of Executive Council and other members of the Executive Council, at the President of Executive Council's sole discretion;
- Any other deliverables as may be requested by the President of Executive Council in relation to the Panel's objective.
- The President of Executive Council may extend the above deadlines as required.

Support for the Panel and related Budget

Support will be provided to the Panel for its work by personnel from such departments of the Government of Alberta as determined by the Deputy Minister of Executive Council. This support will include arranging for access to information as required (including in relation to all departments and agencies of the Government of Alberta).

The third party contract support will be selected on the basis that the Panel members, together with the contracted support, have as a collective expertise in all of the following areas:

- General public health and health information;
- Mental health and wellness;
- Child and student health, mental health and education
- Health professionals' practice standards;
- Effective implementation of emergency measures;
- Protection of rights and freedoms;
- Economic and financial effects;
- Employment standards.

Department Contact(s) for the Panel

The Panel's primary contact in the Government of Alberta will be the Deputy Clerk of Executive Council & Deputy Secretary to Cabinet.

Public Communications

A website for the purpose of public engagement will be established and maintained by Communications and Public Engagement.

APPENDIX 2

Review of Public Input

March 2023

Summary of Public Responses to the Public Health Emergencies Governance Review Panel's Website Question

Context

The Public Health Emergencies Governance Review Panel was formed to review the legislation that guided Alberta's response to COVID-19 and recommend changes to improve the response to future public health emergencies.

Albertans were asked to share their input on what amendments should be made to legislation that could better equip the province to cope with future public health emergencies.

The Question and Preliminary Response

Albertans were asked a single question:[1]

What, if any, amendments to legislation should be made to better equip the province to cope with future public health emergencies?

A total of **3,131** Albertans responded between January 19 and March 15, 2023.

82 per cent of responses were under 100 words, and the average word count was 66. There were also indications of "coordinated responses."

Preliminary responses indicated that very few Albertans were aware of the legislation that guided the government's response to COVID-19. Most responses therefore consisted of the expression of views on the COVID-19 crisis itself and how it was handled.

[1] The online survey was hosted through Engagement HeadQuarters (EHQ), the Government of Alberta's digital engagement platform. No demographic information was collected during this engagement.

When more information was provided as to the actual legislation governing Alberta's response (e.g., *Public Health Act*, *Emergency Management Act*, etc.) there was a modest increase in the number of responses addressing the question.

Additional Findings

While very few respondents addressed the question asked, other responses emphasized the following:

1. Opposition to health regulated mandates and calls for expanded human rights protection legislation.

References made to importance of freedom of choice and opposing any regulations restricting health choices (e.g., vaccine mandates). Calls for legislation protecting these freedoms as well as protection against discrimination based on vaccine status and an individual's ability to freely decide on their own health and well-being.

2. Support for enhanced public health regulations, stricter enforcement of these regulations, and overall evidence-based health practices.

Support for enhanced public health regulations included calls for a cohesive response between jurisdictions and strong enforcement of relevant regulations. Answers also supported a response based on national (e.g., Health Canada) and international standards (e.g., WHO) and recommendations based on the best available science/evidence.

3. Greater support for health protection decisions and orders made by independent experts and civil servants (e.g., CMOH) than for those made by elected officials assumed to be partisan.

There was little interest expressed in the need for political accountability for COVID-19 responses. Responses stressed that the CMOH should be someone with sufficient credentials and extensive background in science/medicine/public health, and that decisions should be based on the most readily available evidence/science.

4. Comments on the Panel and the review process.

Questions/criticisms of the appointed chair and Panel, the associated costs, potential for bias among the members and need for public engagement.

5. Miscellaneous themes mentioned by small numbers of respondents.

Mistrust of public health information, support for/opposition to more private care options within the healthcare system, need to increase healthcare resources, need for better emergency planning, stronger role for municipal governments, need for data sharing and more transparency with respect to emergency response decisions.

Provision for Future Feedback

The public input most desired by the Public Health Emergencies Governance Review Panel, and which will be of greatest interest to the government, will be public commentary on the Panel's report and its recommended amendments to legislation to better equip the province to respond to future public emergencies. A website to receive such input and feedback is to be established.

APPENDIX 3

Analyzing and Improving Regulatory Systems:

Principle-based Criteria Review and Recommended Amendments to Alberta's Emergency Management, Public Health, and Related Legislation

SECONDMENT
REPORT

RRI CANADA

Principle-based Criteria, Review and Amendment Recommendations Alberta's Emergency Management, Public Health Legislation, and Applicable Subordinate Legislation

Prepared by

Gerard A. Lucyshyn, B.A. (Hons), M.A.
President/Executive Director of The Regulatory Research Institute of Canada

Prepared for

Public Health Emergencies Governance Review Panel [of Alberta]

April 10, 2023

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EXECUTIVE SUMMARY

The Public Health Emergencies Governance Review Panel (PHEGRP) was established on January 19, 2023, by Premier Danielle Smith. PHEGRP's primary goal is to review the legislation and governance practices used by the Government of Alberta during the management of public health emergencies and other crises, and recommend any changes that PHEGRP deems necessary to improve the government's response to future emergencies. This report was completed at the request of PHEGRP and is intended as an informational document to aid in PHEGRP's official work.

This report is divided into three main parts. The first part defines a set of principle-based criteria for evaluating regulatory regimes. These criteria are then used to evaluate an inventory of regulations and orders promulgated by the Government of Alberta in response to the COVID-19 pandemic. The second part of this report provides the reader with an overview of the applicable emergency management and public health legislation along with subordinate legislation in Alberta and how such legislation was used in directing the pandemic response. The third part proposes some legislative amendments, for PHEGRP's consideration, to the applicable legislation reviewed in the second part of this report to improve government effectiveness in responding to future emergencies.

Part I recommends 17 principle-based criteria and 13 check element criteria (see Part I Section F). These criteria together provide a comprehensive assessment tool for regulations and orders and will help identify areas of concern that may require modifications to improve the government's effectiveness in responding to future emergencies while ensuring adherence to the principles of good governance.

Part II reviews the applicable emergency management and public health legislation and applicable subordinate legislation which includes the relevant sections of the *Emergency Management Act*, the *Public Health Act*, and the *Regional Health Authorities Act*, as well as select subordinate legislation (regulations) enabled under these statutes. The regulations reviewed include the *Disaster Recovery Regulation*, *Government Emergency Management Regulation*, the *Local Authority Emergency Management Regulation*, the *Communicable Disease Regulation*, and the *Emergency Powers Regulation*.

Part II identifies the proposed problematic sections within the selected Acts and regulations (see summary in Part I Section G) and provides the reader with the current section language along with explanations as to why these sections may be of concern based on the principle-based criteria and check element criteria established in Part I. The areas of concerns that have been commonly identified across the selected statutes and regulations include: the principle-based criteria of *accountability*, *policy coherence*, *balance*, *consistency*, and *impact assessment* and check element criteria include: *infringement*, *trespass*, *unduly dependent*, and *unusual use of power*.

Additional reports from different organizations concerning provincial emergency management were also reviewed. These include: the *Alberta Pandemic Influenza Plan: Roles and Responsibilities* (2014) prepared by the Health Quality Council of Alberta, which established the roles and responsibilities of various organizations based on their mandates and expertise in pandemic influenza. The *Alberta Pandemic Influenza Plan* (2014) which designates the Alberta Emergency Management Agency (AEMA) as the coordinating and support agency for the government of Alberta and all emergency

partners, including Alberta Health, Alberta Health Services (AHS), and First Nations and Inuit Health Branch - Alberta Region (FNIHB). The *Provincial Hazard Assessment for Emergency Management* by Alberta Auditor General (2020) which found that the AEMA did *not* have an effective system to coordinate a provincial hazard assessments and warned that the government may not have the information necessary to identify and fund its highest priorities, overlooking areas where additional emergency planning or policy-related decisions were required. The *Review of Alberta's COVID-19 Pandemic Response* (2021) by KPMG found data collection on governance and decision making was difficult due to the Province's establishment of a new formal response structure to manage decisions and enable a coordinated provincial response during the first wave of the COVID-19 pandemic. This new formal response structure drew on the Province's existing emergency management systems and added new features for the response to the COVID-19 pandemic emergency. Lastly, *Decision Making During the COVID-19 Pandemic* (2023) a presentation by Deputy Ministers involved in the response to COVID-19 to PHEGRP advised that the pandemic response was directed by a Cabinet committee and coordinated by the Health Emergency Operations Centre (HEOC), the Pandemic Response Planning Team (PRPT), and the Provincial Operations Centre (POC) and that the AEMA largely maintained its *usual operations* during the pandemic, However the AEMA was tasked with two pandemic response programs, namely, the Personal Protective Equipment (PPE) Task Force and the provincial *Bits-and -Pieces* program. AEMA support to other pandemic initiatives primarily involved sharing of knowledge and personnel to the HEOC and PRPT. In addition, the AEMA Managing Director, pursuant to the policy direction of the EMCC, PICC, Cabinet, and the Premier's Office. was deployed (outside his role as the Managing Director of AEMA) to support the COVID-19 Vaccine Task Force and Rapid Testing Force.

Based on the findings in part I and part II of this report, it is recommended that PHEGRP consider several legislative amendments (see Part III). Amendments to such relevant sections identified in existing legislation that should strengthen the accountability of those involved in emergency management within the province, eliminate jurisdictional overlap across various emergency partners, define precise roles for agencies and organizations, as well as non-elected participants, and elected officials who have responsibilities under emergency management. The recommendations also include emergency management training for all provincial government staff and elected officials who have designated emergency management responsibilities. Lastly, the author recommends the PHEGRP to consider the re-establishing the AEMA as an *independent* emergency management agency with overarching jurisdiction with respect to emergency management of all hazards and is the official agency that carries out the coordination of all emergency partners once a state of emergency/disaster has been declared. The *independent* AEMA should have a governing board of directors (appointed from the public) who are directly accountable to the Premier.

INTRODUCTION

On January 19, 2023, by way of Executive Council Ministerial Order 01/2023, Premier Danille Smith directed the establishment, appointment, and designation of the Public Health Emergencies Governance Review Panel (PHEGRP).

The Order set out the PHEGRP's primary goals: to review the legislation and governance practices used by the Government of Alberta during the management of public health emergencies and other crises along with recommending any changes that it deems necessary to improve the government's response to future emergencies.

The PHEGRP was tasked with carefully considering and balancing a variety of factors related to public health emergencies, which included: general public health and health information, mental health and wellness, child and student health, mental health, and education, health professionals' practice standards, effective emergency measures, protection of rights and freedoms, economic and financial effects, and employment standards. PHEGRP will review all relevant Alberta legislation, including applicable regulations, orders in council, and ministerial orders.

The PHEGRP will also review any governance practices it deems necessary to examine in meeting its objectives and consider submissions from the public and stakeholders. The Panel will also undertake any additional analysis or provide additional recommendations, as requested by the President of the Executive Council.

This is an independent report which was completed at the request of PHEGRP and is to be used solely as an informational document in support of PHEGRP’s work, any opinions and/or recommendations contained herein are those of the author alone based on independent research and the contents contained herein and *do not* form part of the official report of the PHEGRP.

The following document is divided into three main sections, each addressing specific tasks outlined in the services engagement agreement EXC23-10. Part I examines various government sources, both provincial and federal, as well as academic sources to identify a comprehensive set of principle-based criteria and check element criteria that, in the author's opinion, would provide the PHEGRP with recognized best practices for evaluating legislation and regulations.

Part II reviews the applicable emergency management and public health legislation that pertains to emergency management within the Province of Alberta, along with subordinate legislation. This review examines selected sections of the Acts and regulations and applies the principle-based criteria and check element criteria established in Part I. It is important to note that the document points out the specific sections or parts of sections where readers can review the applicable criteria and check element criteria that may require careful consideration when providing recommendations. Additionally, other public documents are reviewed in Part II, which provides readers with greater context regarding the legislation

and governance practices used by the Government of Alberta during public health emergencies and other crises.

Part III provides suggested legislative changes that the PHEGRP may wish to consider during its deliberations and work.

Note that the following work does not necessarily need to be read in order, however, for readers that are not necessarily fully versed on political frameworks, reading in order ensures clarification on the use of acronyms and terminology along with the logical progression of the report's findings and subsequent justifications for its recommendations.

I. PRINCIPLE-BASED CRITERIA

In accordance with the terms outlined in the engagement agreement EXC23-010 dated March 23, 2023, the initial task involves identifying and defining a set of principle-based criteria aimed at evaluating regulatory regimes and their role in directing pandemic responses. This task is organized into five sections. Section A presents essential background information to distinguish between principle-based and rule-based criteria. The objective is to define a set of principle-based criteria and apply them to assess the inventory of regulations and orders promulgated by the Government of Alberta in response to the COVID-19 pandemic. Section B provides readers with information on regulatory regimes, including definitions, objectives, and key elements of an ideal regulatory regime. Section C presents an overview of previous principles adopted by the Province of Alberta to review and examine provincial regulations. Section D provides an overview of current principles employed by the Government of Canada to review and examine federal regulations. Section E presents an overview of some notable academic literature on rule-based and principle-based criteria that should be considered when examining regulations and regulatory regimes. Section F compiles a set of 17 principle-based criteria along with 13 check element criteria based on the research from sections A-E. Using the established principle-based criteria and the check element criteria. Section G provides an evaluation summary of the inventory of public emergency legislation and subordinate legislation.

A. Principle-based v. Rule-based Criteria

Principle-based criteria refer to standards or guidelines that are based on fundamental principles or values rather than specific rules or procedures. *Principle-based* criteria provide more general guidance that allows for interpretation and application in diverse contexts. *Principle-based* criteria offer a framework that focuses on transparency, accuracy, and disclosure of all relevant information to stakeholders. They are commonly employed in ethical or regulatory contexts where flexible guidelines are needed to be applicable in a wide range of situations. *Principle-based* criteria are often utilized in fields where there is a need to balance competing interests and consider multiple factors when making decisions. They offer a decision-making framework based on fundamental principles and values, adaptable to various situations.

Rule-based criteria are more prescriptive and specific. *Rule-based* criteria refer to a set of specific instructions that dictate how to act in a given situation. They provide clear and unambiguous guidelines for decision-making, leaving little room for interpretation or deviation. *Rule-based* criteria are often employed in fields where consistency and uniformity are essential, such as in manufacturing or quality control. They are frequently used in situations where compliance with a set of standards or regulations is required, and where deviation from these standards could result in significant consequences, such as fines

or legal action. *Rule-based* criteria are typically easier to measure and evaluate, as they provide clear benchmarks for performance and compliance. However, they can be inflexible and may not be suitable for all situations, particularly those requiring a more nuanced approach.

B. Regulatory Regime

A *regulatory regime* refers to a collection of laws, rules, policies, and procedures established by a governing body that has been tasked to oversee and control a specific industry or sector. The purpose of a *regulatory regime* is to establish the standards and guidelines that all individuals, organizations and businesses (including the government) must comply with in order to operate legally within the industry or sector, or in society as a whole.

Ideally, *regulatory regimes* aim to promote public safety, protect the environment, ensure fair competition, and maintain stability and integrity. Most regulatory regimes typically involve licensing and registration requirements, product safety and quality standards, and enforcement mechanisms for non-compliance.

While the specific elements of a *regulatory regime* may differ considerably depending on the objectives and preferred outcomes of the government, legal and political framework in which the specific *regulatory regime* operates, all *regulatory regimes* have the common objective of ensuring that all parties operate within established guidelines.

C. Government of Alberta's Criteria

The Government of Alberta (GOA) established the Regulatory Review Secretariat (RRS) in 1994. The RRS was established as an *independent body* responsible for reviewing and recommending changes to government regulations. During its existence, the RRS's mandate was to promote *efficiency*, *reduce regulatory burden*, and ensure that regulations were *necessary*, *effective*, and *in the public's interest*.

At that time, the GOA established a set of guiding principles (GOA-SGG) for regulations which the RRS used in fulfilling its mandate. Note that while these principles were established nearly 30 years ago, these principles were in place and used by the members of the RRS until October 2013. In October 2013, Premier Alison Redford[1] redesignated and transferred responsibility of the RRS to the President of the Executive Council, where the designated Minister responsible for administration of the RSS (which was disbanded in 2013) continues to remain.[2]

It is undetermined whether or not GOA-SGG continued to be used and remain intact after 2013, however, the reader should note that these principles did provide general guidance to the RRS for nearly 30 years during its operation between 1994–2013.[3]

The Secretariat's general guidance contained five criteria: (1) necessity, (2) effectiveness, (3) proportionality, (4) accountability, and (5) consistency.

- *Necessity* is based on demonstrating that there is justification to regulate and that once regulation is implemented, on-going review takes place to ensure regulations remain relevant.

[1] Parrish, Julia. "Premier Redford unveils new Cabinet", CTV News, October 12, 2011.
[2] Government Organization Act, RSA 2000, c G-10, Designation and Transfer of Responsibility Regulation, Alberta Regulation 11/2023.
[3] Government of Alberta, *Government of Alberta Guidelines for Regulation Impact Reporting*, July 2011.

- *Effectiveness* is based on using a results-based approach in designing and implementing regulations and regulations that are implemented can be complied with and enforced.

- *Proportionality* is based on wide consultation before regulating or changing regulations and any adopted regulations be stated in clear, simple language, properly communicated and be responsive to feedback from Albertans.

- *Accountability* is based on mutual accountability with both the public and private sector stakeholders.

- *Consistency* ensures regulatory requirements in different sectors are consistent and coordinated.

D. Government of Canada Criteria

In 1971, the Standing Joint Committee for the Scrutiny of Regulations (SJC) was established in Canada under the Statutory Instruments Act. The SJC was established due to concerns about the increasing volume of regulations created by government agencies and departments. The primary objective of the SJC is to ensure that the government bodies with delegated legislative authority remain accountable to Parliament.

Over the past 52 years, the SJC has refined its set of criteria to 13 elements, including: authorization, conformity, retroactive effect, charge on public revenues, authority to impose, exclusion of the courts, compliance, infringement, trespass, unduly dependent, unusual use of power, substantive legislative power, and drafting defect.

- *Authorization:* The regulation possesses authorization through the enabling legislation's terms or has failed to adhere to any condition stipulated in the legislation.

- *Conformity:* The regulation is in accordance with the *Canadian Charter of Rights and Freedoms* and the *Canadian Bill of Rights*.

- *Retroactive Effect:* The regulation claims retroactive effect but lacks explicit authorization from the enabling legislation.

- *Charge on Public Revenues:* The regulation levies a charge on public revenues or mandates payment to the Crown or another authority, or sets the amount of such charge or payment, without the enabling legislation expressly authorizing it.

- *Authority to Impose:* The regulation imposes a fine, imprisonment, or other penalty without explicit authorization from the enabling legislation.

- *Exclusion of the courts:* The regulation has a tendency, either directly or indirectly, to exclude the courts' jurisdiction without explicit authorization from the enabling legislation.

- *Compliance:* The regulation is in compliance with the Statutory Instruments Act.

- *Infringement:* The regulation seems, for any reason, to violate the rule of law.

- *Trespass:* The regulation encroaches on an individual's rights and liberties.

- *Unduly Dependent:* The regulation unreasonably makes an individual's rights and liberties dependent on administrative discretion or is incompatible with the principles of natural justice.

- *Unusual Use of Power:* The regulation employs the powers granted by the enabling legislation in a peculiar or unforeseen manner.

- *Substantive Legislative Power:* The regulation exercises a significant legislative authority that is accountable to parliamentary scrutiny.

- *Drafting Defect:* The regulation has a drafting flaw or needs clarification regarding its structure or intent.

E. Literature on Measuring Regulatory Performance

In the ongoing debate between the merits and drawbacks of *principle-based* versus *rule-based* regulatory regime and legislative systems, it is often oversimplified into an *either-or* logical fallacy. In reality, most regulatory systems incorporate both rules and principles, with rules having the *flexibility* to include exceptions and qualifications, and principles being *strengthened* by incorporating requirements and best practices which take on a more rule-like form. The balance between principles and rules within a regulatory system may correlate with the age/experience of the standard-setting authority, with the newer authorities adopting a more principle-based approach due to the lack of a tried-and-true comprehensive set of rules.

The objective of this section is not to take sides in the ongoing debate surrounding the merits of *rule-based* versus *principle-based* criteria; rather, it is to establish a set of *principle-based* criteria for assessing regulatory regimes and their efficacy in shaping responses to public health emergencies. However, it is important that the reader is aware of such debate and the various viewpoints expressed in the academic literature. Bearing this in mind, a review of select scholarly articles has yielded additional criteria for consideration. The articles are presented in chronological order.

E.1. Black (2007)[4]

In Black's (2007) research, the focus is on the benefits and opportunities that a *principle-based* regulatory regime can bring to the UK financial services industry, as well as what is meant by such a regime. The study explored four main themes: the elaboration of principles, supervision and enforcement, accountability, and regulatory relationships.

Black's research proposes the following eight necessary preconditions for a successful *principle-based* regulatory regime: balance, discipline, inclusive, supervision and enforcement, role of enforcement, accountability, skills of regulators, and constructive dialogue.

- *Balance:* The balance achieves a suitable equilibrium between the set of principles and other regulations imposed by the regulatory framework.

- *Discipline:* Regulatory discipline involves allowing some flexibility for general guidance.

[4] Black, Julia, *Making a success of Principles-based regulation*, London School of Economics, 2007. https://www.lse.ac.uk/law/people/academic-staff/julia-black/Documents/black5.pdf

- *Inclusive*: Inclusive takes into account the requirements of the various stakeholders impacted by the regulatory framework.

- *Supervision and enforcement:* Supervision and enforcement facilitate an adequate approach and equilibrium between overseeing and enforcing.

- *Role of enforcement:* The role of enforcement takes into account the results of previous enforcement cases and utilizes them as feedback for future interpretation.

- *Accountability:* Accountability guarantees the existence of accountability mechanisms and ensures that they are not circumvented.

- *Skills of regulators:* Regulators' skills must include the ability to regulate collaboratively rather than relying solely on a command and control approach.

- *Constructive dialogue:* Constructive dialogue necessitates mutually beneficial communication between regulatory bodies and the regulated entities. The dialogue must enable both to meet their respective responsibilities, expectations, and common core principles.

E.2. Ford (2009)[5]

In his research report prepared for an expert panel on securities regulation, Ford (2009) argues that while regulatory systems will inevitably include both rules and principles, principles should be favored wherever possible in a *principle-based* system. However, Ford cautions that implementing *principle-based* legislation and regulations without considering its implementation is insufficient for improving such legislation and/or regulation. To achieve better regulation, *principle-based* regulation needs to be complemented by using: (a) greater reliance on *outcome-based* and *management-based* regulation, rather than *process-based* regulation; (b) transparent, accessible, ongoing guidance from regulators; (c) methods for incorporating industry experience into regulatory expectations; (d) analytical methods for evaluating regulatory success and allocating regulatory resources; and (e) meaningful oversight of regulated entities, based on an *enforcement pyramid* that includes compliance examinations, as well as civil and criminal enforcement.

Ford (2009) identifies six elements which are important to a well-functioning *principle-based* regulatory regime: regulatory culture, accounting for impact, learning systems, outcome-orientated, regulatory credibility, and maintaining control.

- *Regulatory culture*: A principle-based regulator focuses on defining broad themes articulating them in a flexible and outcome-oriented way, accepting input from industry, and managing incoming information effectively. This requires expertise, a more trusting and communicative relationship with industry, restraint in providing administrative guidance, and the continued use of notice-and-comment rulemaking where appropriate.

- *Accounting for the impact on market participants*: In order to be able to take advantage of the benefits of principle-based regulation, industry needs reasonable lead times to adjust

[5] Ford, Cristie, "Principles-Based Securities Regulation A Research Study Prepared for the Expert Panel on Securities Regulation", University of Toronto, 2009. https://www.rotman.utoronto.ca/-/media/Files/Programs-and-Areas/CMI/2009-papers/Principles-Based-Securities-Regulation---Ford_English.pdf?la=en.

to the new model, education and support, and the ability to rely on legacy rules during the transition period.

- *Learning systems and information management*: A principle-based and outcome-oriented regulator needs information to be credible as it develops its guidance, evaluates results, and interacts with industry.

- *Outcome-oriented regulation*: A focus on results, rather than processes, is crucial in a principle-based regulatory environment to keep the system flexible and capable of learning.

- *Regulatory credibility*: In order to have its judgments respected under a principle-based system, a regulator's conduct must be reasonable, predictable, and responsive.

- *Maintaining control*: A principle-based regulator needs the statutory power to promulgate rules and guidance, and it (not the courts) needs to be the primary interpreter of its principles.

E.3. Burgemeestre (2009)[6]

Burgemeestre's (2009) research examines the underlying reasoning behind the two styles of regulation, *principle-based* and *rule-based* from a legal and accounting perspective. Burgemeestre adapts Verheij et al.'s (1998) framework, taking into account aspects of the *implementation*, such as the adoption process of a new norm and the roles of the participants.

Burgemeestre's conclusions support the view of other scholars in the fields of law and accounting, in that there is no fundamental difference in the logical structure of the two styles of regulation. Burgemeestre argues that the two styles, consisting of both rules and principles, may be considered as extremes on a continuum with three dimensions: temporal, conceptual, and functional.

- The *temporal* dimension: The timing of when regulatory content is established. *Rule-based* systems define boundaries before the adoption and implementation stages, while *principle-based* systems establish principles after compliance has been reviewed. Adhering to a set of rules provides certainty in compliance, that is, one is compliant or not. A *rule-based* approach requires greater initial effort from regulators to establish detailed rules, whereas a *principle-based* approach requires greater effort from the regulated to comply with the established principles.

- The *conceptual* dimension: This makes a distinction based on the degree of specificity, concreteness, and universality *rule-based* v. *principle-based* systems. Indicators such as the number of details, exceptions, clarifications, or limitations are included in this dimension. Collectively, this difference can be referred to as *relative vagueness*.

- The *functional* dimension: This assesses the level of discretionary power granted to those responsible for the regulatory process. While regulators may establish rules, it is *principles* that provide greater room for interpretation by both the subjects and auditors.

[6] Burgemeestre, Brigitte, Joris Hulstijn, Yao-Hua Tan, "Rule-based versus Principle-based Regulatory Compliance", Conference Paper, 2009.

E.4. Coglianese (2012)[7]

Coglianese (2012) argues that in order to assess any regulatory progress in a credible and meaningful manner, it is necessary to use indicators that measure relevant *outcomes* and research designs that support *inferences* about the extent that a regulation or regulatory policy has caused any change by way of a measured outcome. Coglianese finds that in order to evaluate the performance of a regulatory policy, two types of evaluations are required: assessment of the substantive outcome(s) of the regulation developed under the regulatory policy and assessment of any relevant process outcome(s) based on administrative, democratic, or technocratic values.[8]

Such assessments may come in three separate forms: regulatory administration, behavioural compliance, or outcome performance.

Regulatory administration assessments focus on the implementation and delivery of a regulation or regulatory policy. These assessments examine how thoroughly a regulation has been enforced, the number of inspections and enforcement actions, or the adoption of regulatory policy elements or best practices. While these assessments can provide quantitative feedback to officials on administrative performance, such assessments do not evaluate whether the regulation has been effective in changing behavior or achieving specified outcomes.

Behavioural compliance (also referred to as behaviour or compliance assessments) examines whether the regulated are complying with the regulation or the regulatory policy. For example, are individuals complying with mask requirements while shopping. These assessments seek to determine the extent to which behaviour adheres to regulatory or policy standards.

Outcome performance assessments measure the outcome of the regulatory policy. Outcome is the ultimate objective goal of any regulation, as compliance only matters if the desired outcome is achieved. Outcome assessments focus on quantifiable empirical outcomes such as costs and benefits of regulations, regardless of compliance level or implementation quality.

Coglianese argues that one or more of the following four criteria should be used when evaluating regulatory regimes: impact/effectiveness, cost-effectiveness, net benefits/efficiency, and equity/distributional fairness.

- *Impact/Effectiveness:* Impact/Effectiveness pertains to the degree to which each regulatory option could modify the targeted behavior or result in better conditions in the world (e.g., to enhance automobile safety which alternative would cause the largest reduction in fatalities?).

- *Cost-effectiveness:* Cost-effectiveness evaluates the expenses associated with each regulatory option for a given level of behavioral change or reduction in the problem. In other words, it assesses the cost-per-unit of each alternative (e.g., a policy is evaluated based on its cost-per-life saved).

- *Net Benefits/Efficiency:* Net Benefits/Efficiency considers the monetized positive and negative impacts of policy options, allowing for a comparison of net benefits by deducting costs from benefits. Cost-benefit analysis can typically provide answers to

[7] Coglianese, Cary, Measuring Regulatory Performance: Evaluating The Impact Of Regulation And Regulatory Policy. OECD. August 2012.

[8] Technocratic refers to or characterizes a government or control of society or industry by an elite of technical experts.

questions such as: which option generates the highest net benefits? The most efficient option is the one with the greatest net benefits.

- *Equity/Distributional Fairness:* Equity/Distributional Fairness evaluates the potential unequal impact of various options on distinct groups of people, where certain individuals may bear greater costs while others experience more benefits. This criterion aims to determine which option would result in the most just distribution of impacts.

E.5. Belfield (2018)[9]

This article discusses the importance of cost-benefit analysis (CBA) in regulatory decision-making and examines the quality of 28 regulatory impact assessments on education regulations by the U.S. federal government since 2006. The study finds that most of the assessments estimated costs, but failed to report benefits adequately, lacked transparency in method and assumptions, and did not attempt social CBA. Furthermore, the study reveals that the focus on administrative burdens affects the structure of economic evaluation and impairs the ability to use CBA as a tool in policy-making. The authors suggest that CBA should be a guide to decision-making, rather than being an instrument of justification for predetermined policies. They also emphasize the need for high-quality CBA to be informative in the decision-making process. Seven criteria needed for high-quality CBA include: transparency, best data, accurate estimation, sensitivity analysis, comparison, time horizon, and distributional impact.

- *Transparency:* Transparency in cost-benefit analysis implies that the methods employed for data collection, the underlying assumptions, and the resulting calculations based on such data and assumptions are open and available to the public.

- *Best data:* The term *best data* denotes the utilization of the most suitable and reliable data available. Any data employed in a cost-benefit analysis must be of superior quality and be pertinent to the policy under examination.

- *Accurate estimation:* Accurate estimation involves the use of suitable measures and methodologies in a cost-benefit analysis to ensure precise calculation of costs and benefits.

- *Sensitivity analysis:* Sensitivity analysis is a component of a cost-benefit analysis that involves re-evaluating the outcomes by altering specific variables or environmental conditions to determine their impact on the results.

- *Comparison:* Comparison involves comparing various viable policy options to determine the most cost-effective among them.

- *Time horizon:* Time horizon refers to the appropriate consideration of the duration of time and level of discounting used to determine the present value of costs and benefits accrued over time.

- *Distributional impacts:* Consideration of the distributional impacts involves examining the effects of the policy on various groups of people and determining whether the policy is equitable and fair.

[9] Belfield, Clive R. et.al, Evaluating Regulatory Impact Assessments in Education Policy, American Journal of Evaluation, 2018.

E.6. Sylvestre (2022)[10]

Sylvestre (2022) argues that governments need to re-examine fundamental principles when formulating effective guidelines for regulatory criteria. Sylvestre recommends more principled approaches to regulation, using criteria that can address the dynamic nature of political, economic, environmental, and social changes, while acknowledging the impact of regulation as a policy instrument. Sylvestre argues in favour of the following four principles: performance evaluation, engagement, evidence-based, and fair and competitive.

- *Performance evaluation:* In terms of protecting the health, safety, security, social and economic well-being of Canadians, and the environment, regulations must be supported by a clear rationale that justifies their necessity and effectiveness in advancing the public interest and promoting good governance.

- *Engagement:* Engagement in regulations requires modern, transparent, accessible, and understandable regulations that are created, maintained, and reviewed in an open and inclusive manner, involving active participation from both the public and stakeholders.

- *Evidence-based:* Being evidence-based means that regulations and policies are grounded in factual information, rigorous cost-benefit analysis, and risk assessment, and are transparent to the public for scrutiny.

- *Fair and competitive:* Fair and competitive regulations are those that promote an economy that is fair and competitive, benefiting all Canadians and businesses inclusively, while avoiding unnecessary harm to the economy.

E.7. Other General Principles for Consideration

In today's world, with the ever-increasing pace of scientific and technological advancements, it is crucial to have a set of guiding principles that can help ensure the safety of human health and the environment. The *Precautionary Principle* is one such principle that advocates for taking precautionary measures even if the scientific cause and effect relationships are not fully established. The process of applying this principle must be open, informed, and democratic, and it must involve all the affected parties. Along with the Precautionary Principle, other principles such as the *Principle of Accountability*, *Principle of Proportionality*, the *Principle of Scientific and Technical Basis,* and the *Principle of Reducing Regulatory Over-Burden* (also known as the *One-for-one rule)* play a vital role in ensuring the effectiveness of regulatory decisions.

- *Precautionary Principle:*[11] The *Precautionary Principle* refers to taking precautionary measures in situations where an activity poses a threat to human health or the environment, even if the scientific cause and effect relationships are not fully established. The application of this principle requires an open, informed, and democratic process that includes all potentially affected parties. It also involves a thorough examination of all possible alternatives, including taking no action.

- *Principle of Accountability:*[12] The *Principle of Accountability* involves regulatory agencies being responsible and answerable for their actions and decisions. It involves

[10] Sylvestre, Ben, "A More Principled Approach to Regulation", Policy Options, IRPP, 2022.
[11] Tickner. Joel. The Precautionary Principle in Action a Handbook, Science and Health Network. 1999.
[12] Treasury Board of Canada Secretariat, Policy on Regulatory Transparency and Accountability. 2018.

asking whether these agencies were held accountable for their actions and decisions, rather than relying on statutes that exempt them from responsibility.

- *Principle of Proportionality:*[13] The *Principle of Proportionality* states that regulations must be proportional to the risk or harm they aim to prevent.

- *Scientific and Technical Basis:*[14] The *Principle of Scientific and Technical Basis* involves making regulatory decisions based on the most reliable scientific and technical information available, while avoiding false or misleading research.

- *Principle of Regulatory Reduction* (also known as one-for-one rule):[15] is a method used by governments to control the growth of administrative burden of imposed regulations on business and society in general. The "one-for-one" rule requires any regulatory changes that increase administrative burden must be *offset* with an equal amount of reductions in administrative burden, that is, removal of existing regulation when new regulation is introduced.

[13] Boss, Michael, Gerald Lederer, Naida Mujic, and Markus Schwaiger. "Proportionality in banking regulation." Monetary Policy & The Economy, Oesterreichische Nationalbank Q 2 (2018).
[14] Jasanoff, Sheila. The Fifth Branch: Science Advisers as Policymakers. Harvard University Press, 1990.
[15] Government of Canada, Backgrounder – Legislating the One-for-One Rule, 2015.

F. Recommended Principle-based Criteria

To undertake a comprehensive evaluation of the regulatory framework implemented by the Government of Alberta during the pandemic, it is recommended that a set of 17 principle-based criteria and 13 check element criteria (refer to Table 1) be utilized.[16] This approach will facilitate a meticulous assessment of the regulations and orders, identifying any areas that necessitate modifications to augment the GOA response to public health emergencies in the future, and to ensure adherence to the general principles of good governance, efficacy, and efficiency.

Table 1. Recommended Principle-Based Criteria and Check Element Criteria

Principle-based Criteria	Check Element Criteria[17]
1. Accountability 2. Balance 3. Constructive dialogue 4. Efficiency 5. Effectiveness 6. Equity/Fair 7. Consistency 8. Impact assessment (cost-benefit analysis) 9. Learning Systems (feedback) 10. Maintaining control 11. Necessity 12. Open/Transparency 13. Outcome orientated 14. Policy Coherence 15. Precautionary Principle (public interest and good governance) 16. Proportionality 17. Scientific/Evidence Based	1. Authority to impose 2. Authorization 3. Charge on Public Revenues 4. Compliance 5. Conformity 6. Drafting defect 7. Exclusion of the courts 8. Infringement 9. Retroactive effect 10. Substantive legislative power 11. Trespass 12. Unduly dependent 13. Unusual use of power

[16] Note that the check element criteria are derived from SJC criteria and relate to more technical elements of a regulation, which may warrant a closer examination or evaluation of that particular regulation or order.
[17] See Standing Joint Committee for the Scrutiny of Regulations for details on the 13 check element criteria.

F.1. Principle-based Criteria Reviewed

The proposed criteria have their origins in principles and concepts put forward by various government bodies, including Alberta, as well as by academic experts within and beyond the province and across the globe. Here, I provide a succinct overview of each of the recommended criteria:

- *Accountability:* The *principle of accountability* necessitates mutual responsibility between stakeholders in the public and private sectors. Regulatory agencies must take responsibility for their actions and decisions, have mechanisms in place to ensure accountability, and must not circumvent any processes which enforces accountability.

- *Balance:* The principle of balance plays a critical role in decision-making, necessitating the evaluation of competing interests and a diverse range of factors. Decision-making criteria must fairly balance principles and other rules, while upholding adequate supervision and enforcement. Regulations are useful for managing social and economic interests, and ensuring fair consideration of all parties. By incorporating the principle of balance, decisions can factor in all relevant considerations and produce optimal outcomes for stakeholders.

- *Constructive Dialogue:* Establishing and maintaining a constructive dialogue between regulators and the regulated parties is essential in interpreting and applying the principles. This fosters effective regulatory practices by clarifying expectations and responsibilities for both parties. Continuous, transparent communication allows regulators to understand the unique circumstances and challenges of the regulated parties, promoting more effective regulation. Similarly, the regulated parties gain a better understanding of regulatory expectations, leading to a more compliant and cooperative relationship. Ultimately, a constructive dialogue between regulators and the regulated parties is critical to ensure efficient and effective regulation that benefits all stakeholders.

- *Net Benefits/Efficiency:* The concept of Net Benefits/Efficiency entails assessing the monetized positive and negative impacts of various policy options to calculate the difference between benefits and costs. This can be achieved through cost-benefit analysis, which facilitates the comparison of options by answering questions such as w)hich option is likely to generate the highest net benefits? The option with the greatest net benefits is deemed the most efficient.

- *Effectiveness:* The effectiveness of regulations hinges upon adopting a results-oriented approach to their design and implementation and ensuring that they are both feasible for compliance and enforceable in practice.

- *Equity/Fair:* The *principle of equity or distributional fairness* assesses the differential impact of various options on different groups, some of which may incur more costs than others or reap greater benefits. Consequently, the equity criterion evaluates which option results in the most equitable distribution of impacts and ensures that regulatory burdens and benefits are proportionally distributed. Thus, it is critical to determine whether regulatory burdens and benefits are equitably distributed, and regulations should foster a fair and competitive economy that promotes inclusive economic growth, entrepreneurship, and innovation for the benefit of Canadians and businesses. To attain these objectives, opportunities for regulatory cooperation and the development of aligned regulations should be pursued. Ultimately, the principle of equity is vital in ensuring that

regulatory decisions and their outcomes promote fairness and equality for all stakeholders.

- *Consistency:* Consistency is crucial in regulatory practices to harmonize requirements, reduce duplication, and promote clarity. The principle of consistency fosters predictability, stability, and a level playing field for all stakeholders, making compliance easier and more effective. In summary, consistency ensures clear, coordinated, and cost-effective regulatory requirements.

- *Impact assessments:* To take advantage of the benefits of principle-based regulation, it is crucial to consider the *impact on participants*. This requires providing reasonable lead times for the industry to adjust to the new model, education and support, and the ability to rely on legacy rules during the transition period.

- *Learning Systems:* To be credible in its guidance, results evaluation, and interaction with industry, it is vital that the regulator has access to relevant and timely information. This includes methods for incorporating the experiences of those who are regulated into regulatory expectations. Therefore, the effective management of information is critical for a principle-based and outcome-oriented regulator to achieve its objectives.

- *Maintaining Control:* Requires the statutory power to promulgate rules and guidance and to be the primary interpreter of its principles. This is necessary to ensure consistency, clarity, and predictability in regulatory outcomes. By having control over the interpretation of its principles, a regulator can promote regulatory certainty, maintain public confidence, and effectively manage risks. To achieve regulatory credibility, a regulator's conduct must be reasonable, predictable, and responsive.

- *Necessity:* The *principle of necessity* entails demonstrating that regulation is justified, and continuous review is conducted to ensure regulations remain relevant. Regulatory impact analysis considers the *do nothing* option, which maintains the status quo by not implementing new or changing existing regulations. The do nothing option serves as a baseline for comparing the costs and benefits of a regulatory proposal.

- *Open/Transparency:* The *principle of transparency* is critical in regulatory decision-making as it requires the regulator to be open and accessible to the public. When making regulatory decisions, it is essential to ensure that the process is open and accessible to the public, promoting efficiency and accountability. Therefore, transparency enhances efficiency and accountability by making publicly available information.

- *Outcome oriented:* The regulator defines broad themes and interprets them in a *flexible and outcome-oriented way*. Industry input is also considered, and incoming information is managed effectively. This approach requires expertise and a more trusting and communicative relationship with industry. Providing administrative guidance is done with restraint, and notice-and-comment rulemaking is still utilized when appropriate. An outcome-oriented approach is essential in a principle-based regulatory environment, where the focus is on results rather than processes. This approach ensures that the system remains flexible and capable of learning.

- *Policy Coherence:* The *principle of policy coherence* stresses the importance of well-designed and focused policies to effectively tackle the problems they are actually intended to solve. Incoherent policies lead to ineffective regulation, highlighting the

critical role of upholding the *principle of policy coherence* in ensuring regulatory effectiveness.

- *Precautionary Principle:* The *precautionary principle* provides a decision-making framework in situations where activities pose potential risks to human health or the environment. It dictates that precautionary measures should be taken, even when the scientific evidence establishing a causal link between the activity and harm is incomplete. A full examination of all alternative courses of action, including taking *no action* must be undertaken. The aim of the precautionary principle is to ensure that decision-making in such situations is prudent and responsible.

- *Proportionality:* The *principle of proportionality* necessitates a comprehensive consultation process before implementing or amending regulations, and the resulting regulations must be clearly stated in simple language, effectively communicated, and responsive to public feedback. The *principle of proportionality* asserts that regulations should be proportionate to the risk or harm they aim to prevent. This principle underscores the significance of balancing regulatory benefits with the associated costs, preventing undue burdens on individuals or businesses.

- *Scientific/Evidence Based:* The *principle of scientific and technical* basis in regulatory decision-making mandates that decisions be grounded in the most precise and current scientific and technical information accessible. Although this principle may counter the *precautionary principle*, neither principle should override the other. Proposals and decisions must be evidence-based, incorporating comprehensive analyses of costs and benefits, as well as risk assessments.

F.2. Check Element Criteria Review

The recommended check element criteria aligns with those utilized by the federal Standing Joint Committee for the Scrutiny of Regulations (SJC). These criteria play a crucial role in enabling the SJC to discharge its mandate of ensuring that individuals entrusted with delegated legislative authority remain answerable to Parliament. Consequently, it is my recommendation to the members of PHEGRP that non-elected entities, groups, associations or provincial bodies delegated by provincial legislative authority should also be held to the same level of accountability as their federal counterparts. The following provides the reader with a brief review of what each of the 13 check element criteria evaluates:

- *Authority to Impose:* The *Authority to Impose* criterion evaluates whether a regulation, in the absence of explicit authorization in the enabling legislation, imposes a penalty such as a fine or imprisonment for non-compliance.

- *Authorization:* The *Authorization* criterion scrutinizes whether the regulation under review has been duly authorized by the enabling legislation, or if it fails to comply with a condition prescribed in the legislation.

- *Charge on Public Revenues:* The *Charge on Public Revenues* criterion evaluates whether a regulation, in the absence of explicit authorization in the enabling legislation, imposes a charge on public revenues, mandates payment to the Crown or any other authority, or specifies the amount of such payment or charge.

- *Compliance:* The *Compliance* criterion examines whether the regulation under review adheres to the [Alberta] *Regulations Act*, R-14.

- *Conformity:* The *Conformity* criterion evaluates whether the regulation under review aligns with the *Canadian Charter of Rights and Freedoms*, Canada's *Constitution Act*, and the *Alberta Bill of Rights*, A-14.

- *Drafting Defect:* The *Drafting Defect* criterion examines a regulation that includes a flaw in its drafting or requires clarification to its structure or intent, for any other reason.

- *Exclusion of the courts:* The *Exclusion of Courts* criterion pertains to a regulation that, without explicit authorization in the enabling legislation, seeks to exclude the jurisdiction of the courts, either directly or indirectly.

- *Infringement:* The *Infringement* criterion pertains to a scenario where a regulation seems to violate the rule of law, for any reason.

- *Retroactive Effect:* The *Retroactive Effect* criterion pertains to a regulation that seeks to have a retroactive effect without explicit authorization provided by the enabling legislation.

- *Substantive Legislative Power:* The *Substantive Legislative Power* criterion pertains to a regulation that constitutes the use of a substantive legislative power, which should typically be the subject of direct parliamentary enactment.

- *Trespass:* The Trespass criterion pertains to a regulation that unjustly encroaches upon an individual's rights and liberties. Note that there is a distinction between *unjustly encroaches* used in the Trespass criterion and *violation* used in the Conformity criterion. Violation conveys an explicit breach or disregard of someone's rights, whereas unjustly encroaching suggests a more implicit infringement. For example, a regulation that completely prohibits the freedom of expression would be considered a clear violation of the right to freedom of speech. On the other hand, a regulation that restricts freedom of expression within certain reasonable limits could be seen as an unjust encroachment on the right to freedom of speech, but not necessarily a blatant violation of it.

- *Unduly Dependent:* The *Undue Dependent* criterion pertains to a regulation that renders an individual's rights and liberties excessively reliant on administrative discretion or contravenes the principles of natural justice, more specifically, *audi alteram partem* (opportunity to be heard), *nemo judex in causa sua* (decision-maker must be impartial and unbiased), and *ratio decidendi* (reasons for decision).

- *Unusual Use of Power:* The *Unusual Use of Power* criterion pertains to a regulation that employs the powers granted by the enabling legislation in an unusual or unexpected manner. For example, an unusual or unexpected manner could be a regulation that allows a government agency to seize and sell private property without due process or compensation.

G. Evaluation Summary of Legislation and Subordinate Legislation

Table 2 presents a condensed overview of potential concerns that seem to arise when examining the pertinent statutes and regulations. The author acknowledges that while these elements appear to be present within the current legislative framework, it is ultimately up to the PHEGRP to determine the significance of the identified criteria or check element criteria or if they deem others to be more relevant.

Table 2. Reviewed Legislation and Potential Concerns

EMA	*Emergency Management Act*, RSA 2000, c E-6.8. *Principle-based Criteria:* Accountability, Maintaining Control, Policy Coherence *Check Element Criteria:* Infringement, Trespass
DRR	Disaster Recovery Regulation, Alta Reg 51/1994. *Principle-based Criteria:* Accountability *Check Element Criteria:* Unduly Dependent
GEMR	Government Emergency Management Regulation, Alta Reg 248/2007. *Principle-based Criteria:* Policy Coherence *Check Element Criteria:* no major concerns
LAEMR	Local Authority Emergency Management Regulation, Alta Reg 203/2018. *Principle-based Criteria*: no major concerns *Check Element Criteria:* Trespass
PHA	*Public Health Act*, RSA 2000, c P-37. *Principle-based Criteria:* Accountability, Balance, Consistency *Check Element Criteria*: Trespass, Infringement, Unusual use of Power
CDR	Communicable Diseases Regulation, Alta Reg 238/1985. *Principle-based Criteria:* Net Benefits/Efficiency, Consistency *Check Element Criteria:* Unduly Dependent, Unusual use of Power
EPR	Emergency Powers Regulation, Alta Reg 187/2009. *Principle-based Criteria:* Balance, Constructive Dialogue, Equity/Fairness, and Impact Assessment *Check Element Criteria:* Infringement, Trespass, Unusual use of Power
RHA	*Regional Health Authorities Act*, RSA 2000, c. E-10. *Principle-based Criteria:* Accountability, Net Benefits/Efficiency *Check Element Criteria:* no major concerns

II. EMERGENCY MANAGEMENT AND PUBLIC HEALTH LEGISLATION AND APPLICABLE SUBORDINATE LEGISLATION

Part II of this report covers the current emergency management and public health legislation, as well as applicable subordinate legislation. Section A of Part II provides the reader with an overview of the relevant sections of *Emergency Management Act*, the *Public Health Act*, and the *Regional Health Authorities Act*, as well, some minor discussion around certain sections that may have played a particular role during the pandemic. Each Act has a varying number of subordinate legislation (regulations) enabled under the specific statute, however, Section A only examines the regulations and specific sections that are most relevant to the objective of this report, specifically to *conduct an overview of emergency management and public health legislation (including subordinate legislation) in [Alberta] and how it was used to direct pandemic responses*. The regulations which have been identified as most relevant to the task at hand are the *Disaster Recovery Regulation*, *Government Emergency Management Regulation*, the *Local Authority Emergency Management Regulation,* the *Communicable Disease Regulation,* and the *Emergency Powers Regulation*.

Section B provides the reader with a very brief description of interrelated federal and international legislation that the reader should be aware of and take into consideration when assessing the recommendations contained in Part III of this report.

Section C provides the reader a very brief description of interprovincial agreements or memorandums of understanding that the reader should be aware of and take into consideration when assessing the recommendations contained in Part III of this report.

Section D reviews the roles and responsibilities of Alberta Health, Alberta Emergency Management Services, other government ministries, the Pan-Canadian Public Health Network Council, and the First Nations and Inuit Health Branch - Alberta Region as specified in the *Alberta Pandemic Influenza Plan* (March 2014).

Section E reviews the applicable recommendations regarding the Alberta Emergency Management Agency (September 2020) made by the Alberta Auditor General report.

Section F reviews the applicable roles and responsibilities of government departments as specified under the *Alberta's Business Continuity Guide* (2017).

Lastly, Section G reviews the applicable recommendations made by KMPG's *Review of Alberta's COVID-19 Pandemic Response* (January 2021).

A. Provincial Legislation

A.1. Emergency Management Act

The *Emergency Management Act*, RSA 2000, c. E 6.8 (EMA) empowers the Minister[18] to respond to disasters, as well as provides guidance on the different roles that the GOA and local authorities play in responding to an emergency or disaster. Pursuant to section 24(1)(b) of the EMA, a municipality (or municipality equivalent) may request additional support and resources from the GOA *without* declaring a State of Local Emergency (SOLE), however, if the municipality declares a SOLE then the local authorities have the same powers as the Minister within the municipality's boundaries.

Definitions specified in the EMA provide clarity with regard to what is *meant* under the statute by certain words, phrases, or positions. Items of particular interest have been emphasized in bold for the reader's convenience along with any necessary or applicable explanatory footnotes.

> *1(1)(b) "declaration of a state of emergency" means an order of the Lieutenant Governor in Council*[19] *under section 18.*
>
> *1(1)(c) "declaration of a state of local emergency"* [SOLE] *means a resolution or order of a local authority under section 21;*
>
> *1(1)(g.1) "Managing Director" means the person designated under section 3.1(2), and includes any person acting in the capacity of the* ***Managing Director*** [emphasis added]***;***
>
> *1(1)(h) "Minister" means the Minister determined under section 16 of the Government Organization Act as the* ***Minister responsible for this Act*** [emphasis added]*;*
>
> *1(2) For greater certainty, a reference in this Act to an order (a) made under section 19(1) or (1.1) includes an* ***order made by the Managing Director*** [emphasis added] *or any other person authorized to make that order under section 19(7), and (b) made under section 24(1)(b) includes an order made by a person authorized by a local authority to make that order under section 24(1)(c).*
>
> *1(1)(f) "emergency" means an* ***event that requires prompt co-ordination of action or special regulation of persons or property to protect the safety, health*** [emphasis added] *or welfare of people or to limit damage to property or the environment;*

The reader should make note that the position of *managing director,* as defined, is an appointed individual who is authorized to make orders pertaining to an emergency. In addition the term *emergency* is defined as an *event* that requires prompt co-ordination of action "…to protect the safety, health…of people." The definitions under the *Emergency Management Act* do not provide a clear definition of what constitutes an *event,* such as whether or not an *event* is restricted to a natural disaster (i.e., fires, floods, etc.) or if the *event* is more inclusive for health events (i.e., contagious diseases or pandemic influenza, etc.). This is important as it could result in jurisdictional overlap with other organizations, such as public health

[18] Note that in 2022 the Minister responsible for the EMA changed from Minister of Municipal Affairs to the Minister of Public Safety and Emergency Services where it currently remains as of the date of this report. See Designation and Transfer of Responsibility Regulations (Alta Reg. 214/2022).

[19] The *Lieutenant-Governor* serves in a dual capacity: first as representative of the King for all purposes of the provincial government; and secondly, as a federal officer in discharging certain functions on behalf of the federal government. The *Lieutenant Governor in Council* can exercise the powers given to it by statute, regulation or royal prerogative through Orders-in-Council.

authorities, causing issues with respect to the *principle of accountability*, *maintaining control*, and *policy coherence* (see Part I Section F.1).

According to section 3.1(1) of the EMA, the Minister who is responsible for the EMA (see the *Government Organization Act*)[20] has the authority to designate a person to act as the Managing Director of the Alberta Emergency Management Agency [AEMA]. In addition, the Minister also has the authority to appoint other individuals (as officers or employees) whom the Minister deems necessary for the administration of the AEMA. This section provides evidence of the principle of accountability, by specifying that the Managing Director of the AEMA and other officer appointments are directly linked to the responsible Minister, who in turn would be directly responsible to the Lieutenant Governor in Council.

> *3.1(1) There shall be a part of the public service of Alberta known as the "Alberta Emergency Management Agency"* [AEMA]. ***(2) The Minister shall designate a person employed in the Minister's department as the Managing Director of the Agency*** [emphasis added]. *(3) In accordance with the Public Service Act, there may be appointed officers and employees that the Minister considers are required for the administration of the business and affairs of the Agency.*

The responsibilities of the members of Executive Council[21], the Lieutenant Governor in Council, and appointed advisory committees under the EMA are set out in sections 4 and 5(1). The reader should note that the roles are to *appoint* and *advise*.

> *4 The Lieutenant Governor in Council may appoint a committee consisting of those members of the Executive Council whom the Lieutenant Governor in Council designates to* ***advise on matters relating to emergencies and disasters*** [emphasis added].

> *5(1) The Minister may* ***appoint committees*** [emphasis added] *as the Minister considers* ***necessary or desirable to assist*** [emphasis added] *the Minister, the Cabinet Committee or the Managing Director. (2) The members of committees appointed under subsection (1) who are not officers or employees of the Crown, or officers or employees of an agency of the Crown, may be paid remuneration for their services and expenses at a rate or rates fixed by the Minister.*

In addition to the role of *appointing* and *advising,* the Lieutenant Governor in Council may also make regulations for the preparation and implementation of emergency plans, as well as assessing damages and providing funding in terms of compensation and/or reimbursement of costs (section 6) . Under section 7(1) the Lieutenant Governor in Council also has the authority to deal with the GOA's right of subrogation.[22]

> *6 The Lieutenant Governor in Council may make regulations (a) assigning responsibility to departments, boards, commissions or Crown agencies* ***for the preparation or implementation of plans or arrangements or parts of plans or arrangements to deal with emergencies;*** *(b) repealed; (c) governing the* ***assessment of damage or loss caused by a disaster and the payment of compensation*** *for the damage or loss; (c.1) respecting the providing of* ***funding for the reimbursement of costs*** *incurred by local authorities and individuals in connection with measures taken to reduce or mitigate potential flood hazards, including, without limitation, regulations (i)* ***prescribing or describing the measures to be taken to reduce or mitigate potential flood hazards that are eligible for the reimbursement of costs****, and (ii) governing the procedures applicable to and the proof required for the reimbursement of costs;*

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[20] *Government Organization Act*, RSA 2000, c G-10.

[21] The Executive Council is a body of ministers of the Crown, selected by the premier, who along with the lieutenant governor, exercises the powers of the Government of Alberta.

[22] The right of subrogation is the right of the Crown to pursue the party that caused the loss to the Crown in an attempt to recover funds paid to deal with the disaster.

> *7(1) The Lieutenant Governor in Council may make regulations establishing that His Majesty in right of Alberta has a* ***right of subrogation*** [emphasis added] *with respect to (a) payments of compensation made by His Majesty in right of Alberta for damage or loss caused by a disaster, or (b) payments made by His Majesty in right of Alberta for the purpose of sharing costs incurred by a local authority in conducting emergency operations.*

Local authority emergency management is covered in sections 7.1, 9, 10(1), 11(1)-11(3), 18, 19. These sections define the role of the Lieutenant Governor in Council to *make regulations* pertaining to local authorities (municipalities and *like*-municipalities) powers, duties and functions during a state of local emergency. This includes areas of: training requirements, authorizing the establishment of emergency management agencies, appointment of emergency advisory committees, establishing local emergency plans, and conducting emergency training exercises. The Minister's role is to *review* and *approve* emergency plans, conduct surveys and studies, conduct public information programs, and make required payments and/or provide applicable/necessary grants to local authorities (or individuals/organizations) for the development and implementation of emergency plans. It is the local authorities responsibility to *appoint* an emergency advisory committee and to *advise* on emergency plans and programs. It is important for the reader to note it is the authorized emergency management agency that *acts* as the local authorities agent to *exercise* powers and duties under the Act (section 11.2(1)).

> *7.1 The Lieutenant Governor in Council may make regulations (a) respecting the powers, duties and functions of local authorities under this Act; (b) respecting the* ***establishment of emergency advisory committees*** [emphasis added] *referred to in section 11.1, including the duties and functions of the committees; (c) respecting the* ***establishment of emergency management agencies*** [emphasis added] *referred to in section 11.2 including the duties and functions of the agencies; (d) respecting the delegation of a local authority's powers or duties under this Act and the regulations; (e) respecting* ***training requirements for persons designated by the regulations*** [emphasis added]*; (f) respecting the preparation, approval, maintenance and co-ordination of local emergency plans and programs; (g) respecting the* ***conduct of exercises relating to emergency plans*** [emphasis added].

> *9 The Minister may (a)* ***review and approve or require the modification*** [emphasis added] *of provincial and municipal emergency plans and programs; (b)* ***enter into agreements*** [emphasis added] *with the Government of Canada or of any other province or territory or any agency of such a government, dealing with the emergency plans or programs; (c)* ***make surveys and studies*** [emphasis added] *to identify and record actual and potential hazards that may cause emergencies; (e)* ***make payments and grants*** [emphasis added]*, subject to any terms or conditions that the Minister may prescribe, to local authorities for the purposes of assisting in emergency preparedness and the provision of public safety programs; (f)* ***enter into agreements with and make payments or grants, or both, to persons or organizations for the provision of services in the development or implementation of emergency plans or programs*** [emphasis added]*; (g)* ***conduct public information programs*** [emphasis added] *relating to emergency preparedness for the mitigation of disasters.*

> *10(1) The Minister may, by order, (a) divide Alberta into various subdivisions for the purpose of organizing integrated emergency planning, training, assistance and emergency operations programs; (b) require local authorities of those municipalities located with in a subdivision referred to in clause (a)* ***to prepare integrated plans, procedures and mutual assistance programs to deal with emergencies and to submit them to the Managing Director for review*** [emphasis added]*; (c)* ***establish procedures required for the prompt and efficient implementation of plans and programs to meet emergencies*** [emphasis added]*; (d) require a person to whom the order is directed and (i) who is engaged or may be engaged in any operation, (ii) who is utilizing or may be utilizing any process, (iii) who is using any property in any manner, or (iv) on whose real property there exists or may exist any condition, that may be or may create a hazard to persons or*

property, whether independently or as a result of some other event, to develop plans and programs in conjunction with one or more local authorities to remedy or alleviate the hazard and to meet any emergency that might arise from the hazard. (2) ***The Regulations Act does not apply to an order made under subsection (1)*** [emphasis added].

11 A local authority (a) ***shall, at all times, be responsible for the direction and control of the local authority's emergency response unless the Government assumes direction and control under section 19(5.1) or 22(3.1)*** [emphasis added]*; (b) shall approve emergency plans and programs, subject to the regulations; (c) may enter into agreements with and make payments or grants, or both, to persons or organizations for the provision of services in the development or implementation of emergency plans or programs.*

11.1(1) A local authority shall appoint, subject to the regulations, an emergency advisory committee consisting of a member or members of the local authority or, in the case of an improvement district, a special area or a national park, a person or person the local authority designates, ***to advise on the development of emergency plans and programs*** [emphasis added]*, and to exercise any powers delegated to the committee under section 11.3(1)(a).*

11.2(1) A local authority shall establish and maintain, subject to the regulations, an emergency management agency to act as the agent of the local authority in exercising the local authority's powers and duties under this Act [emphasis added]. ***(2) There shall be a director of the emergency management agency, who shall (a) prepare and co-ordinate emergency plans and programs for the municipality, (b) act as a director of emergency operations on behalf of the emergency management agency, (c) co-ordinate all emergency services and other resources used in an emergency, and (d) perform other duties as prescribed by the local authority*** [emphasis added]. *(3) A local authority, except an improvement district, special area, national park or Indian reserve, may by bylaw that is not advertised borrow, levy, appropriate and expend all sums required for the operation of the emergency management agency. (4) For greater certainty, an emergency management agency may be maintained by and may act as the agent of more than one local authority.*

11.3(1) A local authority may delegate some or all of the local authority's powers or duties under this Act [emphasis added] *to (a) a committee composed of a member or members of the local authority, including an emergency advisory committee appointed under section 11.1(1), and (b) subject to the regulations, one or more of the following: (i) a regional services commission established under the Municipal Government Act representing 2 or more local authorities if the regional services commission is authorized by it bylaws to exercise that power or duty; (ii) if authorized by order of the Minister, a joint committee representing 2 or more local authorities that is composed of one or more members appointed by each of the local authorities; (iii) in the case of a summer village and if authorized by order of the Minister, another local authority. (1.1) Where, under subsection (1)(b)(iii), a summer village has delegated its power or duties under this Act to a local authority, the local authority may sub delegate those powers or duties to a committee composed of a member or members of that local authority, including an emergency advisory committee appointed under section 11.1(1). (2) Despite sections 21(1) and 23(1), a delegate of a local authority under subsection (1) that declares or terminates a local state of emergency shall do so by resolution*.

During the COVID-19 pandemic there was considerable discourse with respect to the infringement of Albertans' rights.[23] Members of PHEGRP have also expressed questions with respect to Albertans' rights and freedoms under emergency governance. Section 18(5.1)(b) specifies that the EMA takes priority and

[23] Examples can be found many online articles such as: Kost, Hannah "The Charter of Rights and Freedoms vs. vaccine mandates–and government inaction on COVID" CBC, Oct 3, 2021; Johnson, Lisa, "Stronger COVID-19 restrictions in Alberta not forbidden by the Charter: legal experts", Nov 25, 2020; Martin, Kevin, "Rights were violated for the greater good, Hinshaw tells court", *Calgary Sun*, April 6, 2022.

prevails over any conflicts between the EMA (and its regulations) with any other regulation or Act. However, the reader should note that there is an *exception* to this priority when it comes to the Alberta *Bill of Rights* and/or the Alberta *Human Rights Act* (and related regulations). Section 18(5.1) meets the check element criteria of *Trespass,* in that it contains a specific section outlining the priority between actions under the Act and individual's rights and liberties (see Part I Section F.2).

> *18(1)* ***The Lieutenant Governor in Council may, at any time when the Lieutenant Governor in Council is satisfied that an emergency exists or may exist, make an order for a declaration of a state of emergency relating to all or any part of Alberta.*** *(2) A declaration of a state of emergency under subsection (1) must identify the nature of the emergency and the area of Alberta in which it exists. (3) Immediately after the making of an order for a declaration of a state emergency, the Minister shall cause the details of the declaration to be published by any means of communication that the Minister considers is most likely to make known to the majority of the population of the area affected the contents of the declaration. (4) Unless continued by a resolution of the Legislative Assembly, an order under subsection (1) expires at the earlier of the following: (a) at the end of 28 days, but if the order is in respect of a pandemic, at the end of 90 days; (b) when the order is terminated by the Lieutenant Governor in Council. (5) repealed, (5.1) Unless otherwise provided for in the order for a declaration of a state of emergency, where (a) an order for a declaration of a state of emergency is made and (b)* ***there is a conflict between this Act or regulation, other than the Alberta Bill of Rights or the Alberta Human Rights Act or a regulation made under either of those Acts, during the time that the order is in effect, this Act and the regulations made under this Act shall prevail in Alberta or that part of Alberta in respect of which the order was made.*** *(6) The Regulations Act does not apply to an order made under subsection (1).*

Section 19(1) authorizes the Lieutenant Governor in Council may make orders relating to a variety of issues and the Minister may *authorize* the Managing Director, (or another person) who is charged with the responsibility to co-ordinate and implement the emergency plan and to have control and direction over all persons and agencies involved in the implementation. Section 19(1) establishes a clear line of authority and *accountability* at the local emergency management level, that is, Lieutenant Governor in Council→Minister→Managing Director→emergency worker.

> *19(1) On making of the declaration and for the duration of the state of emergency,* ***the Minister may do all acts and take all necessary proceedings including the following:*** [emphasis added] *(a) put into operation an emergency plan or program; (b) authorize or require a local authority to put into effect an emergency plan or program for the municipality; (c) acquire or utilize any real or personal property considered necessary to prevent, combat or alleviate the effects of an emergency or disaster; (d) authorize or require or make an order to authorize or require any qualified person to render aid of a type the person is qualified to provide; (e) control or prohibit or make an order to control or prohibit travel to or from any area in Alberta; (f) provide for or make an order to provide for the restoration of essential facilitates and the distribution of essential supplies and provide, maintain and co-ordinate emergency medical, welfare and other essential services in any part of Alberta; (g) order the evacuation of persons and the removal of livestock and personal property from any area of Alberta that is or may be affected by a disaster and make arrangements for the adequate care and protection of those persons or livestock and of the personal property; (h) authorize the entry into any building or on any land, without warrant, by any person in the course of implementing an emergency plan or program; (i) cause the demolition or removal of any trees, structures or crops if the demolition or removal is necessary or appropriate in order to reach the scene of a disaster, or to attempt to forestall its occurence or to combat its progress; (j) procure or fix prices or make an order to procure or fix prices for food, clothing, fuel, equipment, medical supplies, or other essential supplies and the use of any property, services, resources or equipment within any part of Alberta for the duration of the state of emergency; (k) authorize the conscription or make an order for the conscription of persons needed to meet an emergency. (1.1) In addition to any other orders the Minister is authorized to make under this Act, the Minister may make any order necessary, in the Minister's opinion, to lessen the impact of the emergency. (2) As*

> *it relates to the acquisition of real property, subsection (1)(c) does not apply to real property located within a national park or an Indian reserve. (3) If the Minister acquires or utilizes real or personal property under subsection (1) or if any real or personal property is damaged or destroyed due to an action of the Minister in preventing, combating or alleviating the effects of an emergency or disaster, the Minister shall cause compensation to be paid for it. (4)* ***The Lieutenant Governor in Council may make regulations in respect of any matter mentioned in subsection (1)****. (5) Subject to subsection (5.1), on the making of an order under section 18(1) respecting an emergency in respect of which a state of local emergency has been declared, the local authority is responsible in the municipality for the co-ordination and implementation of the necessary plans or programs prepared pursuant to this Act.* ***(5.1) If the Minister authorizes the Managing Director or another person under subsection (6), the Managing Director or the other person authorized by the Minister is responsible for the co-ordination and implementation of the necessary plans or programs prepared pursuant to this Act and all persons and agencies involved in the implementation are subject to the control and direction of the Managing Director of the other authorized person*** [emphasis added]. *(7) On the making of an order under section 18(1), the Minister may, by order, authorize the Managing Director or any other person to exercise some or all of the powers given to the Minister under subsection (1) or (1.1). (8) The Regulations Act does not apply to an order made under subsection (1)(d), (e), (f), (g), (j), or (k) or (1.1).*

While section 19(1) meets the *principle of accountability,* sections 27, 28, and 29 circumvent the process of accountability by providing immunity from an action against the Minister, local authority, search and rescue organization or *any person* from *anything done* or *failure to do* when acting under authorization of these positions.

> *27* ***No action lies against the Minister or a person acting under the Minister's direction or authorization for anything done or omitted to be done*** [emphasis added] *in good faith while carrying out a power or duty under this Act or the regulations, including a power or duty under section 19(1)(d), (e), (f), (g), (j) or (k) or (1.1) or 19.1 of this Act.*
>
> *28* ***No action lies against a local authority or a person acting under the local authority's direction or authorization for anything done or omitted to be done*** [emphasis added] *in good faith while carrying out a power or duty under this Act or the regulations including a power or duty under section 19(1)(d), (e), (f), (g), (j) or (k) or 19.1 or the exercise of the powers under section 24(1)(b) of this Act, during a state of local emergency.*
>
> *29* ***No action in negligence lies against a search and rescue organization, the directors of that organization or a person acting under the direction of that organization or a person acting under the direction or authorization of that organization for anything done or omitted to be done*** [emphasis added] *in good faith while acting under an agreement between that organization and the Minister*.

Overall the EMA appears to provide clear direction as to the role of the participants with respect to a local emergency, however, it seems less clear with respect to roles during a province-wide emergency. It appears that in both situations, provincial and local emergencies, the role of the Lieutenant Governor in Council is to *appoint*, *make regulations,* and deal with financial issues. The Minister's role is to *appoint, advise, and ensure* that there is an emergency plan in place, while the role of the Managing Director is to *implement* and *manage* the emergency plan. The reader should note there appears nothing within the EMA to suggest a more *hands-on* role for the Lieutenant Governor in Council or a Minister, rather it does appear to be clear about restricting their roles to *advising* and *appointing*.

A.1(i). Disaster Recovery Regulation (AR 51/1994)

The *Disaster Recovery Regulation* (AR 51/1994) (DRR) defines the obligations and protocols related to disaster recovery. This regulation, enabled under the EMA, establishes the framework for the Disaster

Recovery Program (DRP). The DRP provides financial aid to individuals, businesses, and municipalities affected by emergencies, such as floods, wildfires, and *other* disasters. DRP is to assist impacted communities that are recovering from disasters in re-establishing economic stability. The DRR outlines eligibility requirements for disaster recovery assistance, the types of losses that are covered, and the claims procedure. DRR specifies the roles and responsibilities of the various positions that are involved in disaster recovery, including the GOA, municipalities, and the individuals affected by the disaster.

The definitions, particularly with respect to the position of Director of the Recovery Branch, provide a further insight for the reader with respect to the roles that different individuals play during an emergency. The role of the Minister under the DRR is one of oversight, specifically, in terms of *approval* and *establishing guidelines* related to *assessing* damages, and *adjudicating* the amounts of compensation. Section 4(3) defines the role of a *Director* (the Director of the Recovery Branch) is to be responsible for the *administration* of the program.

> *1(b) "Director" means the Director of the Disaster Recovery Branch of the Alberta Public Safety Services Agency;*
>
> *1(c) "disaster recovery program" means a* ***program of the Government of Alberta intended to respond to the needs of a large number of people, businesses, or municipalities affected by a disaster*** [emphasis added] *or to restore the operations of the Government of Alberta affected by a disaster;*
>
> *2 The Minister may* ***establish guidelines*** *that (a) govern the* ***assessment of damage or loss caused by a disaster*** [emphasis added]*, (b) govern what damage or loss caused by a disaster or costs incurred in emergency operations* ***may be compensated*** [emphasis added]*, and (c) establish limits on the* ***amount of compensation*** [emphasis added] *that may be provided to an applicant.*
>
> *4(1) The Minister may approve a disaster recovery program in respect of a disaster if the Minister is satisfied that (a) the disaster has caused widespread damage to property, and (b) the cause of the disaster was extraordinary. (2) A disaster recovery program may include (a)* ***terms and conditions for providing compensation*** [emphasis added]*, (b) the forms in which the compensation may be provided, and (c) special provisions dealing with the assessment of damage and loss. (3) The* ***Managing Director is responsible for the administration of a disaster recovery program*** [emphasis added] *in respect of a widespread disaster.*

Section 8(1) provides for an appeal process where there is disagreement with the Director's decision. The decision is reviewable by the Minister. This appeal process meets the principle-based criteria of *accountability* and provides those affected by the Director's decision with an avenue of appeal.

> *8(1) An applicant who receives the Managing Director's notice referred to in section 5(4), 6(4) or 7(4)* ***may appeal the decision of the Managing Director set out in the notice to the Minister*** [emphasis added].

Overall, the DRR is geared towards management after a disaster; it emphasizes that the Managing Director is responsible for the administration of the DRP and the Minister's role is establishing the guidelines which the Director needs to follow when performing his duties. Note that there is no appellate process set out under the regulation for the Ministerial decisions which may cause a check element criteria concern regarding *Unduly Dependent*.

A.1(ii). Government Emergency Management Regulation (AR 248/2007)

The *Government Emergency Management Regulation* (AR 248/2007) (GEMR) provides a framework for emergency management in the Province of Alberta and establishes the roles and responsibilities of

various organizations and individuals involved in emergency response. The GEMR also sets out a number of requirements for emergency management in Alberta including: the establishment of an Emergency Management Agency (i.e., AEMA) and for it to *coordinate* the emergency response efforts of the GOA; the creation of an *Emergency Management Plan* for the province (the *Alberta Emergency Plan*) which outlines the procedures and protocols for responding to emergencies; the establishment of Emergency Operations Centers (EOCs) to coordinate emergency response efforts during a crisis; and the requirement for municipalities and other organizations to develop their own emergency management plans, and *procedures for declaring* a state of emergency.

The GEMR was designed to ensure that Alberta is prepared to respond *effectively* to emergencies and disasters of *all kinds*. The regulation provides the framework for coordinated emergency management and establishes clear roles and responsibilities for all parties involved.

Definitions under the GEMR provide clarity to what is meant by certain words (or positions) under this Regulation and assists the reader in understanding the roles and responsibilities of a variety of different agencies and positions, as well as definitions on a variety of different plans addressed in the GEMR (e.g., Alberta Emergency Plan, business continuity plan, consequence management plan, department plan, emergency plans, Government plans, and hazard-specific plans).

An important definition which the reader should note is that of *Emergency Management*, under the GEMR it is defined to include *all hazards*. Unlike the word *events* under the EMA, the GEMR does provide a definition of *hazards* to mean "a potentially damaging physical event, phenomenon or human activity that may cause the loss of life or injury, property damage, social and economic disruption or environmental degradation."

> *"Agency" means the Alberta Emergency Management Agency;*
>
> *"Alberta Emergency Plan" means the plan referred to in Section 2(1)(c);*
>
> *"Business continuity plan" means, with respect to a business disruption, a plan through which (i) essential services will be prioritized, (ii) mitigation measures are employed, and (iii) continuity of service strategies are co-ordinated and implemented;*
>
> *"Consequence management plan" means a plan that set out actions to be taken for mitigation, preparedness, response and recovery with regard to emergencies, including human-induced intentional threats;*
>
> *"Department" means (i) a department of the Government established under the Government Organization Act, (ii) the Office of the Public Service Commission, and (iii) the Agency;*
>
> *"Department plans" means business continuity plans and consequence management plans and any additional plans required by a responsible Minister under section 2(1)(f)(i),*
>
> *"Deputy head" means (i) the deputy minister of a department referred to in clause f(i)*
>
> *"Emergency management" means the* ***management of emergencies concerning all hazards*** [emphasis added]*, including all activities and risk management measures related to prevention and mitigation, preparedness, response and recovery;*
>
> *"Emergency management partners" means those persons or organizations that have a role in Alberta's emergency management systems;*

"Emergency management system" means the elements required for effective emergency management, including legislative, regulatory and policy frameworks, emergency plans and procedures and the involvement of emergency management partners;

"Emergency plans" means the following plans: (i) Government plans; (ii) department plans; (iii) municipal plans;

"Government plans" means the following plans: (i) the Alberta Emergency Plan, (ii) hazard-specific plans; (iii) the Government of Alberta Business Continuity Plan referred to in section 2(1)(d);

"Hazard-specific plan" means ***a plan that sets out actions for mitigation of a specific hazard*** [emphasis added] *and preparedness, response and recovery activities with regard to an emergency caused by that hazard;*

"Responsible Minister" means (i) the Minister responsible for this Regulation, and (ii) the Minister responsible for the plan referred to in section 2(1)(g).

The responsibilities of the AEMA are set out in section 2. The GEMR mandates that the AEMA is to be the *coordinating* agency and to provide strategic policy direction *to* the GOA and its emergency management partners. The AEMA is responsible for the training of employees of the GOA, municipal employees and elected officials who have responsibilities under GEMR. In addition, the AEMA must operate a provincial facility that facilitates the coordination of the Government's response to emergencies and disasters.

2(1) ***The Agency shall (a) be the co-ordinating agency for, and provide strategic policy direction and leadership to the Government and its emergency management partners*** [emphasis added]*, (b) develop, implement, manage and maintain the Alberta emergency management system as described in the Alberta Emergency Plan; (c) in consultation with departments and emergency management partners, develop, implement and maintain a comprehensive plan to be known as the 'Alberta Emergency Plan', which shall include (i) a description of the Alberta emergency management system; (ii) the Government of Alberta Business Continuity Plan and any hazard-specific plan required under clause (e); (iii) the roles and responsibilities of departments and emergency management partners, (A) generally in the Alberta emergency management systems, and (B) specifically in the preparation, implementation and maintenance of plans required by departments and local authorities, and (iv) the procedures for the co-ordination of emergencies. (d) in consultation with departments, develop, implement and maintain a business continuity plan to be known as the Government of Alberta Business Continuity Plan, (e) in consultation with one or more departments, co-ordinate the development of hazard-specific plans to be implemented and maintained under the responsibility of one or more of those departments, (f) co-ordinate with departments (i) to prepare, implement and maintain, in accordance with the Government plans, consequence management plans, business continuity plans and any other plans required by a responsible Minister, and (ii) ro review the effectiveness of the plans referred to in subclause (i) based on (A) identified exercise objectives for a simulated emergency; or (B) the lessons-learned evaluation criteria established for a real emergency, (f.1) require departments, in consultation with the Agency, to carry out the functions and responsibilities set out in the Alberta Emergency Plan. (g) repealed, (h) establish mutual aid arrangements and maintain liaison with (i) the departments, agencies, boards, commissions and Crown corporations of the governments of the provinces and territories and of Canada, (ii) the State of Montana and its agencies, and (iii) other provincial, national, international or regional organizations involved in emergency management, (i) assist local authorities in the preparation, implementation and maintenance of their municipal plans, (j)* ***conduct or facilitate training for employees of the Government or of municipalities or for other persons who have functions and responsibilities under this Regulation,*** *(k)* ***operate a provincial facility that facilitates the co-ordination of the Government's response to emergencies and disasters*** [emphasis added]***,*** *and (l) maintain or*

> *support the provision of a public alerting system that is available across Alberta. 2(1.1) The Agency may establish training guidelines for business continuity and consequence management training as set out in the Alberta Emergency Plan. 2(2) Nothing in subsection (1) affects the responsibilities that local authorities, departments or agencies, boards, commissions and Crown corporations may have in respect of emergency plans under other legislation.*

Each government department is responsible for having a prepared and maintained *department emergency plan* and are responsible to implement such a plan in the event of an emergency. Section 3 specifies that the department emergency plans need to be reviewed for its effectiveness against the Alberta Emergency Plan. The deputy minister of a department, under section 4, has the responsibility to ensure that the department carries out the specified duties under the GEMR and the *Alberta Emergency Plan*.

> *3(1) The functions and responsibilities of departments in respect of emergency management are those set out in this Regulation and the Alberta Emergency Plan. (2)* ***Each department must prepare, implement and maintain plans, including reviewing the effectiveness of the plans, as required under section 2 and the Alberta Emergency Plan.*** [emphasis added] *(3) A department may require an agency, board, commission or Crown corporation that reports to the Minister of the department to prepare, implement and maintain emergency plans for that agency, board, commission or Crown corporation. (4) Each department, where it is required to meet its responsibilities under this Regulation and the Alberta Emergency Plan, may establish mutual aid arrangements and liaison with (a) the departments, agencies, boards, commissions, and Crown corporations of the Government of Canada or a province or territory of Canada, (b) the State of Montana and its agencies and (c) other provincial, national, federal and international organizations involved in emergency management.*
>
> *4* ***The deputy head of a department is responsible for ensuring that the department's functions and responsibilities under this Regulation*** [emphasis added] *and the Alberta Emergency Plan are properly carried out including (a) the* ***appointing of appropriately trained and qualified persons in accordance with the Alberta Emergency Plan*** [emphasis added]*,and (b) approving the plans referred to in section 3(2) and the Alberta Emergency Plan.*

Overall, the GEMR defines that the AEMA[24] shall *coordinate* the government's emergency response for *all hazards* in accordance with clauses set out in the GEMR and those responsibilities assigned under the *Alberta Emergency Plan*.[25] The reader should note that while conducting the research for this report, I was unable to locate the Alberta Emergency Plan in effect in 2019.

A.1(iii). Local Authority Emergency Management Regulation (AR 203/2018)

The *Local Authority Emergency Management Regulation* (AR 203/2018) (LAEMR) specifies the role and responsibilities of local authorities in handling emergency situations within their respective jurisdictions. This regulation requires all local authorities (municipalities), Indigenous communities, and regional authorities to develop emergency management plans and protocols to ensure preparedness and to have the ability to respond to and recover from emergencies that *may arise* within their jurisdiction. LAEMR

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[24] The Managing Director of the AEMA between June 2013 and August 2020 was Shane Schreiber. PHEGRP may wish to speak to Mr. Schreiber in order to gain a deeper understanding of the role, historically, the AEMA played with respect to emergency management in Alberta. Currently, Mr. Schreiber serves as the Assistant Deputy Minister for Parks (Government of Alberta). PHEGRP may also wish to speak to Sonya Perkins, former Emergency Management Officer with AEMA, for more "real life" historical context of how the AEMA played a role in emergency management in Alberta. Ms. Perkins currently serves as the Provincial Director, Emergency Management Accommodations and Security Services.

[25] Schrieber, Shane. "Emergency Management in Alberta." Presentation Nov 2014. https://www.alberta.ca/assets/documents/ma-emergency-management-in-alberta-making-communities-more-resilient.pdf.

specifies the protocols for *requesting* and *receiving* assistance from the Province, as well as *coordinating* response efforts between local authorities and provincial agencies. LAEMR provides the framework for devising plans and other critical elements, such as *risk evaluations*, *emergency response strategies*, and *communication plans.* The role of the responsible Minister (see the *Government Organization Act*) for LAEMR is to provide *guidance* and *support* to local authorities in their emergency management planning and response activities.

Section 2 requires the local authority to appoint an emergency advisory committee and to specify the *purpose of the committee* during an emergency/disaster. The emergency advisory committee's role is to provide *guidance* and *direction* to the local authorities established emergency management agency.

> *2(1) A local authority shall* ***appoint an emergency advisory committee*** [emphasis added] *by (a) bylaw, if the local authority is a municipal council, the settlement council of a Metis settlement, or the bank council of an Indian band, or (b) order, if the local authority is the Minister responsible for the Municipal Government Act, the Minister responsible for the Special Areas Act, or a park superintendent of a national park or a superintendent's delegate. (2) The bylaw or* ***order must set out the purposes of the committee, both during an emergency or disaster and when those events are not occurring****, (b)* ***establish that the committee provides guidance and direction*** [emphasis added] *to the local authority' emergency management agency, (c) establish procedures that must be followed when declaring a state of local emergency, (d) identify the committee's membership and Chair by title or position, (e) set out a minimum meeting frequency for the committee, which must be at least once per year, and (f) outline committee quorum and procedural requirements for decision making unless these requirements are set out in another local authority bylaw. (3) The bylaw or order must be enacted or made and in effect on or before the date when this Regulation comes into force or, if an entity becomes a local authority under the Act after that date, within one year of the entity becoming a local authority.*

The local authority must establish an emergency management agency and specify the responsibilities of such agency. In addition, the local authorities must appoint a director that is responsible for the *management* of the emergency management agency. Section 3(1) of the LAEMR specifies that the "[emergency] agency is responsible for the administration of the local authority's emergency management program."

> *3(1) A local authority shall establish the local authority's emergency management agency by (a) bylaw, if the local authority is a municipal council, the settlement council of a Metis settlement, or the band council of an Indian band, or (b) order, if the local authority is the Minister responsible for the Municipal Government Act, the Minister responsible for the Special Areas Act, or a park superintendent of a national park or a superintendent's delegate.* ***(2) The bylaw or order must (a) set out the responsibilities of the agency, (b) appoint a person as the director of emergency management, or state that a person who holds a specified title or position is appointed as the director of emergency management by virtue of holding that title or position, (c) state that the agency is responsible for the administration of the local authority's emergency management program, (d) identify the frequency at which the agency must report to the emergency advisory committee to provide updates on agency activities, which must be at least once per year and must include an update on the agency's review of the local authority's emergency plan, (e) state that a command, control and coordination system prescribed by the Managing Director of the Alberta Emergency Management Agency will be used by the local authority's emergency management agency*** [emphasis added]***,*** *and (f) indicate if an agency is acting as the agent of more than one local authority, which local authorities the agency is acting as an agent for. (3) The Managing Director of the Alberta Emergency Management Agency shall prescribe the command, control and coordination system referred to in subsection (2)(e) by posting notice of the incident command, control and coordination system to the Alberta Emergency Management Agency's website. (4) The bylaw or order must be enacted or made and in effect on or before the date when*

> *this Regulation come into force or, if an entity becomes a local authority under the Act after that date, within one year of the entity becoming a local authority.*

Section 4(i) specifies that the designated roles and responsibilities for the local authority, its employees, and the *elected* officials during an emergency, must be contained in the *mandatory* local emergency plan.

> *4 A local authority's emergency plan must include (a) a description of the administration of the local authority's emergency management program, (b) the procedures for implementing the emergency plan during an emergency or exercise response, (c) the local authority's plan for preparedness, response and recovery activities, (d) a hazard and risk assessment, (e) emergency management program exercises that the local authority will engage in, (f) the local authority emergency management agency's plan for regular review and maintenance of the local authority's emergency plan, (g) the local authority emergency management agency's plan for the review and maintenance of the local authority's emergency plan after an exercise, emergency or disaster, (h) how the command, control and coordination system prescribed by section 3(3) will be used by the local authority's emergency management agency, (i)* ***the assignment of responsibilities to local authority employees and elected officials, by position, respecting the implementation of the local authority's emergency plan*** [emphasis added]*, (j) a training plan for staff assigned with responsibilities under the local authority's emergency plan, (k) the mechanism that will be used to prepare and maintain an emergency management staff contact list for employees and elected officials who have been assigned responsibilities respecting the implementation of the local authority's emergency plan, (l) the local authority's plan for communications, public alerts and notifications during exercises, emergencies and disasters, and (m) the local authority's plan for providing emergency social services during an emergency or disaster.*

The local authority's emergency management agency is required to review the local authorities emergency plan at least once per year and ensure such a plan must be made available to the AEMA for review and for comment (section 5). Furthermore, under section 6 the local emergency management agency must engage in at least one exercise per year where participants need to identify a possible emergency/disaster scenario and discuss how it will respond. Following the exercise, the local emergency management agency will implement any necessary changes required to resolve any emergency management issues that may have arisen.

> *5(1) A local authority's emergency management agency must review the emergency plan that applies to that local authority at least once per year. (2)* ***A local authority's emergency management agency must make the emergency plan that applies to that local authority available to the Alberta Emergency Management Agency for review and comment annually*** [emphasis added]. *(3) In the case of a summer village that has been delegated the summer village's duties relating to the maintenance of an emergency plan to another local authority, that other local authority's emergency management agency is responsible for complying with subsections (1) and (2).*

> *6(1) Unless an exercise under subsection (2) is carried out that year, a* ***local authority's emergency management agency must engage in at least one exercise per year in which participants identify a significant possible emergency or disaster scenario and discuss how the local authority would respond to and resolve emergency management issues that may arise from the scenario*** [emphasis added]. *(2) A local authority's emergency management agency must engage in at least one exercise every 4 years in which participants identify a significant possible emergency or disaster scenario and carry out actions if the significant emergency or disaster was actually occurring, but without deploying personnel or other resources. (3) Subsection (2) does not apply to a local authority emergency management agency that has responded to an emergency or disaster within the previous 4 years that resulted in the implementation of the local authority's emergency plan and a written post-incident assessment that included observations and recommendations for improvement and corrective action being conducted. (4) A local authority emergency management agency may fulfill the obligations set out in the subsection (1) and (2) by*

> *participating in regional emergency exercises that require the local authority to utilize relevant portions of the local authority's emergency plan. (5) A local authority emergency management agency must submit an exercise notification to the Alberta Emergency Management Agency 90 days before engaging in the exercise required by subsection (2). (6) The exercise notification must outline the exercise scenario, state the exercise objectives, identify the participants and state the date the exercise will be conducted.*

The Managing Director of the AEMA, under section 8, 9 of the LAEMR, is authorized to prescribe mandatory training courses for the elected officials of local authorities. Such mandatory training must be completed by elected officials within 90 days of being elected. In addition, the AEMA may prescribe similar training courses for any local authority employees who have or will have duties and responsibilities in the local authority's emergency plan. Employee training must be completed within 6 months of being assigned such duties or responsibilities. However, the reader should note that section 8(6) explicitly states that such training "...does not apply to the Minister…or to any other Minister."

> *8(1) The* ***Managing Director of the Alberta Emergency Management Agency*** **[AEMA]** ***may prescribe courses that each of the local authority's elected officials must complete by posting notice of the courses on the Alberta Emergency Management Agency's website*** [emphasis added]. *(2) Any courses that are prescribed under subsection (1) must be completed (a) within 90 days of the elected official taking an official oath as required by section 156 of the Municipal Government Act or section 23 of the Metis Settlements Act, as the case may be, or within one year of this Regulation coming into force, whichever is later, or (b) within 90 days of the councillor of an Indian band assuming office, or within one year of this Regulation coming into force, whichever is later, in the case of an Indian band that is a local authority under the Act. (3) In the case of an improvement district for which a council has been established, each councillor shall take any courses prescribed under subsection (1) within 90 days of the councillor being appointed to the council, or within one year of this Regulation coming into force, whichever is later. (4) In the case of an improvement district for which a council has not been established, each person to whom the Minister has delegated powers or duties under the Act as a local authority for that improvement district shall take any courses prescribed under subsection (1) within 90 days of the person being delegated those powers or duties, or within one year of this Regulation coming into force, whichever is later. (5) Each of the members of the Special Areas Board shall take any courses prescribed under subsection (1) within 90 days of being appointed to the Board, or within one year of this Regulation coming into force, whichever is later. (6) For greater certainty,* ***this section does not apply to the Minister responsible for the Municipal Government Act or the Minister responsible for the Special Areas Act, or to any other Minister*** [emphasis added].
>
> *11(1) The* ***Managing Director of the Alberta Emergency Management Agency may prescribe courses that each employee who has been assigned responsibilities respecting the implementation of the local authority's emergency plan must complete*** [emphasis added] *by posting notice of the courses on the Alberta Emergency Management Agency's website. (2) Any courses prescribed under subsection (1) must be completed within 6 months of the employee being identified for a role in the local authority's emergency plan.*
>
> *14 A* ***local authority may delegate any of the powers or duties out in this Regulation to (a) a committee composed of a member or members of the local authority, including an emergency advisory committee*** [emphasis added], *(b) a regional services commission established under the Municipal Government Act representing 2 or more local authorities if the regional services commission is authorized in its establishing regulation to exercise that power of duty. (c) if authorized by ministerial order, a joint committee representing 2 or more local authorities that is composed of one or more members appointed by each of the local authorities, or (d) in the case of a summer village and if authorized by ministerial order, another local authority.*

Recall that the scope of this report is provincial and is to recommend legislative changes for the governance of emergencies at the provincial level. The reader may take away that the LAEMR appears to

be much more developed than the process at the province level. Furthermore, it is important to point out that under the LAEMR the local authorities emergency agency is responsible for *implementing* municipal emergency plans, while the elected officials and employees of the local authorities have pre-assigned roles and responsibilities under the municipal emergency plan. The most salient point is the mandatory training of the local authorities' elected officials and staff who have roles and responsibilities in the event of an emergency, while training courses for provincial elected officials and staff is not required.

A.2. Public Health Act

The primary powers and tools available to prevent, treat, and control public health emergencies, including pandemic influenza in Alberta, are set out in the *Public Health Act*, RSA 2000, c. P-37 (PHA).[26] These powers are allocated across several key positions, including the Lieutenant Governor in Council,[27] the Minister of Health,[28] other Ministers, the Chief Medical Officer of Health (CMOH), medical officers of health (MOHs),[29] and regional Health Authorities.[30] Working together with complementary powers, these different positions are to manage public health issues and emergencies in the public's interest. Although at the time of this report, there were nineteen regulations enabled under the *Public Health Act,* only two pertain to the scope of this report, specifically, the *Communicable Diseases Regulation* (AR 238/1985) and the *Emergency Powers Regulation* (AR 187/2009).

Most of the applicable sections to this report fall under Part 3 of the PHA. These sections cover communicable diseases and public health emergencies (sections 18.3–66). However, there are five other sections that are outside of this range, specifically, 1.1.hh.1, 9, 12.1(2), 13(1), 16. These sections provide definitions, position descriptions, and define services by individuals.

> *1.1.hh.1. "Public health emergency" means an occurrence or threat of (i) an illness. (ii) a health condition. (iii)* ***an epidemic or pandemic*** [emphasis added]*. (iv) a novel or highly infectious agent or radioactive material that poses a significant risk to the public health;*
>
> *9(1) A regional health authority shall appoint one or more persons as medical officers of health and one or more persons as executive officers for the regional health authority for the purposes of carrying out this Act and the regulations. (2)* ***The Minister may appoint one or more persons as medical officers of health for a regional health authority if the Minister is of the opinion that the number of medical officers of health*** **[MOH]** ***appointed by the regional health authority is insufficient*** [emphasis added]*. (3) A person who is appointed as a medical officer of health under this section is, by virtue of the appointment, also an executive officer. (4)* ***A medical officer of health and an executive officer*** **[EO],** ***appointed under this section must have the qualifications, if any, set out in the regulations*** [emphasis added].

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[26] As of March 21, 2023 there were 19 regulations in force under the *Public Health Act*, RSA 2000, c. P-37.

[27] The position of the Lieutenant Governor is apolitical. This means that the Lieutenant Governor does not get involved in any political activity, intervene in day-to-day issues and decisions made by Alberta government ministries, or advocate for groups or individuals seeking to change government policy. The term "Lieutenant Governor in Council" appears in many government documents, such as acts of legislation. Legally, it refers to the Lieutenant Governor acting on and with the advice of the Executive Council or Cabinet. When the Cabinet makes a decision and it has been approved by the Lieutenant Governor, it is said to have been made by the Lieutenant Governor in Council.

[28] As defined by the Act "'Minister' means the Minister determined under section 16 of the *Government Organization Act* as the Minister responsible for this Act.

[29] Under the Act "'medical officer of health' means a physician appointed by the Minister or a regional health authority under this Act as a medical officer of health, and includes the Chief Medical Officer and the Deputy Medical Officer."

[30] As defined by the Act "'regional health authority' means a regional health authority established under the *Regional Health Authorities Act*."

Note the definition of *public health emergency* may cause *jurisdictional overlap* with the definition of *emergency* under the EMA (section 1(1)(f) of *the Emergency Management Act*). To recap, *emergency* is defined under the EMA as "...an event that requires prompt co-ordination of action or special regulation of persons or property to protect the safety, health or welfare of people."

Section 12.1(2) authorizes the Minister or the Chief Medical Officer (CMOH) to specify the qualifications that an individual must have in order to provide a type of service that may be required in a state of public health emergency. The Minister is to appoint the Chief Medical Officer of Health and the Deputy Chief Medical Officer of Health (DCMOH) (section 13(1)). In addition, the Minister, under section 16, is to appoint one or more qualified physicians as MOHs and one or more *qualified* persons employed in the department (Department of Health) as EOs.[31]

> *12.1(2) Despite subsection (1), where the existence of a public health emergency has been confirmed under section 29(2.1) or where* ***a state of public health emergency has been declared under section 52.1 (a) the Minister or Chief Medical Officer may by order specify qualifications that an individual must have or requirements that an individual must meet in order to provide a type of service instead of or in addition to any qualifications or requirements set out in the regulations*** [emphasis added]*, and (b) an individual may provide the type of service referred to in clause (a) if (i) the individual has the qualifications or meets the requirements specified in the order made under clause (a), and (ii) the individual has the qualifications or meets the requirements set out in the regulations that the order made under clause (a) requires the individual to have or meet, if any, in order to provide the service.*
>
> *13(1) The* ***Minister may appoint a person as Chief Medical Officer of Health and a person as Deputy Chief Medical Officer of Health*** [emphasis added] *for the purposes of this Act.*
>
> *16(1)* ***The Minister may appoint one or more physicians as medical officers of health*** [emphasis added] *for the purposes of Part 3. (2) A person who is appointed as a medical officer of health under subsection (1) is, by virtue of the appointment, also an executive officer. (3)* ***The Minister may designate one or more persons employed in the Department as executive officers for the purposes of this Act*** [emphasis added]*. (4) A medical officer of health appointed under this section and an executive officer designated under this section must have the qualifications, if any, set out in the regulations.*

MOHs are given authority (section 19(1)) to compel any person in charge of the public place or any person (section 19.1(1)) to provide to a medical officer of health *any* information relating to the public place or relating to a person who is suspected of suffering from a communicable disease. Note although at first glance such authority of the MOH may appear to be reasonable, the reader may wish to consider the following check element criteria: *trespass*, *infringement*, and *unusual use of power* and the principle-based criteria of *balance* (see Part I Section F of this report).

> *19(1) Where a medical officer of health knows or has reason to believe (a) that a person suffering from a communicable disease is or may be in or has frequented or may have frequented a public place; or (b) that a public policy may be contaminated with a communicable disease,* ***the medical officer of health may by notice in writing to the person in charge of the public place require that person to provide to the medical officer of health within the time specified in the notice any information relating to the public place*** [emphasis added]*, the person and the communicable disease that is specified in the notice. (2) A person who receives a notice referred to in subsection (1) shall comply with it.*

[31] Section 9(3) of PHA states "A person who is appointed as a medical officer of health under this section is, by virtue of the appointment, also an executive officer." Note that the designated person or persons from the Department of Health who are appointed do not have to be a medical officer, rather only hold the qualifications set out by the Minister in section 12.

> *19.1(1) Where a medical officer of health (a) knows of or has reason to suspect the existence of, or the threat of the existence of, a public health emergency, and (b) has reason to believe that* ***a person has information relevant to the public health emergency that will assist the medical officer of health in carrying out duties and exercising powers under section 29 in respect of the public health emergency, the medical officer of health or an executive officer or community health nurse designated for that purpose by the medical officer of health may, by notice in writing, require the person who has the information to provide the information*** [emphasis added] *that is specified in the notice to the medical officer of health, executive officer or community health nurse. (2) A person who receives a notice referred to in subsection (1) shall comply with it.*

Section 29 authorizes MOHs to take whatever steps they deem necessary to suppress the communicable disease, protect those who have not already been exposed, break the chain of transmission and remove the source of infection. This includes prohibiting persons from engaging in an activity, attending school, having contact with other people and even engaging in one's occupation. Again, while at first glance it may appear reasonable, this section appears to provide an extensive range of authority which the reader may wish to consider the check element criteria and principle-based criteria relating to *trespass, infringement, unusual use of power, and balance* (see Part I Section F).

> *29(1) A medical officer of health who knows of or has reason to suspect the existence of a communicable disease or a public health emergency within the boundaries of the health region in which the medical officer of health has jurisdiction may initiate an investigation to determine whether any action is necessary to protect the public health. (2) Where the investigation confirms the presence of a communicable disease, the* ***medical officer of health (a) shall carry out the measures that the medical officer of health is required by this Act and the regulations to carry out, and (b) may do any or all of the following: (i) take whatever steps the medical officer of health considers necessary (A) to suppress the disease in those who may already have been infected with it, (B) to protect those who have not already been exposed to the disease, (C) to break the chain of transmission and prevent spread of the disease, and (D) to remove the source of infection*** [emphasis added]*. (ii) where the medical officer of health determines that a person or class or persons engaging in the following activities could transmit an infectious agent,* ***prohibit the person or class of persons from engaging in the activity by order, for any period and subject to any conditions that the medical officer of health considers appropriate: (A) attending school, (B) engaging in the occupation of the person or the class of persons, subject to subsection (2.01); (C) having contact with any person or any class of persons*** [emphasis added]*; (iii) issue written orders for the decontamination or destruction of any bedding, clothing or other articles that have been contaminated or that the medical officer of health reasonable suspects have been contaminated.*

> *29(2.1) Where the investigation confirms the existence of a public health emergency, the medical officer of health (a) has all the same powers and duties in respect of the public health emergency as he or she has under subsection (2) in the case of a communicable disease; and (b)* ***may take whatever other steps are, in the medical officer of the health's opinion, necessary in order to lessen the impact of the public health emergency*** [emphasis added].

Section 29(3) and 29(3.1) stipulates there must be a clear chain of notification from the MOH to the CMOH and from the CMOH to the Minister on whatever action that the MOH has taken under section 29(2)(b). Note that these sections satisfy the *principle of accountability* (see Part I Section F of this report).

> *29(3) A* ***medical officer of health shall forthwith notify the Chief Medical Officer*** [emphasis added] *of any action taken under subsection (2)(b) or of the existence of a public health emergency.*

> *29(3.1) On being notified of the existence of a public health emergency under subsection (3) the* ***Chief Medical Officer shall forthwith notify the Minister*** [emphasis added].

Sections 29(5) and 29(6) pertain to orders that may be made by the MOH under subsection 29(2) or 29(2.1) of the PHA as well as investigations that can be undertaken by a MOH who knows or has reason to suspect a communicable disease within the boundaries of a health region. Section 29(5) may cause issues with the principle-based criteria of *Open/Transparency* (see Part I Section F). The Lieutenant Governor in Council has the authority to close any public place and order the postponement of election, under to section 38(1), In addition, the Lieutenant Governor in Council (LGIC) may postpone any election subject to the *Legislative Assembly Act* and the *Senatorial Selection Act* for a period of time of up to three months. Note this section appears to provide for the suspension of democratic practices during a public health emergency. This issue, which falls outside the scope of this report, is not considered in the check element criteria and would require a broader conversation. The reader should note that there appears to be very little academic research on election postponement.[32]

> *29(5) An order made under subsection (2) or (2.1) or an exemption made under subsection (2.2) may* ***incorporate, adopt or declare in force a code, standard, guideline, schedule or body of rules as amended or replaced from time to time, including a code, standard, guideline, schedule or body of rules by the Minister or the Chief Medical Officer*** [emphasis added]*, that relates to the order or exemption.*
>
> *29(6)* ***The Regulation Act[33] does not apply to an order made under subsection (2) or (2.1) or an exemption made under subsection (2.2) or to a code, standard, guideline, schedule or body of rules that the order or exemption incorporates, adopts or declares in force*** [emphasis added].
>
> *38(1) Where the Lieutenant Governor in Council is satisfied that a communicable disease referred to in section 20(1) has become or may become epidemic or that a public health emergency exists, the* ***Lieutenant Governor in Council may do any or all of the following: (a) order the closure of any public place; (b) subject to the Legislative Assembly Act and the Senatorial Selection Act, order the postponement of any intended election for a period not exceeding 3 months*** [emphasis added].

Recall under section 2(1) of the GEMR, the AEMA *shall* "...be the co-ordinating agency for, and provide strategic policy direction and leadership to the Government and its emergency management partners" and to implement the Alberta Emergency Plan. Section 52.1 and section 52.2(1) of the PHA appear to allow for *jurisdictional overlap* with the AEMA, as well as *jurisdictional overlap* with section 3(1) of the LAEMR which requires that locally appointed Emergency Management Agencies are responsible for co-ordinating the municipal emergency plans.

> *52.1 Where, on the advice of the Chief Medical Officer, the Lieutenant Governor in Council is satisfied that (a) a public health emergency exists or may exist, and (b)* ***prompt co-ordination of action special regulation of persons or property is required in order to protect the public health, the Lieutenant Governor in Council may make an order declaring a state of public health emergency relating to all or any part of Alberta*** [emphasis added].
>
> *52.2(1) Where, on* ***the advice of a medical officer of health and in consultation with the Chief Medical Officer, a regional health authority is satisfied that (a) a public health emergency exists***

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[32] Toby S. James and Sead Alihodzic. "When Is It Democratic to Postpone an Election? Elections During Natural Disasters, COVID-19, and Emergency Situations." Election Law Journal: Rules, Politics, and Policy.Sep 2020.344-362.http://doi.org/10.1089/elj.2020.0642.

[33] The Regulation Act describes the details about regulations including rules on filing and publishing. It establishes the role of the Registrar of Regulations and sets out the Registrar's responsibilities.

> ***or may exist in the health region, and (b) prompt co-ordination of action or special regulation of persons or property is required in order to protect the public health, the regional health authority may make an order declaring a local state of public health emergency relating to all or part of the health region*** [emphasis added]. *(2) Where the number of members of a regional health authority who attend a meeting for the purpose of making an order under subsection (1) is less than the quorum required under the bylaws of the regional health authority, the Minister may, notwithstanding the bylaws, order that the number of members attending constitutes a quorum for the purposes of the meeting.*

Section 52.6(1) demonstrates the principle-based criteria of *Necessity* (see Part I Section F) by imposing a *limitation* on orders made under section 52.1, however, despite the such limitations, section 52.6(1) allows for fairly substantive powers that may be exercised by the Minister, a regional health authority, and EOs. The reader may wish to review the check element criteria and principle-based criteria relating to *trespass, infringement, unusual use of power*, and *balance*.

> *52.6(1) On the making of an order under section 52.1 and for* ***up to 60 days following the lapsing of that order the Minister or a regional health authority may do any or all of the following for the purpose of preventing, combating or alleviating the effects of the public health emergency and protecting the public health: (a) acquire or use any real or personal property; (b) authorize or require any qualified person to render aid of a type the person is qualified to provide; (c) repealed; (d) authorize the entry into any building or on any land, without warrant, by any person; (e) provide for the distribution of essential health and medical supplies and provide, maintain and co-ordinate the delivery of health services*** [emphasis added]**.**

> *62(9) If, in the course of an inspection under this Act,* ***the executive officer[34] is of the opinion that a condition of emergency exists due to the existence of a nuisance, the executive officer may, notwithstanding anything in this Act, forthwith take any steps the executive officer considers appropriate to remove or lessen the nuisance*** [emphasis added].

Lastly, section 66.1(2) grants protection from any liability for *any* person or organization acting under the direction of the Crown, the Minister, the CMOH, DCMOH or the MOH for anything *done* or *not done* in good faith while exercising duties and powers during a public health emergency. Similar to sections 27, 28, and 29 of the EMA, section 66.1(2) circumvents the process of accountability by providing immunity based on what is done or not done "in good faith."[35] The reader may wish to review the recommended principle-criteria A*ccountability* (see Part I Section F).

> *66.1(2)* ***No action for damage may be commenced against any person or organization acting under the direction of the Crown, a Minister of the Crown, the Chief Medical Officer, the Deputy Chief Medical Officer or a medical officer of health for anything done or not done by that person or organization in good faith directly or indirectly related to a public health emergency while carrying out duties or exercising powers under this or any other enactment*** [emphasis added]**.**

A.2(i). Communicable Diseases Regulation (AR 238/1985)

The prevention and control of communicable diseases are guided by the *Communicable Diseases Regulation* (AR 238/1985) (CDR). The CDR provides directives and criteria for curtailing the spread of communicable diseases and protecting public health.

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[34] Under the Act "'executive officer' means an executive officer within the meaning of section 9 or 16.

[35] There is extensive legal literature on "good faith" which would require legal experts' opinion and is outside the scope of this report.

All healthcare providers must comply with the CDR. It is mandatory that healthcare providers report any presumptive or confirmed cases of specific communicable diseases to the local MOH. The MOH is accountable for monitoring and managing the spread of the disease. Furthermore, the CDR sets out provisions for isolating and quarantining individuals with communicable diseases to prevent further transmission.

Section 2(1) provides authority to the Minister to provide necessary services, equipment, and medicines for the prevention of communicable diseases, as well as the ability to *determine* who is eligible for those services and/or equipment, and under what conditions and protocols such services or equipment may be administered. The CDR appears to bestow a great deal of responsibility on the Minister above the common roles of appointing, providing guidance and dealing with monetary issues. The reader may wish to review principle-based criteria *Benefits/Efficiency* and *Consistency*, in addition, the check criteria of *Unduly Dependent* and *Unusual use of Power*. The reader should note the CDR appears to allow more of a management role by the Minister than under the EMA, DRR, GEMR, LAEMR, and even the CDR's enabling statute the PHA.

> *2(1)* ***The Minister may (a) provide health promotional, preventative, diagnostic, treatment, rehabilitative or palliative services, supplies, equipment and care and any drugs, medicines and biological agents for the prevention, treatment or modification or communicable diseases, and (b) with respect to the services or things referred to in clause (a) determine (i) the persons eligible to receive those services or things, (ii) the persons who may administer those services or things, (iii) the condition under which those services or things may be provided and administered (iv) the methods and protocols respecting distribution and, where applicable, storage and handling of these services and thing*** [emphasis added]**.**
>
> *2.1(1) A regional health authority shall provide (a) provide health promotional, preventative, diagnostic, treatment, rehabilitative or palliative services, supplies, equipment and care and any drugs, medicines and biological agents for the prevention, treatment or modification or communicable diseases, and (b) any drugs, medicines and biological agents provided by the Minister under section 2(1)(a),* ***as directed by the Minister*** [emphasis added].
>
> *2.1(2) A* ***regional health authority shall, with respect to the provision of those services and things referred to in subscription (1). (a) implement distribution, storage and handling methods and protocols as directed by the Minister*** [emphasis added]*, (b) provide data, records or reports at the times and in the form and manner required by the Minister, (c) create and maintain the data and records required by the Minister, and (d) monitor, as directed by the Minister, the health and safety of persons to whom the services or things are provided.*
>
> *2.1(3) A regional health authority shall ensure that employees and other persons who provide or administer those services and things referred to in subsection (1)* ***under its authority are trained to do so in accordance with any requirements established by the Minister*** [emphasis added].

A.2(ii). Emergency Powers Regulation (AR 187/2009)

The *Emergency Powers Regulation* (AR 187/2009) (EPR) mandates that *any* individual exercising emergency powers must provide specific information to those who are affected by the exercise of such powers. This information includes the nature of the emergency, the type of emergency power being exercised, the individuals or groups that are targeted by the exercise of these powers, the duration of the powers, the contact details of the issuer, and any compensation that may be available to those affected, as well as any additional information required by the Minister.

The EPR defines *emergency power* as an act authorized under section 52.6(1) of the PHA. Recall that the Minister or the regional health authority may do a number of things for the purpose of preventing, combating or alleviating the effects of a public health emergency, including acquire or use any real or

personal property and enter any building or land without warrant. The reader may wish to review the check element criteria and principle-based criteria relating to *trespass*, *infringement*, *unusual use of power*, and *balance*. Section 2 specifies that both the Minister and the regional health authority are subject to the EPR, however, recall that section 66.1(2) of the PHA, the Minister or *any* person or organization are not liable for anything done or not done in *good faith* directly or indirectly related to a public health emergency while carrying out their duties or *exercising power* under the PHA or "...any other enactment." This would appear to negate the purpose of section 2 of the EPR.

> *1(c) "emergency power" means a power authorized under* ***section 52.6(1) of the Act*** [emphasis added].
>
> *2 In exercising an emergency power,* ***the Minister or regional health authority is subject to this Regulation*** [emphasis added].

Pertaining to the communication of exercising an emergency power, section 3(1) ensures that *any* person exercising emergency powers must make the information available to the affected person or persons of whom the exercise of power affects. While section 3(1) appears to follow the recommended principle-based criteria of *Openness/Transparency,* this section may create conflict regarding the recommended principle-based criteria *constructive dialogue, equity/fairness, and impact assessment*. Again recalling section 66.1(2), there is no accountability for failing to advise those who are affected by the use of the emergency power.

> *3(1) If an emergency power is exercised, the person exercising the emergency power shall provide or make available the following information in accordance with subsection (2): (a) the nature of the public emergency; (b) the nature of the emergency power being exercised; (c) the person or class of persons to whom it is directed; (d) the time period during which it is in effect; (e) the issuer's contact information; (f) it applicable, that compensation may be available under section 52.7 of the Act; (g) any other matter required by the Minister. (2)* ***The information shall be provided or made available, subject to any directions of the Minister, in the manner the person exercising the emergency power considers will likely make the information known to an affected person or, in the case of a class of affected persons, the majority of affected persons*** [emphasis added]. *(3) If reasonably practicable, the information shall be provided at the time of the exercise of the emergency power and in writing.*

A.3. Regional Health Authorities Act

The Regional Health Authorities Act, RSA 2000, c. E-10 (RHA) provides the Minister with authority to coordinate and direct a regional health authorities' operations in a manner that *prioritizes* the province's goals. Note that Alberta's *integrated* regional health authority is Alberta Health Service (AHS).

The responsibilities of a regional health authority are set out in section 5 of the RHA. Part of the responsibilities of the regional health authority under the RHA is preparedness for public health emergencies, such as pandemic influenza.

Sections 2(1) and 5(1) outline the role of the Minister as one of *establishment* and *direction* concerning the operation or winding-up of the regional health authority. The regional health authority is to plan for the provision of health services in the health region and *provide* health services in accordance with any applicable accountability framework established by the Minister.

> *2(1) The Minister may by order establish one or more health regions in Alberta. (2) An order under subsection (1): (a) shall name the health region and describe its boundaries,*

and (b) may be made effective on a date that is before the date on which the order is made. (3) Where the Minister amends of rescinds an order under subsection (1), the order shall contain any provisions the Minister considers are necessary to protect the interests of creditors and debenture holders and, in the case of a rescinding order, to otherwise provide for the winding-up of the affairs of the health region, subject to the regulations. (4) All the powers conferred on the regional health authority are, to extent necessary for the purpose, transferred to and vested in the person appointed to wind up the affairs of the health region. (5) The ***Minister may from time to time give any directions the Minister considers proper concerning the winding-up of the affairs of a disestablished health region*** [emphasis added]. *(6) The Regulations Act does not apply to an order under this section.*

5(1) Subject to this Act and the regulations, a regional health authority shall, in accordance with the subsection (2) and ***any applicable accountability framework established under section 8.1.*** **[**emphasis added] *(a) plan for the provision of health services in the health region, and (b) provide health services in the health region.*

Section 8 outlines the Minister's role to give direction for the purpose of *providing priorities and guidelines* to the regional health authority when exercising the authority's powers and to coordinate with other GOA programs, and other public and private institutions. As previously mentioned, the Minister may establish an accountability framework and reporting requirements for the regional health authority (section 8.1). In addition, the Minister may dismiss all members of the regional health authority and appoint an administrator, if the Minister considers it is in the public's best interest.

8 ***The Minister may give directions to a regional health authority for the purpose of (a) providing priorities and guidelines*** [emphasis added] *for it to follow in the exercise of its powers, and (b) co-ordinating the work of the regional health authority with the programs, policies and work of the Government and public and private institutions in the provision of health services in order to achieve the best health outcome and to avoid duplication of effort and expense.*

8.1 The Minister may by order (a) ***establish an accountability framework*** [emphasis added] *in respect of a regional health authority or regional health authorities, and (b)* ***establish reporting requirements*** [emphasis added] *applicable to a regional health authority or regional health authorities in respect of an accountability framework.*

11(1) The Minister may by order ***dismiss all the members of a regional health authority or community health council and appoint an official administrator*** [emphasis added] *in the authority's council's place if the Minister considers that the regional health authority or community health council is not properly exercising its powers or carrying out its duties under this Act or if for some other reason the Minister considers it is in the public interest to dismiss the members of the regional health authority or community health council.*

Sections 16 and 17(1) authorize the Minister to provide or arrange for the provision of health services in any area of Alberta, whether or not health services are also being provided in that area by any other government, person, or authority, as well as establishing Provincial health boards. Note the reader may wish to review the principle-based criteria of *Net Benefits/Efficiency.*

16 The Minister may if the Minister considers that it is in the public interest to do so (a) ***provide or arrange for the provision of health services in any area of Alberta, whether***

> ***or not health services are also being provided in that area by any other government, person or authority*** [emphasis added]*, and (b) do any other thing that the Minister considers necessary to promote and ensure that provision of health services in Alberta.*
>
> *17(1) The Lieutenant Governor in Council may make regulations (a) providing for the establishment of provincial health boards to do any or all of the following on a province-wide basis or in more than one health region: (i) to act in an advisory capacity to the Minister, existing health authorities, regional health authorities, subsidiary health corporations and community health councils; (ii) to deliver or co-ordinate the delivery of health services, diagnostic services or treatment services provided for in the regulations; (iii) to engage in and promote research related to health matters; (iv) to carry out other activities assigned to it in the regulations; (b) respecting the management. Functions, duties and jurisdiction of provincial health boards; (c) the size and composition of provincial health boards; (d) respecting the manner in which members of provincial health boards are appointed, the terms of office of members, the filling of vacancies and the appointment or election of officers; (e) respecting the remuneration and expenses payable to members of a provincial health board; (f) governing the winding-up of the affairs of a provincial health board; (g) making applicable in respect of a provincial health board any of the provisions of this Act of the regulations under this Act, with necessary modifications.*

Lastly, section 22 provides protection from liability for members of a regional health authority, including the official administrator, for *anything* done or not done by that person in good faith while carrying out duties or exercising power under the RHA. The reader may wish to review the recommended principled-criteria *Accountability* (see Part I Section G).

> *22* ***No action for damages may be commenced against a member of a regional health authority*** [emphasis added]*, including an official administrator appointed under section 11, for anything done or not done by that person in good faith while carrying out duties or exercising powers under this or any other enactment.*

B. Federal and International Legislation

The scope of this report is to examine provincial legislation and applicable subordinate legislation, however, it is important for the reader to be aware of the federal and international interconnections that need to be taken into consideration when contemplating provincial amendments. Two examples include the Canadian *Emergency Management Act* and the World Health Organization's *International Health Regulation*. While the International Health Regulation is binding on Canada and the Canadian Government, it is important to note that there may be some trickle down effects from this legislation.

For example, section 6(1) of the federal *Emergency Management Act*,[36] requires each minister, who is answerable to Parliament for a government institution, to identify risks linked to their area of responsibility and develop emergency management plans concerning those risks. In addition, each Minister must maintain, test, and execute those plans, as well as conduct relevant training and exercises. Some important points to note are under the *Emergency Management Act*, the Governor in Council may on the recommendation of the Minister make orders or regulations "…declaring a provincial emergency to be of concern to the federal government." and "A [federal] government institution may not respond to a provincial emergency unless the government of the province requests assistance or there is an agreement with the province that requires or permits the assistance."

[36] https://laws-lois.justice.gc.ca/eng/acts/e-4.56/page-1.html#h-214398

The federal Minister of Health is responsible for devising, testing, and updating emergency plans tailored to the federal health portfolio, which comprises Health Canada and Public Health Agency of Canada (PHAC). These federal emergency plans outline the federal response to national public health crises or incidents, such as major disease outbreaks including pandemics *like influenza*.

Under the federal *Quarantine Act,* the federal Minister of Health is authorized to enforce public health measures necessary to prevent the introduction and spread of communicable diseases in and out of Canada.

The World Health Organization (WHO) has established a global legal framework, the *International Health Regulation* (2005)[37] (IHR). The IHR defines countries' rights and obligations in handling public health events which have crossed over international borders. Note that the stated purpose and scope of the IHR is to "...prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid *unnecessary* interference with international traffic and trade." As a member of the WHO Canada, along with 195 other countries, is bound to follow the IHR.

C. Other Interprovincial Agreements

There are interprovincial agreements or memorandums of understanding which may need to be considered when the reader considers any amendments to the above statutes or regulations.

In 2009, all Federal/Provincial/Territorial Ministers of Health signed a Memorandum of Understanding (F/T/P-MOU) on the provision of mutual aid in relation to health resources during an emergency affecting the health of the public. This F/T/P-MOU became the *Operational Framework for Mutual Aid Requests* (OFMAR).[38] OFMAR was created as a resource to operationalize the F/T/P-MOU and was approved by the Pan-Canadian Public Health Network Council[39] in December 2013. OFMAR is an optional tool that can be utilized by provinces and territories to identify and exchange healthcare professionals and assets across jurisdictions during emergencies. Initially OFMAR was developed for physicians and nurses, but the mechanism has adapted and can include other healthcare professionals. OFMAR is activated during an emergency/disaster event and deactivated at the conclusion of an event or upon request from the impacted jurisdiction.

There are other MOUs which may also need to be reviewed and considered, such as the F/P/T-MOU on the Sharing of Information during a Public Health Emergency, and the F/P/T-MOU Management of Influenza Vaccine in the Event of a Pandemic with the First Nations and Inuit Health Branch (FNIHB) and Health Canada.

D. Alberta Pandemic Influenza Plan: Roles and Responsibilities (March 2014)

The scope of this report is to review the public health and emergency management legislation and subordinate legislation for the purpose of making recommendations on how to improve the governance of

[37] International Health Regulations (2005) 3rd. Edition." World Health Organization. Accessed March 31, 2023.
[38] https://publications.gc.ca/collections/collection_2018/aspc-phac/HP45-13-2017-eng.pdf
[39] The Pan-Canadian Public Health Network is the formal public health governance for federal, provincial and territorial governments across Canada. The Pan-Canadian Public Health Network (PHN) is composed of the PHN Council, the Council of Chief Medical Officers of Health (CCMOH), the PHN Secretariat and 3 steering committees. The PHN Council is accountable and reports to the Conference of Federal, Provincial and Territorial (FPT) Deputy Ministers of Health, which is accountable to FPT Ministers of Health.

applicable legislation or regulations. In doing so, it is important that the reader has as much context as to roles and responsibilities which have been defined in the past and which may assist in identifying areas of improvement. As such Section D will provide the reader with a brief overview of the contents of the Alberta Pandemic Influenza Plan (March 2014) (APIP-2014) and the role and responsibilities of different emergency partners.

Pandemic planning at the provincial and regional levels has been in place since the late 1990s. In 2009, Alberta Health (AH) and AEMA consolidated their plans with the newly-formed Alberta Health Service (AHS) and developed a provincial pandemic plan to reflect activities required for the pH1N1 virus.[40]

Post pH1N1, the Minister of Health authorized the Health Quality Council of Alberta[41] (HQCA) to conduct a formal review of the provincial response. In the *Review of Alberta's Response to the 2009 H1N1 Influenza Pandemic* (December 2010), the HQCA provided a number of recommendations.[42] These recommendations and lessons learned from pH1N1 provided the motivation for revising the *Alberta Pandemic Influenza Plan*. The specified goals of pandemic planning is to provide *guidance* and *direction* for activities aimed at:

- Controlling the spread of influenza disease and reducing illness (morbidity) and death (mortality) by providing access to appropriate prevention measures, care, and treatment;
- Mitigating societal disruption in Alberta through ensuring the continuity and recovery of critical services;
- Minimizing adverse economic impact;
- Supporting an efficient and effective use of resources during response and recovery.

At the time of their review, HQCA found that during an emergency, the Government of Canada, Alberta Health, AEMA, AHS and local authorities may have powers which overlap and these participants *must be coordinated* to work effectively together.

The APIP-2014 establishes roles and responsibilities based on each organization's mandate and expertise. Clear communication and decision-making *pathways* coordinate all emergency *partners,* that is Alberta Health, Alberta Health Services (AHS), Alberta Emergency Management Agency (AEMA), and First Nations and Inuit Health Branch - Alberta Region (FNIHB).

D.1. Alberta Health (AH)

The role of AH, under the APIP-2014, was to lead and coordinate the provincial pandemic influenza health planning, response, and recovery. Specifically, AH responsibilities included:

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[40] Pandemic (H1N1) 2009 virus was confirmed in all provinces and territories in Canada and carried a mortality rate of 1.3 per 100,000 population. The highest hospitalization rates occurred in children aged less than 5 years of age. In Alberta, wave one lasted from April 19 to July 25, 2009 and the second wave from October 11 to December 5, 2009. Overall, a younger population had significantly more illness from pH1N1 influenza than with the typical seasonal influenza virus strains typically seen in a given year. Incidence of disease among school aged children (aged 5–18 years) was particularly high. Deaths were lower than expected in the 65 years and over age group, but higher in younger age groups. For more information see Alberta Health Services "Pandemic (H1N1) 2009: The Alberta Experience" (December 15, 2010).

[41] The Health Quality Council of Alberta (HQCA) is an independent organization that aims to improve the quality of healthcare services in the Canadian province of Alberta. Established in 2003 as a non-profit corporation under the Health Quality Council of Alberta Act, the organization is responsible for monitoring and reporting on the quality of healthcare services in Alberta.

[42] Note this report was published in March 2014 and warned that "**Pandemic influenza is inevitable**" [emphasis added] see pg. 5, in addition, this report proposed four planning scenarios: mild impact (pH1N1 2009), moderate impact (Asian 1957), moderate impact (Hong Kong 1968), and **severe impact** (Spanish 1918) [emphasis added],

- Assess and communicate pandemic influenza severity and impact in Alberta to stakeholders;
- Exercise legislative authority (applies to both the Minister and the CMOH) under the *Public Health Act* and the *Communicable Diseases Regulation* to protect the health of Albertans, including the declaration of a provincial public health emergency, if required;
- As necessary, develop provincial policies, legislation, guidelines and standards for responding to pandemic influenza;
- Maintain Alberta's portion or the National Antiviral Stockpile (NAS);
- Manage Alberta's pandemic influenza vaccine;
- Seek necessary funding or resources to enable an effective health sector response;
- Connect with federal/provincial/territorial (F/P/T) counterparts on health impacts, resources and communications;
- Direct the provincial communication strategy and messages in conjunction with the Public Affairs Bureau AHS;
- Collaborate with AHS in the delivery of influenza-related public information and education programs and co-ordinate the dissemination of health information;
- Liaise with and support other GOA Ministries.

D.2. Alberta Health Services (AHS)

Under APIP-2014, the role of AHS[43] was to provide continuity of health services to Albertans. AHS responsibilities specific to response and recovery are to:

- Review and implement pandemic influenza operational health service response and recovery plans;
- Prioritize delivery of critical health services and programs during a pandemic influenza;
- Carry out the legislated roles of the MOH under the Public Health Act and the Communicable Disease Regulation, including advising (in consultation with the CMOH) on the declaration of a local state of public emergency, if necessary;
- Collaborate with Alberta Health on matters related to policy, resource acquisition and cross-governmental collaboration in the delivery of influenza-related public information and education programs;
- Liaise with and provide health advice and counsel to local authorities and stakeholders.

D.3. Alberta Emergency Management Agency (AEMA)

GEMR provides the AEMA with the responsibility for acting as the coordination and support agency for the GOA and its emergency management partners. In this capacity and in the context of the APIP-2014, AEMA specific responsibilities are:

- **Coordinate the cross-governmental response to a pandemic** [emphasis added];
- Monitor and assess the impact of pandemic influenza on GOA critical services, and if required, coordinate restoration of GOA critical services list as per the *GOA Business Continuity Plan;*
- Coordinate and support requests for assistance from local authorities as necessary;
- Coordinate requests for assistance under existing F/P/T and international mutual assistance agreements.

[43] Alberta Health Services (AHS) is the provincial health agency tasked with delivering health services to Albertans. Alberta Health is the government department.

D.4. Government Ministries

Under the APIP-2014, GOA Ministers were to manage activities in accordance with their legislated mandates and government priorities. GOA Ministers responsibilities were:

- Review business continuity plans[44] and activate as appropriate to deal with the impact of pandemic influenza;
- **Maintain departmental critical services, and through AEMA** [emphasis added], ensure that activities align with the GOA health response and recovery;
- Communicate with AEMA any issues, concerns or requests for assistance;
- Liaise and support their key stakeholders groups in their response and recovery activities.

D.5. Pan-Canadian Public Health Network Council

The role of the Pan-Canadian Public Health Network Council as established by the F/P/T Conference of Deputy Ministers is the senior forum for F/P/T collaboration on public health issues. Under APIP-2019 the Council was responsible for:

- Providing **scientific and policy advice** [emphasis added] to the F/P/T Conference of Deputy Ministers;
- Serving as a focal point for coordination of F/P/T pandemic influenza response.

D.6. First Nations and Inuit Health Branch - Alberta Region (FNIHB-AB)

Health Canada's FNIHB-AB was responsible for providing community and public health services for individuals living on First Nation reserves in Alberta, as well as:

- Leading and coordinating the public health response and recovery of First Nations communities in Alberta;
- Coordinating and supporting the provision and administration of pandemic influenza vaccine to individuals living on-reserve, in collaboration with AH and AHS;
- Collaborating with AH and AHS to ensure that individuals living on-reserve have equitable access to antiviral medications;
- Providing infection control and self-care education in coordination with AH and AHS.

E. Business Continuity Guide (2017)

Under the GEMR, the AEMA is responsible for developing, implementing, and maintaining the *Alberta Emergency Plan* (AEP) and the GOA Business Continuity Plan (BCP). AEMA is also responsible for working with each department to develop, implement, and maintain the individual department's BCP. The *deputy heads of departments* are accountable to ensure that the business continuity planning within their respective departments are updated and implemented in the event of an emergency.

Business continuity planning is gaining recognition nationally and globally within the emergency management community. The GOA acknowledges that the standard–ISO 22301:2012[45] (note this standard

[44] A plan that prioritizes essential services, employs mitigation measures and coordinates and implements the continuity of service strategies when a business disruption occurs.

[45] ISO 22301:2012 specifies requirements to plan, establish, implement, operate, monitor, review, maintain and continually improve a documented management system to protect against, reduce the likelihood of occurrence, prepare for, respond to, and recover from disruptive incidents when they arise. The requirements specified in ISO 22301:2012 are generic and intended to be applicable to all organizations, or parts thereof, regardless of type, size

has been revised to ISO 22301:2019[46]) provides the comprehensive standards for business continuity professionals to benchmark against when developing their business continuity programs. Note that the AEMA uses CSA Z1600[47] to establish measurable goals within a national context.

Important to our discussion are some select definitions from the GOA *Business Continuity Guide* (2017) which provide some context regarding the use of business continuity plans as a part of the emergency management system and governance.

> *"Business continuity management" A holistic process that identifies potential threats/risks to the organization and the impacts those threats/risks may pose to continuity of essential services. This is a framework for building organizational resilience with the capability for an effective response that safeguards the interests of key stakeholders and organizational reputation.*
>
> *"Business continuity plan"* ***A plan that prioritizes essential services****, employs mitigation measures and coordinates and implements the continuity of service strategies when a business disruption occurs.*
>
> *"Business continuity program" Ongoing management and governance process supported by top management and appropriately resourced to implement and maintain business continuity management.*
>
> *"Business disruption" Any event, anticipated or not, which causes an unplanned, negative deviation from the expected delivery of essential services accounting to GOA objectives.*
>
> *"Business impact analysis" Process of analyzing government activities and determining their critically based on a set of criteria.*
>
> *"Department" A department is a cabinet minister's area of responsibility, or portfolio, and the people who work for the ministry. The Minister, who is head of the ministry, is a member of the Executive Council. For the purpose of this plan, a department will include Agencies, Boards, and Commissions (ABCs) with the understanding that their* ***participation in the program is largely voluntary and at the discretion and direction of their department deputy head****.*

At its core, *business continuity* focuses on minimizing preventable disruptions to the essential programs and services offered by a government, an industry, or a business, if preventing service gaps is no longer an option due to the disruption, business continuity plans describe the processes and practices to restore and resume business as efficiently as possible.

F. Report of the Auditor General (September 2020)

Under the EMA, PHA and other legislation that has been reviewed, the role of the AEMA appears to be defined as the agency responsible for *coordinating* all other agencies and even GOA departments. The following is a summary of the findings and recommendations of the Alberta Auditor General published in their *Provincial Hazard Assessment for Emergency Management* (September 2020). Note that the audit work was completed prior to COVID-19 pandemic and therefore *does not evaluate* the Government of Alberta's pandemic planning or response.

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and nature of the organization. The extent of application of these requirements depends on the organization's operating environment and complexity.

[46] https://www.iso.org/standard/75106.html.

[47] https://www.driecentral.org/2008-Z1600.pdf.

The Auditor General found that in order for the government of Alberta to effectively reduce its risk, plan for and respond to emergencies such as flooding, wildfires and pandemics, it must understand and plan for multiple effects that a disaster can bring. The key to any mature emergency management system is having an effective *provincial hazard assessment* system in place. While a provincial hazard assessment system does not guarantee reducing the impact of future disasters/emergencies, it can assist the government to make better informed decisions on funding policies and mitigation strategies, especially where disasters/emergencies do not stay confined within government jurisdictions or particular geographical boundaries.

The AEMA, under the Municipal Affairs department, is responsible for developing, implementing, managing, and maintaining Alberta's emergency management system and has the responsibility under the *Alberta Emergency Plan* for the coordination of the development of a *provincial hazard assessment*. While AEMA had done some work on assessing provincial hazards, the Auditor General's report found that the AEMA "...**does not have an effective system to coordinate a provincial hazard assessment**[48] [emphasis added]" and due to this "**the government may not have the information necessary to identify and fund its highest priorities, and may overlook areas where additional emergency planning or policy-related decisions are required, and it may find itself responding to disasters that could have been avoided or mitigated.** [emphasis added]"

In Alberta, like many other jurisdictions, the emergency management system operates on a decentralized or graduated approach. The graduated approach means that emergency management is complex–it involves many systems and is a shared responsibility amongst many emergency management partners.

For example, local authorities, including municipalities and Metis and First Nation settlements have the primary responsibility to plan for and control the community's emergency response. If an emergency is too big for a local authority to handle or if additional resources are required, the response will escalate to an appropriate next level, such as the Government of Alberta. In turn, the Government of Alberta may call upon the Government of Canada for additional resources if required.

In an ideal situation, the AEMA brings partners together into a cohesive and integrated system with all partners working together to produce a provincial hazard assessment. In order for the integrated system to be effective, it must be supported by policies, including legislation, processes, and collaborative relationships amongst all emergency management partners (see Figure 1 Role of AEMA).

[48] The hazard assessment is a "qualitative or quantitative" approach to determine the nature and extent of disaster risk by analyzing potential hazards and evaluating existing conditions or exposure and vulnerability that together could harm people, property, services, livelihoods and the environment on which they depend. A hazard assessment has several essential elements, including: risk identification–identifying potential hazards; risk analysis–assess the nature of the risk, characteristics and level or risk; risk evaluation–compare risk analysis with criteria to determine if the risk level is acceptable or tolerable; risk treatment–recommend and select options to manage the risk.

Figure 1. Role of AEMA

Source: Report of the Auditor General (September 2020)

The Auditor General Report findings:

- AEMA has elements of a provincial hazard assessment system. For example, it has processes to review local authority emergency management plans and it meets with its emergency management partners annually to prepare for the upcoming hazard season. However, AEMA needs to make improvements for the provincial hazard assessment system to be effective.

- AEMA drafted a preliminary provincial hazard assessment in collaboration with various ministries in 2014 and 2015. However, the assessment faced various challenges, including a lack of available information and concerns raised by ministries. The provincial hazard assessment was not completed and was stalled from 2016 to 2019.

- Since 2011, post-incident disaster reviews have included several recommendations to AEMA regarding the hazard assessment system. AEMA has not implemented the hazard assessment recommendations fully and there were

> weaknesses in its systems for monitoring the status of outstanding recommendations.

The Auditor General Report recommendations:

- Implement a system to develop and maintain a provincial hazard assessment; recommend that the Department of Municipal Affairs implement a system to develop and maintain a provincial hazard assessment.

- Improve monitoring and reporting of recommendations from post-incident disaster reviews; recommend that the Department of Municipal Affairs improve the monitoring and reporting of recommendations from post-incident disaster reviews.

The Auditor General's report indicated that during the mentioned period, AEMA had certain shortcomings, which were summarized as follows:

- It is not clear who must ensure that recommendations are implemented. The status of recommendations are reported to the ADM (Assistant Deputy Minister) and DM (Deputy Minister) committees periodically, but it is not clear if they are supposed to ensure implementation. Their terms of reference do not refer to the post-incident disaster review recommendations or their role.

- AEMA classifies each recommendation into one of five status categories–*completed*, *underway*, *under review*, *under discussion*, or *evergreen*. Evergreen means that the work will recur or be a standing function within an existing program. The Auditor General's report noted that "...of the 66 recommendations arising from the disaster reviews, 37 have evergreen status, including all the recommendations related to hazard assessments."

- For most recommendations, there is no estimated completion date, so it is not possible to tell if implementation is on track.

- The post-incident disaster reviews are public, but there is only limited public reporting on the status of recommendations, actions taken, and actions outstanding.

In summary, the Auditor General's report highlighted several areas of concern with respect to the provincial hazard assessment system of AEMA. While there are some processes in place, such as reviewing local authority emergency management plans and partnering with other emergency management agencies, there were some *significant* gaps in the system that required attention. The report identified a lack of clarity regarding who is *responsible* for ensuring that recommendations are implemented and limited public reporting on the status of such recommendations. The report recommended that the Department of Municipal Affairs implement a system to develop and maintain a provincial hazard assessment and improve the monitoring and reporting of recommendations from post-incident disaster reviews. It was warned that these recommendations be implemented and is done towards addressing the identified shortcomings to enhance the AEMA effectiveness in emergency management planning and response.

G. KPMG Review of Alberta's COVID-19 Pandemic Response (January 2021)

The scope of work for this report is ***not*** to evaluate the response of GOA with respect to the COVID-19 pandemic, however, it is important for the reader to take into consideration areas of improvement which

have previously been recommended by other independent organizations that were tasked with reviewing the GOA response.

Between March 2020 and October 2020 the GOA contracted the services of KPMG LLP (KPMG) to conduct an *independent* review of the Province's response to the COVID-19 pandemic. The purpose of the review was to provide the Province with observations and recommendations based on research, analysis and investigation, however, KPMG indicates that the *Review of Alberta's COVID-19 Pandemic Response* was not as comprehensive as was originally planned due to the ongoing challenges that the pandemic posed. KPMG cautions the reader of their report that their observations and recommendations are limited.

KPMG's report recommended the following five items:

- The Province should continue to conduct analysis and stakeholder engagement to strengthen its ongoing pandemic response. The pandemic response will continue to require adaptation and changes in health and economic measures over time, and it will be important to remain open to different stakeholder perspectives and measures in support of decision making.

- Once the current State of Public health Emergency is ended and vaccine administration is well underway, it is recommended that the Province conduct a comprehensive review of its pandemic response to strengthen its future efforts.

- Implement strategies to support healthcare labour capacity and flexibility to backfill staffing shortages in Alberta's Continuing Care system.

- Implement strategies to increase uptake of support for small and medium-sized businesses.

- Work closely and collaboratively with municipalities to communicate and implement pandemic response measures

KPMG noted that during its review, it was unable to include extensive data collection on governance and decision making because of the Province's governance and decision making during the first wave included "...**establish[ing] a new formal response structure to manage decisions and enable a coordinated provincial response.** [emphasis added]"

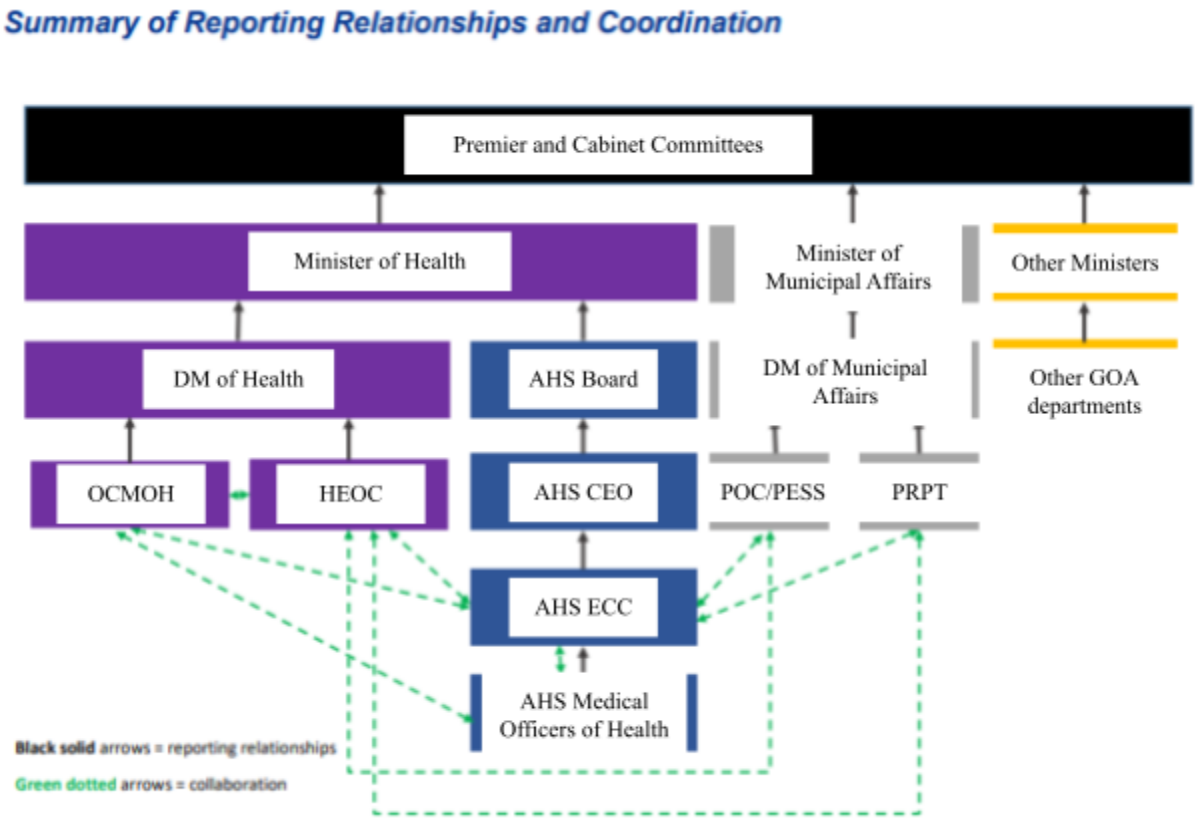
The new formal response structure to manage decisions and coordinate a provincial response drew on the Province's existing emergency management systems that were in place and added new features for the response to the COVID-19 pandemic emergency.

Several key elements of the Province's COVID-19 response structure were pre-defined through planning and previously enacted legislation, such as the Provincial Operations Centre (POC) and the role of the Alberta Health's Emergency Operations Centre (HEOC). KPMG found that both of these bodies had clear roles within Alberta's Incident Command System structure during an emergency, and both bodies were consistent with leading international practices.

KPMG found that there were several governance and decision making structures that were created specifically for the response to the COVID-19 pandemic. For example, the Emergency Management Cabinet Committee (EMCC) which was to set policy and make rapid decisions and the Pandemic Response Planning Team (PRPT) to address cross-government planning needs.

KPMG also reported that as the first wave ended, some of the emergency structures stood down, such as EMCC and the PRPT while others decreased their level of activity, such as POC and responsibilities were transferred to other emergency structures such as HEOC, which continued to work with the Emergency Coordination Centre (ECC) in AHS. The Priorities Implementation Cabinet Committee (PICC) took on the policy decision making role previously fulfilled by the Emergency Management Cabinet Committee (EMCC). Figure 2 outlines the reporting relationships.

Figure 2. Reporting Relationships and Coordination (KPMG 2021)



Source: KPMG Review of Alberta's COVID-19 Pandemic Response: March 1-October 12, 2020

H. Decision Making During the COVID-19 Pandemic

The following information is from a presentation given by senior Deputy Ministers to the PHEGRP in February 2023 entitled *Public Health Emergencies During the COVID-19 Pandemic*. The following summary captures the relevant parts of the presentation with respect to the governance of the public emergency in 2022.

During COVID-19 public health emergency, the Province of Alberta utilized an Incident Command System (ICS). An ICS is a standardized system for managing incidents on-site and aims to facilitate

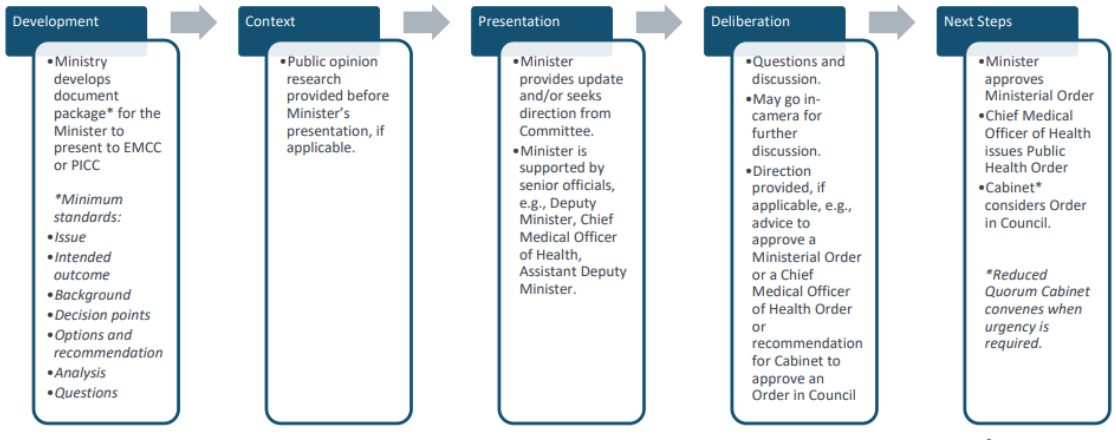
effective and efficient incident management by integrating various resources within a common organizational structure.[49]

The pandemic response was *directed* by a Cabinet committee and *coordinated* by the Health Emergency Operations Centre (HEOC), the Pandemic Response Planning Team (PRPT), and the Provincial Operations Centre (POC).

The Ministry of Health utilized a standardized Emergency Operations Centre (EOC) model[50] (COVID-19 EOC) which included an Incident Commander (ADM-level), Deputy Incident Commander (ADM or ED-level), Section Chiefs (ED or Director-level), Chief Legal Advisor, and the Chief Medical Officer of Health (CMOH) to lead the response. The COVID-19 EOC was formed on January 29, 2020 and deactivated on July 31, 2020. The role of the COVID-19 EOC was to provide *strategic policy* and *implementation recommendations* to the Minister of Health. The COVID-19 EOC utilized a hybrid organizational structure that combined elements of the ICS model with GOA standard divisions.

Policy decisions were made by the Emergency Management Cabinet Committee (EMCC) or Priorities Implementation Cabinet Committee (PICC), based on recommendations from the Minister of Health and expert advice provided by the CMOH and other subject matter experts. Alberta Health Services provided advice related to the management of acute care operations, which was integrated by the EOC and provided to EMCC/PICC. See figure 3 for the EMCC and PICC decision process.

Figure 3. EMCC/PICC Decision Process



Source: Presentation by Deputy Ministers to PHEGRP on February 2023

[49] Through ICS Canada, provincial or territorial [emergency management] agencies are referred to as the Authority Having Jurisdiction (AHJ). There is only one AHJ per province or territory. Typically, the provincial or territorial government department responsible for emergency management is designated as the AHJ. The Ministry of Municipal Affairs is the AHJ for Alberta and delegated the authority to manage and administer the use of ICS to the Alberta Emergency Management Agency (AEMA). As of January 1, 2020, only ICS Canada issued training certificates will be considered compliant, with the exception of AEMA I-200 Online.

[50] An emergency operations center (EOC) is a central command and control facility responsible for carrying out the principles of emergency preparedness, emergency management, and disaster management functions at a strategic level during an emergency, and ensuring the continuation of operation of a company, political subdivision, or other organization.

AHS worked alongside the HEOC to provide the Minister with advice related to the management of acute care operations. HEOC integrated the advice and updates and provided them to EMCC and PICC. COVID-EOC also coordinated with the AEMA through the POC, AHS Emergency Coordination Centre, and with PRPT (while activated) throughout the pandemic response.

The PRPT was established at the beginning of the pandemic at the direction of the government through the DMEC (Deputy Ministers of Executive Council), with representatives (at Executive Director level) from most ministries. The role of the PRPT was to "...facilitate a 'whole' of government-response to the COVID-19 pandemic that had an 'all of society' impact." The PRPT reported to the Deputy Minister of Municipal Affairs. The PRPT was led by ADMs [Assistant Deputy Ministers] from across government and who reported to the DM of Municipal Affairs and consisted of a team of staff seconded from across government. The PRPT was established on March 14, 2020 and deactivated on July 31, 2020. The PRPT was synchronized with both the Health Emergency Operations Centre (EOC) and the Provincial Operations Centre (POC) and all policy decisions were taken to the EMCC

Between March 16, 2020 and June 14, 2022 the CMOH issued 113 CMOH Orders that established public health measures associated with the GOA's pandemic response. The final order was rescinded on June 30, 2022. It was noted during the presentation that the Court of King's Bench confirmed that the *Public Health Act* requires that decisions regarding public health orders be made by the CMOH or an authorized delegate.

The AEMA and its POC largely maintained their usual operations during the pandemic, however, the AEMA were charged with two pandemic response programs, namely, the Personal Protective Equipment (PPE) Task Force[51] and the provincial *Bits-and-Pieces* program.[52] AEMA support to other pandemic initiatives were primarily sharing of knowledge and personnel to the HEOC and PRPT.

It was specified in the presentation that the position of AEMA Incident Commander is not the same as HEOC Incident Commander, as well as "The AEMA Incident Commanders(s) did not have a formal role in the pandemic response." Rather the AEMA Managing Director was deployed (outside his role as the Managing Director of AEMA) to support the COVID-19 Vaccine Task Force[53] and Rapid Testing Force. It was further noted that the activities of the AEMA and the POC, as well as the deployment of the AEMA'a Managing Director were carried out pursuant to the policy direction of the EMCC, PICC, Cabinet and the Premier's Office.

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[51] The AEMA established the PPE task force in April 2020. The PPE task force was to provide PPE to the non-health care sector including the "masks for schools" initiative and the creation of a strategic stockpile. See Standing Committee on Public Accounts, April 19, 2022 (Transcript No. 30-3-3).

[52] The Alberta Bits and Pieces Program is a way for businesses and citizens to submit unsolicited offers of products and services to help others during an emergency or disaster. Originally established during the Second World War, the program coordinated innovative production and procurement efforts from across the country to support the war effort. The program has since evolved to provide critical support to Albertans during emergencies and disasters, including flooding, wildfires, tornadoes and more recently, COVID-19.

[53] The creation of the COVID-19 Task Force was announced by Premier Kenney on November 30, 2020. The purpose of the task force is to execute Alberta's COVID-19 vaccine distribution. The COVID-19 Task Force was led by the Deputy Minister of Municipal Affairs.

III. RECOMMENDED AMENDMENTS TO LEGISLATION

The subsequent section outlines recommended amendments to the legislation and subordinate legislation reviewed under Part II of this report for PHEGRP to consider in their work.

Note the existing sections of legislation and subordinate legislation have been quoted for the convenience of the reader following the recommended changes to that existing section. However, any modifications to the legislation or subordinate legislation should be drafted by legislative experts.

A. Recommendations for the *Emergency Management Act*, RSA 2000, c E-6.8.

Recommendation 1: Section 1(1)(h) should be amended such that all the Ministers whose departments are impacted by the emergency/disaster and who have been appointed to the committee that advises an *independent* AEMA. The section presently reads:

> *1(1)(h) "Minister" means the Minister determined under section 16 of the Government Organization Act as the* ***Minister responsible for this Act*** [emphasis added]*;*

Recommendation 2: Section 1(1)(f) should be changed to include a more comprehensive and specific definition pertaining to "...protect the safety, health or welfare of people…" Note that in its current form *health* is not defined to include or not include health related emergencies (i.e., pandemic, infectious disease, chemical or biological terrorist attack). The section presently reads:

> *1(1)(f) "emergency" means an* ***event that requires prompt co-ordination of action or special regulation of persons or property to protect the safety, health*** [emphasis added] *or welfare of people or to limit damage to property or the environment;*

Recommendation 3: Section 3.1(3) should be changed to disallow the Minister to appoint officers and employees as this should be the requirement or jurisdiction of an AEMA board or the Managing Director. The Managing Director is appointed by the Minister. The section presently reads:

> *3.1(1) There shall be a part of the public service of Alberta known as the "Alberta Emergency Management Agency"* [AEMA]*. (2) The Minister shall designate a person employed in the Minister's department as the Managing Director of the Agency.* ***(3) In accordance with the Public Service Act, there may be appointed officers and employees that the Minister considers are required for the administration of the business and affairs of the Agency*** **[emphasis added].**

Recommendation 4: Sections 4, 5(1), 7.1 create jurisdictional overlap, having the Lieutenant Governor in Council and the Minister with the ability to appoint committees to *assist* the Managing Director creates accountability issues and creates confusion as to which committee has authority. The recommendation would be to remove the Lieutenant Governor in Council and leave the Minister the only one authorized to appoint a committee. The sections presently read as:

> *4 The Lieutenant Governor in Council may appoint a committee consisting of those members of the Executive Council whom the Lieutenant Governor in Council designates to* ***advise on matters relating to emergencies and disasters*** [emphasis added]*.*
>
> *5(1) The Minister may* ***appoint committees*** [emphasis added] *as the Minister considers* ***necessary or desirable to assist*** [emphasis added] *the Minister, the Cabinet Committee or the Managing Director. (2) The members of committees appointed under subsection (1) who are not officers or*

employees of the Crown, or officers or employees of an agency of the Crown, may be paid remuneration for their services and expenses at a rate or rates fixed by the Minister.

7.1 The Lieutenant Governor in Council may make regulations (a) respecting the powers, duties and functions of local authorities under this Act; (b) respecting the ***establishment of emergency advisory committees*** [emphasis added] *referred to in section 11.1, including the duties and functions of the committees; (c) respecting the* ***establishment of emergency management agencies*** [emphasis added] *referred to in section 11.2 including the duties and functions of the agencies; (d) respecting the delegation of a local authority's powers or duties under this Act and the regulations; (e) respecting* ***training requirements for persons designated by the regulations*** [emphasis added]*; (f) respecting the preparation, approval, maintenance and co-ordination of local emergency plans and programs; (g) respecting the* ***conduct of exercises relating to emergency plans*** [emphasis added].

Recommendation 5: Section 11.2(1) should be amended to remove the requirement that the local authority establish and maintain their *own* emergency management agency; rather this section should specify that the AEMA should coordinate all emergency services on behalf of the local authority. The section presently reads:

11.2(1) A local authority shall establish and maintain, subject to the regulations, an emergency management agency to act as the agent of the local authority in exercising the local authority's powers and duties under this Act [emphasis added]. ***(2) There shall be a director of the emergency management agency, who shall (a) prepare and co-ordinate emergency plans and programs for the municipality, (b) act as a director of emergency operations on behalf of the emergency management agency, (c) co-ordinate all emergency services and other resources used in an emergency, and (d) perform other duties as prescribed by the local authority*** [emphasis added]. *(3) A local authority, except an improvement district, special area, national park or Indian reserve, may by bylaw that is not advertised borrow, levy, appropriate and expend all sums required for the operation of the emergency management agency. (4) For greater certainty, an emergency management agency may be maintained by and may act as the agent of more than one local authority.*

Recommendation 6: Section 18(1) should reflect not only the Alberta Bill of Rights and/or the Alberta Human Rights Act but also address the Canadian Charter of Rights and Freedoms and the Universal Declaration of Human Rights. The section presently reads:

18(1) ***The Lieutenant Governor in Council may, at any time when the Lieutenant Governor in Council is satisfied that an emergency exists or may exist, make an order for a declaration of a state of emergency relating to all or any part of Alberta*** [emphasis added]***.*** *(2) A declaration of a state of emergency under subsection (1) must identify the nature of the emergency and the area of Alberta in which it exists. (3) Immediately after the making of an order for a declaration of a state emergency, the Minister shall cause the details of the declaration to be published by any means of communication that the Minister considers is most likely to make known to the majority of the population of the area affected the contents of the declaration. (4) Unless continued by a resolution of the Legislative Assembly, an order under subsection (1) expires at the earlier of the following: (a) at the end of 28 days, but if the order is in respect of a pandemic, at the end of 90 days; (b) when the order is terminated by the Lieutenant Governor in Council. (5) repealed, (5.1) Unless otherwise provided for in the order for a declaration of a state of emergency, where (a) an order for a declaration of a state of emergency is made and (b)* ***there is a conflict between this Act or regulation, other than the Alberta Bill of Rights or the Alberta Human Rights Act or a regulation made under either of those Acts, during the time that the order is in effect, this Act and the regulations made under this Act shall prevail in Alberta or that part of Alberta in respect of which the order was made*** [emphasis added]***.*** *(6) The Regulations Act does not apply to an order made under subsection (1).*

Recommendation 7: Section 27, 28, 29 should be rewritten to improve the *accountability* of those who have a duty/requirement to act in states of emergency. The sections presently read as:

> *27* ***No action lies against the Minister or a person acting under the Minister's direction or authorization for anything done or omitted to be done*** [emphasis added] *in good faith while carrying out a power or duty under this Act or the regulations, including a power or duty under section 19(1)(d), (e), (f), (g), (j) or (k) or (1.1) or 19.1 of this Act.*
>
> *28* ***No action lies against a local authority or a person acting under the local authority's direction or authorization for anything done or omitted to be done*** [emphasis added] *in good faith while carrying out a power or duty under this Act or the regulations including a power or duty under section 19(1)(d), (e), (f), (g), (j) or (k) or 19.1 or the exercise of the powers under section 24(1)(b) of this Act, during a state of local emergency.*
>
> *29* ***No action in negligence lies against a search and rescue organization, the directors of that organization or a person acting under the direction of that organization or a person acting under the direction or authorization of that organization for anything done or omitted to be done*** [emphasis added] *in good faith while acting under an agreement between that organization and the Minister*.

B. Recommendation for the Disaster Recovery Regulation, Alta Reg 51/1994.

Recommendation 8: Section 4(1) should be rewritten to include an appeal process with regard to the decision of the Minister, whether that is specifying the use of the courts to challenge a decision or appealing the decision of the Minister to a cabinet committee. The section presently reads:

> *4(1) The Minister may approve a disaster recovery program in respect of a disaster if the Minister is satisfied that (a) the disaster has caused widespread damage to property, and (b) the cause of the disaster was extraordinary. (2) A disaster recovery program may include (a)* ***terms and conditions for providing compensation*** [emphasis added]*, (b) the forms in which the compensation may be provided, and (c) special provisions dealing with the assessment of damage and loss. (3) The* ***Managing Director is responsible for the administration of a disaster recovery program*** [emphasis added] *in respect of a widespread disaster.*

C. Recommendation for the Government Emergency Management Regulation, Alta Reg 248/2007.

Recommendation 9: Section 4 should be rewritten or amended to include a direct connection to the Minister, such as, "the Minister has the responsibility to ensure the deputy head…" The section presently reads:

> *4* ***The deputy head of a department is responsible for ensuring that the department's functions and responsibilities under this Regulation*** [emphasis added] *and the Alberta Emergency Plan are properly carried out including (a) the* ***appointing of appropriately trained and qualified persons in accordance with the Alberta Emergency Plan*** [emphasis added]*,and (b) approving the plans referred to in section 3(2) and the Alberta Emergency Plan.*

D. Recommendation for the Local Authority Emergency Management Regulation, Alta Reg 203/2018.

Recommendation 10: Section 11(1) should be rewritten or amended to include provincial employees and provincially elected officials who carry responsibility under an emergency plan and who have responsibilities or roles for any sort of emergency management. The section presently reads:

> *11(1) The **Managing Director of the Alberta Emergency Management Agency may prescribe courses that each employee who has been assigned responsibilities respecting the implementation of the local authority's emergency plan must complete*** [emphasis added] *by posting notice of the courses on the Alberta Emergency Management Agency's website. (2) Any courses prescribed under subsection (1) must be completed within 6 months of the employee being identified for a role in the local authority's emergency plan.*

E. Recommendations for the *Public Health Act*, RSA 2000, c P-37.

Recommendation 11: Section 1.1.hh.1 should reflect the role that the AEMA plays in relation to the public health emergency. The section presently reads:

> *1.1.hh.1. "Public health emergency" means an occurrence or threat of (i) an illness. (ii) a health condition. (iii) **an epidemic or pandemic*** [emphasis added]. *(iv) a novel or highly infectious agent or radioactive material that poses a significant risk to the public health;*

Recommendation 12: The Minister and elected officials exercise their responsibilities through their power to appoint the CMOH and DCMOH along with the provision of budget and their capacity to provide and request advice. Sections 9(1) and 16(1) should be amended such that the CMOH and DCMOH appoint MOHs and EOs this would reduce the jurisdictional overlap and which would clarify the lines of accountability. The appointment of the CMOH and the DCMOH remains with the Minister. The sections presently read as:

> *9(1) A regional health authority shall appoint one or more persons as medical officers of health and one or more persons as executive officers for the regional health authority for the purposes of carrying out this Act and the regulations. (2) **The Minister may appoint one or more persons as medical officers of health for a regional health authority if the Minister is of the opinion that the number of medical officers of health** **[MOH]** **appointed by the regional health authority is insufficient*** [emphasis added]. *(3) A person who is appointed as a medical officer of health under this section is, by virtue of the appointment, also an executive officer. (4) **A medical officer of health and an executive officer** **[EO],** **appointed under this section must have the qualifications, if any, set out in the regulations*** [emphasis added].

> *16(1) **The Minister may appoint one or more physicians as medical officers of health*** [emphasis added] *for the purposes of Part 3. (2) A person who is appointed as a medical officer of health under subsection (1) is, by virtue of the appointment, also an executive officer. (3) **The Minister may designate one or more persons employed in the Department as executive officers for the purposes of this Act*** [emphasis added]. *(4) A medical officer of health appointed under this section and an executive officer designated under this section must have the qualifications, if any, set out in the regulations.*

Recommendation 13: Section 29(5) should be amended such that the CMOH (in coordination with the AEMA) to avoid confusion as to which standard or code or guideline or class is exempt. The Minister

appoints the CMOH and the AEMA Managing Director both who are accountable to the Minister. Exemptions are appealable to the Minister of Health or Cabinet. The section presently reads:

> *29(5) An order made under subsection (2) or (2.1) or an exemption made under subsection (2.2) may* ***incorporate, adopt or declare in force a code, standard, guideline, schedule or body of rules as amended or replaced from time to time, including a code, standard, guideline, schedule or body of rules by the Minister or the Chief Medical Officer*** [emphasis added]*, that relates to the order or exemption.*

Recommendation 14: Section 52.6(1) should reflect the Alberta Bill of Rights, Alberta Human Rights Act, the Canadian Charter of Rights and Freedoms, and the Universal Declaration of Human Rights. The section presently reads:

> *52.6(1) On the making of an order under section 52.1 and for* ***up to 60 days following the lapsing of that order the Minister or a regional health authority may do any or all of the following for the purpose of preventing, combating or alleviating the effects of the public health emergency and protecting the public health: (a) acquire or use any real or personal property; (b) authorize or require any qualified person to render aid of a type the person is qualified to provide; (c) repealed; (d) authorize the entry into any building or on any land, without warrant, by any person; (e) provide for the distribution of essential health and medical supplies and provide, maintain and co-ordinate the delivery of health services*** [emphasis added]**.**

Recommendation 15: Section 66.1(2) should be removed or rewritten to allow for accountability for actions or failure of action. The section presently reads:

> *66.1(2)* ***No action for damage may be commenced against any person or organization acting under the direction of the Crown, a Minister of the Crown, the Chief Medical Officer, the Deputy Chief Medical Officer or a medical officer of health for anything done or not done by that person or organization in good faith directly or indirectly related to a public health emergency while carrying out duties or exercising powers under this or any other enactment*** [emphasis added]**.**

F. Recommendation for the Communicable Diseases Regulation, Alta Reg 238/1985.

Recommendation 16: Sections 2(1), 2.1(1) and 2.1(2)(a) should be amended to reflect that the regional health authority has the jurisdiction to provide health care which includes equipment, medicines, etc. It should not be subject to the direction of the Minister, rather the Minister's responsibility needs to be limited to ensuring there are functioning regional health authorities that are established and that such authorities have the financial resources needed to fulfill their mandate. The sections presently read as:

> *2(1)* ***The Minister may (a) provide health promotional, preventative, diagnostic, treatment, rehabilitative or palliative services, supplies, equipment and care and any drugs, medicines and biological agents for the prevention, treatment or modification or communicable diseases, and (b) with respect to the services or things referred to in clause (a) determine (i) the persons eligible to receive those services or things, (ii) the persons who may administer those services or things, (iii) the condition under which those services or things may be provided and administered (iv) the methods and protocols respecting distribution and, where applicable, storage and handling of these services and thing*** [emphasis added]**.**
>
> *2.1(1) A regional health authority shall provide (a) provide health promotional, preventative, diagnostic, treatment, rehabilitative or palliative services, supplies, equipment and care and any drugs, medicines and biological agents for the prevention, treatment or modification or*

communicable diseases, and (b) any drugs, medicines and biological agents provided by the Minister under section 2(1)(a), ***as directed by the Minister*** [emphasis added].

2.1(2) A ***regional health authority shall, with respect to the provision of those services and things referred to in subscription (1). (a) implement distribution, storage and handling methods and protocols as directed by the Minister*** [emphasis added]*, (b) provide data, records or reports at the times and in the form and manner required by the Minister, (c) create and maintain the data and records required by the Minister, and (d) monitor, as directed by the Minister, the health and safety of persons to whom the services or things are provided.*

G. Recommendation for the Emergency Powers Regulation, Alta Reg 187/2009.

Recommendation 17: Section 3(1) should be amended to include specific notification channels, such as mainstream media, King's Printer, or a government website. Note that under this section, the type and manner of notification is left to the person exercising the emergency power. This may cause issues especially since the Minister or the person exercising the emergency powers may not be a communications expert. The section presently reads:

3(1) If an emergency power is exercised, the person exercising the emergency power shall provide or make available the following information in accordance with subsection (2): (a) the nature of the public emergency; (b) the nature of the emergency power being exercised; (c) the person or class of persons to whom it is directed; (d) the time period during which it is in effect; (e) the issuer's contact information; (f) it applicable, that compensation may be available under section 52.7 of the Act; (g) any other matter required by the Minister. (2) ***The information shall be provided or made available, subject to any directions of the Minister, in the manner the person exercising the emergency power considers will likely make the information known to an affected person or, in the case of a class of affected persons, the majority of affected persons*** [emphasis added]*. (3) If reasonably practicable, the information shall be provided at the time of the exercise of the emergency power and in writing.*

H. Recommendations for the *Regional Health Authorities Act*, RSA 2000, c. E-10.

Recommendation 18: Section 16 should be amended to prevent the Minister from providing potential duplicated services where an already existing regional health authority has been appointed. Currently this allows for duplication of services and could cause jurisdiction overlap between two competing regional health services. The Minister should have the authority to appoint and dismiss regional authority but not the ability to duplicate services. The section presently reads:

16 The Minister may if the Minister considers that it is in the public interest to do so (a) ***provide or arrange for the provision of health services in any area of Alberta, whether or not health services are also being provided in that area by any other government, person or authority*** [emphasis added]*, and (b) do any other thing that the Minister considers necessary to promote and ensure that provision of health services in Alberta.*

Recommendation 19: Section 22. should be removed or rewritten to allow for accountability of actions or failure of action. The section presently reads:

> *22* ***No action for damages may be commenced against a member of a regional health authority*** [emphasis added]*, including an official administrator appointed under section 11, for anything done or not done by that person in good faith while carrying out duties or exercising powers under this or any other enactment.*

I. Recommendation for the Alberta Emergency Management Agency

Recommendation 20: AEMA to be formed into an independent Public Agency[54]

Based on the findings in this report as well as undertaking a review and analysis of other reports previously provided to the Province, I recommend the PHEGRP to consider in their deliberations, making the AEMA an *independent* government agency under the governance of the Alberta Public Agencies Governance Act, with the Premier being the Minister responsible for this Agency. The AEMA should have a governing board of directors, appointed by the Premier. The board of directors are *responsible* for ensuring that the AEMA is functioning and is always in a position to fulfill its mandate for Albertans, that is, coordinate *all hazard emergencies* across the province both provincially, municipally, and regionally. For example, an *independent* AEMA may be structured similar to other service delivery agencies that provide and/or direct government services with an appointed board (for example, *Alberta Health Services Board* and the boards of post-secondary institutions such as the Board of Governors of the University of Alberta).

As the responsible Minister, the Premier's role under the Government Organization Act would entail collaborating with the public agency to establish long-term objectives, providing guidance to the agency regarding relevant government policies, and monitoring the agency's compliance with its mandate and progress towards achieving its long-term objectives.

The *Alberta Public Agencies Governance Act*[55] sets out the obligations of public agencies, including the formulation of mandates, the development of codes of conduct for agency members, and the establishment of objectives and targets. It also stipulates the powers and responsibilities of Ministers in relation to such agencies, including the review of public agencies and the appointment of board members.

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[54] A public agency is an organization established by the Government of Alberta, which is vested with the authority to provide public services or perform a public function for the people of Alberta. Although public agencies operate *independently* of the government, they are associated with specific ministries based on their mandate and enabling legislation. They are accountable to a responsible minister. Several public agencies in Alberta possess *representative boards* that allocate specific director positions to various stakeholder groups. Most often the government assigns the selection of these individuals to the respective stakeholder groups, and once nominated, the Cabinet or responsible minister appoints them. However, in some cases, both the *selection* and *appointment* of individuals to the representative board is assigned to the stakeholder group *without* any involvement of the government. Note that these boards are unique as the government does not partake in approving the appointments.

[55] Note that The President of the Treasury Board and Minister of Finance is currently responsible for the Alberta Public Agencies Governance Act.

APPENDIX I. COVID-19 ALBERTA TIMELINE

2020	
February 28	Emergency Management Cabinet Committee established (GOA)
March 5	First confirmed COVID-19 case in Alberta
March 9	First hospitalized COVID-19 case in Alberta
March 15	Closure of K-12 schools, child care facilities, preschools, places of worship (AH order)
March 17	Declaration of State of Public Health Emergency, elevates POC to Activation Level 4 (GOA)
March 18	Postpone all non-urgent scheduled and elective surgeries and non-emergency dental (GOA)
March 20	Restricts non-essential visitors for Continuing Care Facilities (AH Order)
March 27	Active cases in Alberta surpass 500
March 27	Eviction prevention measures (GOA)
March 27	Restricts gathering of more than 15 people, prohibits operation of closed contact business, restaurants, and retail services (AH order)
April 7	Visitor restrictions for healthcare facilities in place (AH order)
April 13	Extends testing to all symptomatic Albertans (GOA)
April 17	Active cases in Alberta surpass 1000
April 30	Releases relaunch strategy (GOA)
May 1	Releases ABTraceTogether App (GOA)
May 4	Resumes non-urgent same-day surgeries and allied health services in selection region with no significant risks (GOA)
May 6	Announces work on school re-entry plan (GOA)
May 11	Biz Connect website announced (GOA)
May 13	Announced that some businesses and facilities could start to resume operations on May 14th in all areas except the cities of Calgary and Brooks. (GOA)
May 14	Begin stage 1 of relaunch: Recommends non-medical mask use (GOA)

May 25	Resumes non-urgent inpatient surgery (GOA)
May 29	Extends testing to all Albertans (GOA)
May 29	Announces non-medical masks will be available at A&W, Tim Hortons, and McDonald's (GOA)
June 5	Announces Small and Medium Enterprise relaunch grant (GOA)
June 10	Announces re-entry plan for 2020-2021 school year with 3 possible scenarios (GOA)
June 12	Begins stage 2 of relaunch strategy (GOA)
June 15	State of Public Health Emergency ends (GOA)
June 26	Mandatory 2m physical distancing requirements (AH order)
June 29	The Government of Alberta announced a plan to address short-term and long-term challenges, including a $10 billion investment in infrastructure, creating 50,000 jobs; a reduction of the corporate tax rate to 8.0%—a year and a half sooner than promised; and strategies to support growth in other high-opportunity sectors such as value-added petrochemical manufacturing, mineral, pharmaceuticals, the financial sector, logistics, and aviation.
July 7	The Government of Alberta announced on July 7th, 2020 that it had introduced Bill 33, the Alberta Investment Attraction Act, which, if passed, would create the Invest Alberta Corporation, an arms-length agency that will promote investment in the province's primary sectors – energy, agriculture, and tourism. The Government said it would provide $6 million annually for the next three years for its operation.
November 12	The Government of Alberta on November 12th, 2020 announced new targeted measures to help protect the health system and limit the spread of COVID-19. The new public health measures included: ● All restaurants, bars, lounges and pubs in regions under enhanced status must cease liquor sales by 10 p.m. and close by 11 p.m. for a two-week period from November 13th to 27th; ● A two-week ban on group fitness classes, team sport activities and group performance activities in Edmonton and surrounding areas, Calgary and surrounding areas, Grande Prairie, Lethbridge, Fort McMurray and Red Deer; ● Additional public health measures including maximum attendance of 50 at wedding or funeral services, recommendations against social gatherings in private homes, and recommendations that employers in office settings reduce the number of employees in the workplace at one time.
November 24	The Government of Alberta on November 24th, 2020 declared a state of public health emergency.
November 24	On November 24th, 2020 the Government of Alberta announced that new mandatory restrictions came into effect and will be in place for at least three weeks. The new restrictions include:

	● No indoor social gatherings in any setting, outdoor gatherings with a maximum of 10 people; ● Wedding and funeral services for a maximum of 10 people and no receptions permitted; ● No festivals or events; ● Grades 7 to 12 at-home learning between November 30th and January 11th, grades K to 6 at-home learning between December 18th and January 11th; ● Working from home should be considered; ● Banquet halls, conference centres, trade shows, auditoria and concert venues, children's play places, and all levels of sport closed for in-person services; ● Restaurants, bars, pubs, and lounges will be open with restrictions; ● Most retail businesses may remain open with capacity limited to 25%.
December 8	The Government of Alberta announced on December 8th, 2020 that expanded health measures would be in effect provincewide for a minimum of four weeks. Measures that took immediate effect included: ● All indoor and outdoor social gatherings prohibited; ● Festivals, parades, events, concerts, exhibitions, competitions, sport and performance remained prohibited. Measures that commenced December 13th included: ● Retail services must reduce customer capacity to 15% of fire code occupancy; ● Restaurants, pubs, bars, lounges and cafes will be closed to in-person service; ● Casinos, bingo halls, gaming entertainment centres, racing entertainment centres, horse tracks, raceways, bowling alleys, pool halls, legions, and private clubs are closed; ● Recreational facilities, including fitness centres, recreation centres, pools, spas, gyms, studios, day and overnight camps, indoor rinks and arenas are closed; ● Libraries, science centres, museums, galleries are closed; ● Community halls and centres, indoor children's play centres and indoor playgrounds, theatres, auditoriums, concert halls, and community theatres, nightclubs, banquet halls and conference centres, and tradeshows are closed.
2021	
January 29	The Government of Alberta announced on January 29th, 2021 the easing of certain health measures as of February 8th, including: ● Children's sport and performance activities are permitted if they are related to school activities; ● Only one-on-one training is permitted for indoor fitness activities; and ● Up to a maximum of six people per table in restaurants, cafes, and pubs, with liquor service ending at 10 p.m. and in-person dining closing by 11 p.m.

February 8	The Government of Alberta announced on February 8th, 2021 that step one of a four-step plan to ease restrictions was underway, which included permitting, provincewide: ● school-related and limited indoor and outdoor children's sport and performance activities, up to a maximum of 10 individuals; ● one-on-one indoor personal fitness with a trainer; and ● dine-in service at restaurants, cafés, and pubs up to a maximum of six people per table with liquor service ending at 10 p.m. and in-person dining closing by 11 p.m.
February 10	The Government of Alberta announced on February 10th, 2021 the Critical Worker Benefit, a joint federal–provincial program that will see $465 million go to approximately 380,000 Alberta public and private sector workers as $1,200 cash payments. The Government said the benefit would be available to workers in the health-care, social services, education, and private sectors who deliver critical services to Albertans or support food and medical supply chains.
February 17	On February 17th, 2021 the Government of Alberta announced the new Enhanced COVID-19 Business Benefit, whereby up to $30,000 in support will be available to small and medium-sized businesses that have been most affected by the pandemic and ongoing health restrictions. The Government said this additional $10,000 payment can be used to offset costs associated with COVID-19, like purchasing personal protective equipment, paying bills, or hiring staff.
February 25	The Government of Alberta released Budget 2021 on February 25th, 2021, which included a $1.25 billion contingency to fight COVID-19 as well as investments in infrastructure and targeted strategies to enhance and diversify sectors like agriculture, energy, technology, and tourism. The Government forecasts an $18.2 billion deficit for 2021-2022 and real GDP growth of 4.8% in 2021.
March 1	On March 1st, 2021 the Government of Alberta announced that, effective immediately, unsupervised low intensity individual and group exercises were allowed by appointment only for indoor fitness and that libraries could open but must limit capacity to 15%. On March 8th, the Government announced that: ● banquet halls, community halls, conference centres, and hotels could open for all activities permitted under Step 1 and Step 2; ● all retail services and shopping malls must limit customer capacity to 25%, an increase from 15%; and ● individuals or groups could now rehearse and perform in preparation for filming or live streaming a performance although no in-person audiences are allowed.
April 6	On April 6th, 2021, the Government of Alberta announced that it was moving back into Step 1 of COVID-19 restrictions and that effective midnight: ● Retail services and shopping malls will be limited to 15% capacity; ● Only one-on-one training with an individual or household is permitted for indoor fitness activities; ● Outdoor physical activity is allowed with up to 10 people; and ● Adult performance activities, including dancing, singing, acting, playing a

	musical instrument and any rehearsal or theatrical performances, are not permitted.
May 4	The Government of Alberta announced on May 4th, 2021 that effective May 5th the following mandatory health measures would apply to all communities with more than 50 cases per 100,000 people and with 30 or more active cases: ● All outside social gatherings must be limited to no more than five people, a decrease from the previous 10-person limit; ● All indoor social gatherings are still prohibited; ● All indoor fitness must close; ● No more than 10 people can attend funeral services, a decrease from the current limit of 20 people; ● Retail services must limit customer capacity to 10%; ● All post-secondary learning must shift to online learning only; ● Working from home remains mandatory; and ● Any workplace with transmission of three or more cases will be required by health officials to close for 10 days. Effective May 7th: ● All kindergarten to Grade 12 students will temporarily shift to at-home learning. Effective May 9th: ● In-person dining on patios is prohibited; ● Hair salons, barbers, nail salons, estheticians, tattoos and piercing, must close; ● All outdoor sports and recreation are now prohibited except with members of your household; ● All indoor sport and recreation is prohibited; and ● All indoor performance activity is prohibited.
June 1	The Government of Alberta announced on June 1st, 2021 that Stage 1 measures of the Open for Summer Plan were effective immediately and that: ● Retail can increase to 15% of fire code occupancy; ● Outdoor social gatherings can increase to up to 10 people, while indoor social gatherings are still not permitted; ● Outdoor patio dining can resume; ● Outdoor physical, performance, and recreational activities are permitted with up to 10 people, ● Personal and wellness services can reopen, by appointment only; ● Wedding ceremonies may have up to 10 people, while receptions remain prohibited; and ● Funeral ceremonies may have up to 20 people, while receptions remain prohibited.
July 1	The Government of Alberta announced on July 1st, 2021 that all COVID-19 restrictions were now lifted. The Government said mandatory isolation and quarantine rules would remain in place, and that masking was still required in hospitals,

	continuing care, mass transit, ride shares, and taxis.
September 3	On September 3rd, 2021, the Government of Alberta announced temporary measures to reduce transmission and prevent the health-care system from being overwhelmed, and that effective September 4th: ● Masks will be made mandatory for all indoor public spaces and workplaces; ● Restaurants, cafés, bars, pubs, nightclubs, and other licensed establishments will be required to end alcohol service at 10 p.m.; ● It is strongly recommended that unvaccinated Albertans limit their indoor social gatherings up to a maximum of 10 people; and ● It is recommended that plans for in-person return to work be paused, and that employers revert to work-from-home where possible.
September 15	September 15, 2021 The Government of Alberta on September 15th declared a state of public health emergency.
October 22	On October 22nd, 2021, the Government of Alberta announced that starting October 25th, Albertans need to provide proof of two COVID-19 vaccine doses to access many restaurants, movies, sporting events, and other businesses provincewide.
December 21	On December 21st, 2021 the Government of Alberta announced new mandatory public health measures, effective December 24th, including: ● For venues in the Restrictions Exemption Program there will be a 50% capacity limit at venues that seat more than 1,000 people and for venues with capacity of between 500 and 1,000 occupants the limit is 500 people; and ● Restaurants, pubs, and bars must stop liquor service at 11 p.m. and close at 12:30 a.m.
2022	
February 8	On February 8th, 2022 the Government of Alberta announced it would begin a three-step plan to phase out public health measures, and that beginning February 9th: ● The Restrictions Exemption Program ends, along with most associated restrictions; ● Facilities with capacity of 500 to 1,000 will be limited to 500; and ● Facilities with capacity of 1,000-plus will be limited to 50%.
February 26	On February 26th, 2022, the Government Alberta said would begin step two and that effective March 1st: ● Capacity limits will be lifted for all venues; ● Limits on social gatherings will be removed; ● The provincial mask mandate will be lifted in most settings; and ● Mandatory work-from-home requirements will be removed.
March 1	On March 1st, 2022 , the Government of Alberta announced that step two of reopening was now in effect and that:

	● Capacity limits are lifted for all venues; ● Limits on social gatherings are removed; ● Restrictions on interactive activities, liquor service and operating hours are lifted; ● Remaining provincial school requirements are removed; ● Mandatory work-from-home requirement is removed; and ● The provincial mask mandate is lifted in most settings.

APPENDIX II. COVID-19 ORDERS and LEGISLATION

Legislation and Subordinate Legislation Reviewed	
EMA	Emergency Management Act, RSA 2000, c E-6.8.
DRR	Disaster Recovery Regulation, Alta Reg 51/1994.
GEMR	Government Emergency Management Regulation, Alta Reg 248/2007.
LAEMR	Local Authority Emergency Management Regulation, Alta Reg 203/2018.
PHA	Public Health Act, RSA 2000, c P-37.
CDR	Communicable Diseases Regulation, Alta Reg 238/1985.
EPR	Emergency Powers Regulation, Alta Reg 187/2009.
RHA	Regional Health Authorities Act, RSA 2000, c. E-10

CMOH Order ~ 174 (2020-2022)	
81	Total CMOH made in 2000 (44 RDs[56], 35 Exemptions[57], 1 Directive[58], 1 Clarification[59])
74	Total CMOH made in 2021 (56 RDs, 18 Exemptions)
19	Total CMOH made in 2022 (10 RDs, 9 Exemptions)

*Note that Order in Council (OICs) and Ministerial Orders (MOs) were reviewed with respect to the scope and objective of this report, all OICs and MOs have already been issued and to evaluate then base on the criteria would be an evaluation of such orders which is outside the scope of this report. However, it should be noted that not all OICs and MOs were available for review. Those that were reviewed were either provided by the Province, accessible at King's Printer or accessible at open.alberta.ca.

[56] RD is a Record of Decision by the CMOH and an order.
[57] Exemption provides an exemption to a group or class of individuals from a RD.
[58] D3-2020 issued on 4/23/2020. This directive from the Chief Medical Officer of Health provides direction to Alberta Health Services and medical officers of health for approving commercial accommodations for the purpose of isolation and quarantine.
[59] Clarification provides clarification on a previously issued RD.

APPENDIX III. PHEGRP MEETING ATTENDANCE

January 23, 2023	March 30, 2023	May 30, 2023
January 30, 2023	April 6, 2023	June 2, 2023
February 7, 2023	April 13, 2023	June 12, 2023
February 15, 2023	April 20, 2023	June 19, 2023
February 24, 2023	April 28, 2023	June 27, 2023
March 6, 2023	May 9, 2023	
March 20, 2023	May 24, 2023	

APPENDIX IV. NOTICE TO READER

This report has been prepared by Gerard A. Lucyshyn exclusively for the Government of Alberta's Public Health Emergencies Governance Review Panel (PHEGRP) pursuant to the terms of an engagement agreement between Gerard A. Lucyshyn and the Province dated March 23, 2023 (EXC23-010).

I, Gerard A. Lucyshyn, neither warrant nor represent that the information contained in this report is accurate, complete, sufficient or appropriate for use by any other person or entity other than the official panel members of PHEGRP or for any purpose other than that which is set out in EXC23-010. This Report may not be relied upon by any person or entity other than the official panel members of PHEGRP, and I hereby expressly disclaim any and all liability to any person or entity other than the official panel members of PHEGRP in connection with their use of the contents in this Report. Note that *nothing* contained in this report constitutes or should be deemed to be legal advice or legal opinion, rather any opinions and recommendations are mine alone.

While this engagement is specifically a *personal* engagement governed by a contract between the Province of Alberta and myself, it is important to clarify that my work with PHEGRP is considered a secondment from my position as the President/Executive Director of the Regulatory Research Institute of Canada. Note that this arrangement does *not* constitute any formal relationship between the Province of Alberta and the Regulatory Research Institute of Canada, rather it is solely intended to provide my experience and skills to the official panel members of PHEGRP. Any financial arrangements pertaining to this engagement are restricted to me personally and are contained within the provisions of the EXC23-10.

The objective of this report is to: (1) Define a set of principle-based criteria for evaluating regulatory regimes and their role in directing pandemic responses and apply those criteria to an evaluation of the inventory of regulations and orders promulgated by the Government of Alberta in response to the COVID-19 pandemic. (2) Conduct an overview of emergency management and public health legislation (including subordinate legislation) in [Alberta] and how it was used to direct pandemic responses. (3) Recommend amendments to legislation authorizing the promulgation of regulations and order for dealing with a public health emergency so as to improve their effectiveness. (4) Attend PHEGRP meetings as requested.

I have relied upon information provided by PHEGRP and the Government of Alberta, as well as information gathered from independent research. I accept no responsibility for loss or damages to any party as a result of decisions based on the information presented. Parties using this information assume all responsibility for any decisions made based on the information contained herein.

Note that the official panel members of PHEGRP will be responsible for the (a) assessment and interpretation of observations and recommendations in this report, (b) any decision to adopt any recommendations, in whole or in part, to be included in PHEGRP's final recommendations to the Government of Alberta, and (c) consideration of impacts that may result from the implementation of any recommendations, in part or whole, contained in this report.

APPENDIX V. LEGISLATION/REGULATION ASSESSMENT

After reviewing the 17 criteria and 13 check elements outlined in this paper that are pertinent to the establishment of an optimal regulatory framework, the PHEGRP has identified three foundational elements: Necessity, Effectiveness, and Accountability. Additionally, the PHEGRP has identified five additional characteristics that are deemed essential for effective and accountable performance of the regulatory regime. These essential characteristics are Evidence Based, Transparency/Openness, Conformity/Consistency, Balance/Fairness, and Self-Correcting via feedback.

The PHEGRP requested the author to provide an analysis of the legislation and subordinate legislation pertaining to Alberta's regulatory regime for public emergencies. The author was asked to rate and identify strengths and weaknesses to relevant legislation that would assist the PHEGRP in addressing deficiencies. The findings of this analysis are presented in the following tables:

Table 1. Assess the essential characteristics as they pertain to examined legislation and subordinate legislation during the COVID-19 emergency?

Statute / Criteria	Necessity	Effectiveness	Accountability
Emergency Management Act (EMA)	5	1	1
Disaster Recovery Regulation (DRR)	4	3	1
Government Emergency Management Regulation (GEMR)	5	1	1
Local Authority Emergency Management Regulation (LAEMR)	4	1	1
Answer Scale: 1 = strongly disagree, 3 = neutral, 5 = strongly agree			
Public Health Act (PHA)	3	3	1
Communicable Diseases Regulation (CDR)	3	5	1
Emergency Powers Regulation (EPR)	2	5	1
Regional Health Authorities Act (RHA)	4	3	1

Table 2. Perceived Strengths and Weaknesses of the *Emergency Management Act* and Subordinate Legislation

Statute & Subordinate Legislation	Perceived Strengths	Perceived Weaknesses
Emergency Management Act (EMA)	Clearly designates the AEMA as the coordinating agency for all hazard emergencies	Fails to clearly defines *all hazard* emergencies, especially around health and welfare of people Jurisdiction overlaps between: - duties of the Lieutenant Governor in Council and managing director of AEMA. - duties of the AEMA and local emergency management agencies. Protection against any liability
Disaster Recovery Regulation (DRR)	Clearly designates the managing director as responsible for the administration of a disaster recovery program and that the Minister is responsible for providing guidelines	No appeal process with regard to a Ministerial decision
Government Emergency Management Regulation (GEMR)	Clearly designates the AEMA as the coordinating agency for all hazard emergencies	No responsibility on the Minister to ensure the deputy head of the department is ensuring the responsibilities under the Alberta Emergency Plan are carried out
Local Authority Emergency Management Regulation (LAEMR)	Clearly defines that the local authority designates an emergency advisory committee and such committee is for the purpose of providing guidance and direction only and that the local emergency management agency is responsible for the administration of the local authority's emergency management program.	Provincial employees and provincial elected officials who have responsibilities under emergency plans are not required to take emergency management training courses, like their municipal counterparts

Table 3. Perceived Strengths and Weaknesses of the *Public Health Act* and Subordinate Legislation

Statute & Subordinate Legislation	Perceived Strengths	Perceived Weaknesses
Public Health Act (PHA)	Clearly establishes the duties of the MOH and the chain of notification (i.e. MOH → CMOH → Minister)	Public health emergency definition should clearly define the responsibilities of AEMA during this type of emergency Jurisdiction overlaps between: - duties of the Minister and CMOH. - duties of the MOHs and EOs Protection against any liability
Communicable Diseases Regulation (CDR)	The regional health authority is responsible to ensure that employees and other persons are appropriately trained to carry out their responsibilities	Jurisdiction overlaps between: - duties of the Minister and regional health authority.
Emergency Powers Regulation	Requires the person exercising an emergency power shall provide and make available the information about the nature of the emergency, who is affected by the emergency power, and any compensation available.	Lack of specific notification channels, such as mainstream media, King's Printer, or a government website

Table 4. Perceived Strengths and Weaknesses of the *Regional Health Authorities Act* and Subordinate Legislation

Statute & Subordinate Legislation	Perceived Strengths	Perceived Weaknesses
Regional Health Authorities Act (RHA)	The Minister is responsible for establishing and dissolving health regions in Alberta.	Allows for duplication of services and could cause jurisdiction overlap between two competing regional health services.

APPENDIX 4

Visibility and Availability of Orders in Council, Ministerial Orders and Regulations Issued by the Government of Alberta and Its Agencies in Response to the COVID-19 Crisis

Visibility and Availability of Orders in Council, Ministerial Orders, and Regulations Issued by the Government of Alberta and Its Agencies in Response to the COVID-19 Crisis

- The Alberta Gazette is the official "newspaper" of the Government of Alberta. The Gazette is updated twice per month.

- Section 3 of the *Regulations Act* requires that Orders in Council and Ministerial Orders that make regulations be published by King's Printer (KP). KP publishes them in Part 2 of the *Gazette*. Part 2 contains amendments to regulations as well as new regulations filed with the Registrar of Regulations. These Regulations, as filed and published under the *Regulations Act*, must be consulted when interpreting and applying the law.

- Some enactments require OCs to be published by KP in the Gazette. This includes things like appointments, proclamations, Resignations and Retirements, Orders in Council, Government Notices, and Advertisements. KP publishes these in Part 1 of the *Gazette.* A link to the Table of Contents for publications under Part 1 for 2023 can be found here. The link to review all of the documents published to date in 2023 is found here.

- Separate from the *Gazette*, King's Printer also publishes on a website Ministerial Orders from Departments that the Department requests to have published. This includes orders such as appointments, the establishment of programs, setting rates and fees, and designating positions. The KP website regarding Ministerial Orders is found here: https://www.alberta.ca/ministerial-orders.aspx.

- Some enactments that require a Department to publish a Ministerial Orders on the Department's website or in some other manner, in which case the Department must comply with the enactment.

- During the pandemic response, Alberta Health maintained a COVID-19 information website on which all CMOH Orders were published.

- The overarching rule is OCs and MOs must be published in accordance with what is set out in the statute that creates the authority to make the order. In addition, departments have discretion to publish MOs regardless of a legislated requirement to do so.

King's Printer Website Statistics

	2022/23 Fiscal Year	2021/22 Fiscal Year as Comparison*
Number of Downloads	2,545,165	1,865,292
Alberta Gazette Statistics	104,553	125,240
Alberta Rules of Court	21,454	5,539
Orders in Council Downloads	181,565	149,579
Ministerial Order Downloads	58,403	35,970
OHS Code	59,190	35,709
OHS Code Explanation Guide	11,389	9,854
Master Agreement	5,453	14,024

*we moved to Alberta.ca platform in June 2021. So website statistics changed in the Alberta.ca environment

Top downloaded laws from the King's Printer website:

1. Occupational Health and Safety Code
2. Occupational Health and Safety Act
3. Employment Standards Code
4. Residential Tenancies Act
5. Municipal Government Act
6. Freedom of Information and Protection of Privacy Act
7. Education Act
8. Traffic Safety Act
9. Alberta Human Rights
10. Health Professions Act

Number of Legislation Changes Published on King's Printer Website and KP Source Professional

Item Published	2022/23 Fiscal Year	2021/22 Fiscal Year as Comparison
Number of Orders in Council Published	474	383
Number of Ministerial Orders Published	389	507
New or Amended Statutes	678	259
Number of Statutes Repealed	15	58
New or Amended Regulations	615	288
Number of Regulations Repealed	137	19
Total number of legislation changes processed	1445	624
% overall of legislative changes	94.4% and increase of 131% as compared to last year. We saw a significant increase due to Demise of the Crown changes as well as Red Tape Reduction changes.	40.8% of all legislation files were updated. This is a decrease of 39% as compared to 1024 files that were changed in 2020/21

APPENDIX 5

Additional Measures for Strengthening the Capacity of the Alberta Emergency Management Agency to Respond to Public Emergencies

Additional Measures for Strengthening the Capacity of the AEMA to Respond to Public Emergencies

Strengthen the Planning Process

To be effective, it is suggested that the response by AEMA to the hazards posed by an emergency include the following steps:

I. **Identify the hazard**. (This should not be a static, one-off exercise, but rather an ongoing task, as the nature of the hazard becomes clearer over time or may change over time.)
II. **Select and maintain the aim (or mission)**, in this case to minimize the impact of the hazard on the jurisdiction.
III. **Establish a multidisciplinary governance task force**, headed by the Premier, to provide leadership for all policy, programs and actions.
IV. **Conduct a risk/hazard assessment** to give an assessment of the risk from the hazard, with appropriate detail.
V. **Conduct a mission analysis** that lays out a checklist of *what* needs to be done, including tasks given (written) and tasks implied, required to meet the aim.
VI. **Identify options** of *how* the objectives can be met. Assigned teams, with diverse expertise (to prevent groupthink), would determine the options available for each grouping of tasks, and complete a cost-benefit/harms-benefit analysis for each option.
VII. **Publish a response plan**, based in evidence that generates confidence in the government and its response to the emergency. This plan should allow feedback from the public.
VIII. **Repeat steps IV to VII** as more information becomes available and feedback is given; then modify the response and recovery plan as needed.

Suggested additions to this list include:

IX. **Cost every element of the plan** and its implementation, and secure approval for the budget.
X. **Address and rectify** the situation where detailed emergency management plans are developed in advance by responsible agencies only to be disregarded because responsibility for crisis management has been assigned to other agencies or departments.

XI. **Ensure a recovery process** is included in the plan, ready for implementation even before the emergency is officially over.
XII. **Ascertain the main lessons** learned from steps I to XI and incorporate them into planning for the next public emergency.

With respect to point IV above, the Panel suggests the cost/benefit analyses involve three possible aspects:

- Rough preliminary estimates, conducted under tight time constraints, of the potential benefits and consequences of the proposed measures.
- Detailed and substantive mid-crisis analysis of measures that are at least partially taken and are producing data.
- Substantive post-emergency analysis of costs and benefits once the emergency has passed, when the database is substantive and reliable, and when short-term and long-term effects are known and understood.

The aim of such analyses is not merely to maximize the ratio of benefits to costs in financial terms, but to maximize the overall benefit in terms of harms, with benefits and harms very broadly defined.

Employ the Systems Approach

It has been suggested that the AEMA more rigorously employ a "systems approach," in particular:

- Consider the impact of the hazard on all sectors of society, not just a select few.
- Harness the perspective and resources of all the relevant agencies and departments of government, not just those of the designated subject-matter agency or department.
- Ensure that feedback mechanisms are in place, enabling the agency to refine its understanding of the emergency, adjust its priorities, and make corrections to its initial responses.

Expert Advice and Ministerial Training

It has been suggested that more attention should be given to what expert advice needs to be made available to the political leadership, the AEMA, and the subject-matter agency or department, and how that advice should be sourced and

brought to bear on the decision-making process. (The next chapter discusses ways and means of facilitating evidence-based and scientifically informed decision-making, by governments.)

It is further suggested that crash training courses be available to elected officials and public administrators on both emergency management and evidence-based decision-making.

Positioning the AEMA During Periods of Non-Emergency and Emergency

When no state of emergency exists, the AEMA would remain in its current position within the Department of Public Safety and Emergency Services, and report to its minister. It is the responsibility of that minister to ensure the AEMA is maintained in full preparedness.

If a novel public emergency emerges, or one of unprecedented magnitude, for which it appears the AEMA is not adequately equipped to manage the response, it should be the responsibility of the minister to expeditiously expand the capacity and resources of the AEMA rather than to delegate the responsibility for managing the response to a subject-matter agency or department with less emergency management expertise.

When a public emergency is declared, the AEMA then reports, and is directly accountable, to the Premier and the appropriate Cabinet Committee.

APPENDIX 6

Educational Rights, Duties, and School Closures

EDUCATIONAL RIGHTS, DUTIES, AND SCHOOL CLOSURES

By Dr. Irvin Studin

Prepared for Alberta's Public Health Emergencies Goverfnance Review Panel

March 21, 2023

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This paper addresses Alberta's K-12 education system in the aftermath of the Covid-19 pandemic and the school closures that accompanied its management – in particular, what's to be done (and why), primarily in statutory terms, to preserve the integrity of education in the province in future public emergencies. Policy, postural and structural considerations drive the statutory recommendations made in this paper, even if the statutory moves do not, evidently, address all possible policy moves that could be made to reckon with future public health emergencies.

Note to reader: In order to reckon with the future, we must be clear-headed about what happened in the education system. Many of the consequences of the school closures were paradoxical and very foreign to our Canadian understanding. We must be able to psychologically "go there", as it were, in order to avoid future errors or policy and administration, regardless of the best intentions of mice and men.

In the second annex to the paper, I also briefly address some of the systems lessons for Alberta from other important countries and jurisdictions in reckoning with public health, emergency management and education. Finally, in the third annex, I touch on the working relationships, outside of strict statutory bounds, between the Ministry of Education, Health and other ministries of the Government of Alberta, school boards, municipalities, families and other players in Alberta's universe of decision-making in respect of education in general, and school closures in particular.

The Covid-19 Pandemic & School Closures – Context & Problem

The (physical) school closures of the Covid-19 pandemic period, beginning in mid-March 2020, were one of the most "copied" or "replicated" policy and administrative actions not only in Canadian history, but in all of human history.

Alberta, in this sense, was far from alone in closing its schools: to varying degrees of intensity, schools were physically closed by *all* Canadian provinces and territories and the vast majority of countries on all continents – at least until the northern fall of 2020.[1] (British Columbia had the shortest physical school closures in Canada, while Ontario had, by far, the longest. Alberta's school closures were comparable with the mean across the country.)

Most of the initial school closures – in Canada and around the world – were improvised and well-intentioned. They were executed *without* prior planning, with minimal foresight about what was to come (esp. in terms of the pandemic itself), and negligible understanding of the nature of the vast education systems that were being shut down – often for long periods of time.

[1] https://covid19.uis.unesco.org/global-monitoring-school-closures-covid19/regional-dashboard/

(As I note below, there is a huge difference between closing schools for a snow day or week-long planned holiday, and closing them for long, unplanned periods or *indefinitely*; or indeed, repeating such lengthy closures around short periods of "reopening".)

Canada's school systems, for a global K-12 student population of some 5 million (nearly 13% of the national population or, for Alberta's nearly 750,000 students, over 17% of the province's population), were originally designed in the late 19th century on the premise of mass compulsory education. This logic was consolidated, generalized to the entire youth population, and standardized across all 13 provinces and territories over a 20th century in which prolonged mass school closures were anticipated neither in law/statute nor in the psyche and processes of decision-makers.

Neither the Constitution of Canada nor the provincial education statutes have any provisions explicitly envisioning mass shutdown of schools. Critically, the Constitution of Canada – both textually (section 93 of the *Constitution Act, 1867* and section 23 of the *Charter of Rights and Freedoms*) and jurisprudentially – is nearly silent on both the right of the child to education in general (right to education as a *fact*; separate from, say, the right to instruction in a given language) and the duty of the state or governments in Canada to educate children. These rights and duties are implicitly presumed to exist, and not imagined to be endangered or stressed at scale.

The jurisprudence on education access in Canada, in leading cases like *Eaton v. Brant County Board of Education*[2] and *Moore v. British Columbia*[3], deals principally with inequality of educational access or discrimination in the provision of education. The *existence* of education is presumed – i.e. it is goes without saying that the state will provide education for the bulk of the youth population.[4] In short, the *fact* of education is not explicitly protected because there is no implicit (or felt) anticipation that it would or could ever disappear or be severely compromised.

One might also say, on inspection, that our constitutional structure in Canada is, for all practical intents and purposes, an adult structure, written by adults about adults. The child is missing, and education is a debate about adult considerations – not the future of the child, and the future of our society as a result of successful, or poor, education and childhoods.

If the division of federal-provincial powers and minority denominational and language rights in schools were the dominant preoccupations at Confederation (1867) and when Alberta joined Confederation (1905), then the school systems in these early Canadian days were relatively small, informal and parochial, supported by embryonic bureaucracies, processes and behavioural norms. They were not the mass, formal, universal bureaucratic scholastic structures of the early 21st century.

Also noteworthy is that Canada, nearly alone among the major federations (the U.S., India, Australia, Germany, Austria, Brazil, Argentina), has developed its education systems *without* a

[2] [1997] 1 S.C.R. 241
[3] 2012 S.C.C. 61
[4] See also, *inter alia*, *Wynberg v. Ontario*, (2006) 213 O.A.C. 48 (CA); *The Clough v. Simcoe County District School Board*, [2005] O.J. No. 2125; *Mahe v. Alberta*, [1990] 1 S.C.R. 342.

bona fide national minister or ministry of education. The provincial governments not only have exclusive legislative jurisdiction over education (section 93 of the *Constitution Act, 1867*), but the federal government has no one at all thinking about education on a regular basis across the 13 provincial-territorial jurisdictions. This means that Ottawa has little felt understanding of the policy relationship between (the crisis in) education, the schools and Canadian children and its impacts on the future of the country – impacts that affect *all* areas constitutional jurisdiction.

Enter the mass school closures of the pandemic period…

Alberta's school system, as with that of all the provinces and territories, is based on education statutes (*Education* or *School Acts*; in Québec, la *Loi sur l'instruction publique*) that are largely similar across the board, allowing for jurisdictional specificities:

- The right to education (Alberta calls it "right to access education")
- Compulsory education (mostly until age 16, with Alberta's at 16 minus a day; Ontario and New Brunswick until 18); relatedly, attendance requirements, enforced in extremis by attendance officers and attendance boards, but largely underpinned by longstanding societal and academic norms
- Responsibilities and rights of students, parents, teachers, principals and boards of education
- Powers of the Minister of Education
- Minority language educational rights (per by s. 23 of the *Charter*) or denominational educational rights
- Provisions relating to private schools, charter schools, home schooling and other bespoke arrangements

None of the provincial and territorial statutes in Canada anticipate long-term mass closures of schools. None, therefore, could have anticipated the *catastrophic* consequences of the physical school closures for (and pressures on) attendance, learning and the future structure and performance of society.[5] And finally, capitally, nothing but a linear return to pre-pandemic "normal" in the school system could be accommodated by the statutes in their existing, unamended forms. Indeed, nothing in the statutes prevents repetition of the closures and their vast consequences in future public emergencies, near-term or many years from now, whatever their genesis and nature – or even by dint of political or policy caprice or preference.

[5] https://academic.oup.com/wbro/article/36/1/1/6174606?login=false. These future consequences for society are vast – not just in significant future GDP loss and personal income loss for students, but also in individual and overall life expectancy, social cohesion and order (or criminality and delinquency), culture, etc. See also the work of Prachi Srivastava at the University of Western Ontario on this front.

Figure 1: Periods of General (Physical) School Closure in Canada During the Pandemic

Jurisdiction	Periods of Pandemic School Closures
Alberta (detailed chronologies and region-specific measures described below in Figures 2 and 3)	closed March 16, 2020 to June 30, 2020; November 30, 2020 to December 23, 2020 (grades 7-12); January 4-8, 2021; May 7-21, 2021; January 3-7, 2022
British Columbia	closed April 1, 2020 (after spring break) to June 1, 2020
Saskatchewan	closed March 20, 2020 to mid-June; December 14 to end of term; winter term starts late (January 11, 2021)
Manitoba	closed March 23, 2020 to mid-June, 2020; January 6, 2021 to January 10, 2021; mid-May, 2021 to mid-June, 2021
Ontario	closed March 17, 2020 to June 30, 2020; January 7-February 10, 2021; April 19, 2021 to June 30, 2021; first two weeks of 2022
Québec	closed March 16, 2020 to June 30, 2020; one-week delayed return to school for high school students in January 2021; April 1, 2020 to mid-May, 2021: schools in several regions closed; December 21, 2021: schools closed until return to school on January 17, 2022
Nova Scotia	closed March 23, 2020 to mid-June; fall term ended early (December 18, 2020); winter term started late (January 11, 2021); April 17, 2021 to mid-June, 2021; December 20-21, 2021 (term ended early); winter term started late (January 17, 2022)
New Brunswick	closed March 16, 2020 to June 19, 2020; early January to January 21, 2021; January 11, 2022 to January 31, 2022
Prince Edward Island	closed March 23, 2020 to end of school year in mid-June 2020; January 5, 2021 to January 10, 2021; early January, 2022 to January 24, 2022
Newfoundland and Labrador	closed week of March 16, 2020 to June 5, 2020 (school year was ended early); December 21-22, 2020; February 11-26, 2021 (St. John's area); January 4-25, 2022
Yukon	closed March 18, 2020 to end of school year in June 2020; September 2020 to April 2021: alternating school days for high school students
Northwest Territories	closed March 16, 2020 to end of school year in mid June 2020; closed September 14, 2021 to October 25, 2021 in Yellowknife and surrounding regions; closed January 4-21, 2022
Nunavut	closed March 17, 2020 to end of school year in mid-June 2020; closed for two weeks from November 18, 2020; closed for in first week of January 2021; closed April 14, 2021, with sporadic reopening for various schools through to end of school year in mid-June 2021; closed in first three weeks of 2022

Source: Triangulation by Irvin Studin, based on conversations, press releases and public documents

**The table does not reflect specific and highly varied academic, public health and social arrangements within the schools when "open" or the nature and quality of schooling, whatever the external arrangements, when the schools were "closed".*

***Several provinces, including Alberta, Saskatchewan, Manitoba, Ontario and Newfoundland & Labrador, described their school closures as "indefinite" in nature. (In the understanding of the public and students, this could have suggested no return to school or reopening prospects.)*

****Ontario had, by some margin, the longest school closures in North America. Some of its closures were driven by an unusual "bidding up" dynamic between unit-level medical officers of health, leaning on an expansive reading of section 22 of the province's Health Protection and Promotion Act, and forcing the hand of the Premier to close schools, on emergency powers, in order to obtain a general, province-wide closure in lieu of sporadic regional ones (which still occurred or were threatened throughout the pandemic period).*

Figure 2: Detailed Chronology of Alberta Public Health Orders Affecting Schools in Particular, and Education in General

March 15, 2020	AB issued CMOH Order 01-2020, prohibiting attendance, effective immediately, at early childhood service programs, daycares, out-of-school care, preschool programs, K-12 schools, post-secondary institutions and other educational settings.
May 14, 2020	AB issued CMOH Order 18-2020 (applicable to most of Alberta) to permit attendance at daycares, out-of-school care, day camps, post-secondary institutions, places of worship, hair salons and barber shops, retail businesses, restaurants at 50% capacity, and museums and art galleries. AB issued CMOH Order 19-2020 (applicable to Calgary and Brooks) to permit attendance at daycares, out-of-school care, post-secondary institutions, retail businesses, and museums and art galleries effective May 14; restaurants at 50% capacity, hair salons and barber shops effective May 25; and post-secondary institutions, day camps, and places of worship effective June 1.
May 27, 2020	AB issued CMOH Order 24-2020 to allow preschool programs to operate.
June 12, 2020	AB issued CMOH Order 25-2020 to remove restrictions on public access to businesses, schools and places of worship. Amusement parks, indoor children's play centres and nightclubs remain closed to the public. Calgary and Edmonton lifted local states of emergency.
July 21, 2020	AB announced K-12 schools will resume in-person in the fall under Scenario 1 (near-normal daily operations with health measures).
August 4, 2020	AB announced new school safety measures, including mandatory mask use for Grade 4-12 students and all school staff where physical distancing is not possible. Mask use for K-Grade 3 students will be optional. All students and staff to receive two reusable masks from the AB government.
August 29, 2020	AB issued CMOH Order 33-2020, outlining requirements for non-medical mask use for Grade 4-12 students, all staff, and visitors in indoor spaces, including on school buses and in shared areas such as hallways, effective August 31.
January 7, 2021	AB announced that current restrictions will remain in place for at least an additional two weeks, until January 21. In-person school to resume on January 11 as previously planned.
April 15, 2021	AB announced it has approved requests from public and Catholic schools in Calgary to temporarily shift Grades 7-12 to at-home learning due to operational considerations related to

	the pandemic (e.g. lack of substitute teachers and a significant number of students and staff in isolation/quarantine). At-home learning to start on April 19 and last for two weeks.
April 19, 2021	Public and Catholic schools in Fort McMurray temporarily shifted Grades 7-12 to at-home learning for two weeks until April 30. AB issued CMOH Order 12-2021 to put these restrictions into effect. (This order was later modified in CMOH Order 13-2021, effective April 22.)
April 20, 2021	AB announced public and Catholic schools in Edmonton would temporarily shift Grades 7-12 to at-home learning for two weeks, starting April 22.
April 29, 2021	AB announced targeted measures for regions with at least 350 cases per 100,000 people and 250 currently active cases (currently, the cities of Fort McMurray, Red Deer, Grande Prairie, Edmonton, Calgary, Airdrie, and Lethbridge, and Strathcona County), effective for at least two weeks and until regions fell back below the threshold. Effective May 3, Grades 7-12 to move to online learning. AB issued CMOH Order 17-2021 to put these restrictions into effect.
May 4, 2021	AB announced new restrictions for municipalities or areas with more than 50 cases per 100,000 people and with 30 or more active cases. AB issued CMOH Order 19-2021 to put these restrictions into effect. CMOH Order 20-2021 and Order 21-2021 were later issued to clarify these restrictions and those for areas below the threshold of more than 50 cases per 100,000 people and 30 or more active cases.
May 19, 2021	AB announced that students will return to classrooms on May 25 as planned, with the exception of students in the Regional Municipality of Wood Buffalo, who were to continue at-home learning for an additional week. Extracurricular sports, recreational and performance activities for children and youth were to remain closed in high-transmission areas of the province for the next several weeks.
August 13, 2021	AB released the 2021-22 School Year Plan, as well as guidance documents for parents and school staff. The plan was for in-class learning without restrictions (except masking on busses), and included contingency scenarios to account for potential COVID-19 resurgences. School authorities could put local measures in place if needed.
August 17, 2021	The University of Alberta, the University of Calgary and the University of Lethbridge announced that anyone not fully vaccinated would have to undergo regular rapid testing as of September 1.
September 16, 2021	CMOH Order 42-2021 required mandatory masking for students in Grades 4 and up, plus staff and teachers in all grades; elementary schools were to implement class cohorting.
September 23, 2021	CMOH Order 44-2021 amended Order 42-2021 to providing further clarity on requirements for exemptions and implementation of physical distancing requirements.
October 8, 2021	AB issued CMOH Order 48-2021, effective October 12, and set out conditions for excluding unvaccinated K-6 students from in-person school attendance when there were three or more confirmed cases of COVID-19 in the class cohort who attended class while infectious within a five-day period.
December 30, 2021	AB announced the winter break would be extended to January 10 for K-12 students to give school authorities time to gather additional data to assess staffing implications and potential operational impacts of the current COVID-19 situation. Starting the week of January 10, 8.6

	million at-home rapid tests and 16.5 million medical-grade masks were made available for staff and students.
January 5, 2022	AB confirmed ECS to Grade 12 students would return to in-person classes as of January 10 with the access to rapid tests and medical-grade masks that were to be distributed through schools. School authorities would continue to be able to shift classes or grades to at-home learning for short periods of time to address outbreaks.
February 8, 2022	AB announced public health measures would be lifted in three steps starting effective Feb 8 at 11:59 p.m. As part of Step 1: As of 11:59pm February 13, mandatory masking requirements were removed for all children and youth in schools. Alberta would enter Step 2 on March 1 if hospitalizations were trending downward: Any remaining school requirements would be removed (e.g. K-6 cohorting).
February 10, 2022	AB issued CMOH Order 08-2022, which outlined the specific details associated with Step 1 of the province's easing of existing COVID-19 response measures, as announced on February 8.
February 26, 2022	AB announced it would move to Step 2 of its reopening plan. Under Step 2: Remaining provincial school requirements (including cohorting) were to be removed.

Source: Executive Council/Ministry of Health

Figure 3: Detailed Timeline of Alberta (Physical) School Closures

March 16 - June 30, 2020	All K-12 schools closed. (Shift to at-home learning.)
November 30 - December 23, 2020 ○	All Grade 7-12 students province-wide moved to at-home learning; students in ECS to Grade 6 continued in-person
January 4-8, 2021	All K-12 schools closed. (Shift to at-home learning.)
A targeted measure was introduced for regions with at least 350 cases per 100,000 people and 250 active cases was introduced. The shift applied to Grade 7 to 12 students only and to schools located within the boundaries of the following municipalities for the following dates:	
April 19 - May 28, 2021	Regional shift for Fort McMurray Region for Grades 7-12.
May 3-14, 2021	Regional shifts for the Regional Municipality of Wood Buffalo; City of Red Deer; City of Grand Prairie; City of Calgary; City of Airdrie; Strathcona County; City of Lethbridge; City of Edmonton; St. Albert
May 4-14, 2021	Regional shifts for Town of Okotoks and Rocky View County
May 7-21, 2021	All K-12 schools closed. (Shift to at-home learning.)
January 3-7, 2022	School closed (extension of winter break; no at-home learning).

Source: Executive Council/Ministry of Education

Relevant Legislation and Ministerial Orders Used Across Canada to Close Schools

Nearly all of the school closures across Canada – in all 10 provinces and three territories – were undertaken on the authority of orders from officers of medical health – provincially or at regional/public health unit level – operating under *Public Health Acts* (as in Alberta) and/or, more generally, emergency laws relating to a declared provincial emergency (as with section 7.0.1 of Ontario's *Emergency Management and Civil Protection Act*).

Only Newfoundland & Labrador, of all provinces and territories, made specific material amendments to its *Schools Act* during the pandemic period (November 2022) to reckon with apparent pressures to student *attendance* within the school systems of that province. (I deal with the issue of attendance below.) The Newfoundland amendments are detailed in the Annex 1.

No specific ministerial orders or regulations were issued by any of the ministries of education in any province or territory, under the respective *Education Acts* or *Schools Acts*, during the Covid-19 pandemic period in respect of school closures *per se*.

However, Alberta issued or amended five (5) relevant regulations under the *Education Act* during the pandemic to address, to varying degrees, pressures and issues emerging from pandemic management and the concomitant altered pedagogical environment:

- *Alberta Regulation 226/2022* on "in-person learning", allowing boards to provide at-home learning only if the board provides or continues to provide a concurrent in-person learning option. This regulation expires on August 31, 2025. I propose that it should expire from the very start of the 2023-2024 school year, with the at-home learning option retired (with "at home learning" to be understood as distinct from "home education" – discussed in the proposed legislative amendments below).

- *Alberta Regulation 127/2022* on "private schools", in replacing Alberta Regulation 93/2019, added the language of Regulation 226/2022 in respect of at-home learning being permissible only if the in-person option is also offered, as well as a provision barring private schools from denying in-person learning access to students not wearing a face mask or other face covering (in relation to Covid-19). The regulation expires on August 31, 2027, but it should be amended no later than the start of the 2023-24 school year to remove the language in respect of "at-home learning" (no longer relevant).

- *Alberta Regulation 85/2019*, amended through to *Alberta Regulation 227/2022* on "charter schools", repeating the language of the above regulations in respect of the stricture on at-home learning – to be provided only if the in-person learning option is preserved; also a provision barring charter schools from denying in-person learning access to students not wearing a face mask or other face covering (in relation to Covid-19). This language on "at-home learning" and masks is now irrelevant and should be expunged.

- *Alberta Regulation 123/2022* ("Certification of Teachers and Teacher Leader Regulation") to address additional teacher certification and disclosure requirements outlined in the *College of Alberta School Superintendents Act, 2021*.

- *Alberta Regulation 124/2022* ("Practice Review of Teachers and Teacher Leaders Regulation") to address additional teacher certification and disclosure requirements outlined in the *College of Alberta School Superintendents Act, 2021*.

For this paper, review was done on ALL 13 provincial and territorial educational frameworks, as well as the education or school acts of Germany (Hamburg, Bayern), Switzerland (Zurich), Austria (Salzburg), Netherlands, USA (Massachusetts, Virginia, Ohio, Washington state, Wisconsin, Arkansas and Florida), Italy, Sweden, Norway, Denmark, Finland, Estonia, Belarus, Argentina, Nicaragua, Israel, Singapore, Vietnam, China, Japan, South Korea. Quiet conversations were also had with education leaders and specialists in a number of these countries and jurisdictions.

Notable were the multi-layered, explicit protections for students and youth provided in the Germanic states, cantons and Länder, which is where modern Western compulsory education traditions started (Martin Luther through to Frederick the Great). Here, three "protections" obtain where Canada and Alberta have none:

1. Explicit *constitutional* protections for the right to school and for children

2. Explicit articulation of the *duty* to attend school (*Schulpflicht*), accompanying the right thereto

3. Strong official processes and societal norms supporting and locking in the aforementioned *Schulpflicht*.

Relatively short school closures occurred mostly in countries that had explicit constitutional or statutory commitments to education as a national (or jurisdictional) priority – e.g. Vietnam and Singapore. These countries, along with Northeast Asian countries like China, Japan and South Korea, also had better "systems" understanding than Western countries (see Annex 2).

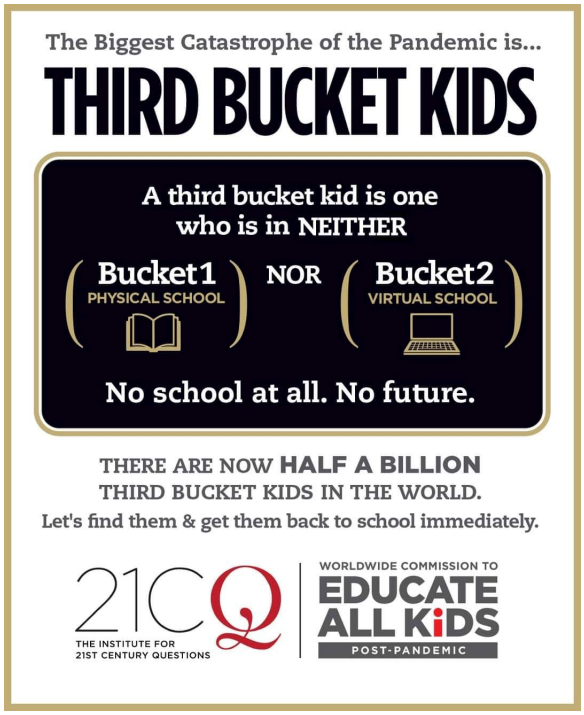
Sweden largely kept its schools open because, as discussed in Annex 2, its medical leadership made an early determination to the effect that Covid-19 did not have conspicuously negative health impacts on the youth (student) population, and that youth infection would also serve the general purpose of herd immunity in the overall society. (Sweden attached no circuit-breaking quality to potential school closures.)

Countries that, paradoxically, had a more "*laissez-faire*" or, conversely, "must-educate-to-survive" pandemic posture *vis-à-vis* their schools also had very short school closures – i.e. Belarus, Nicaragua and Burundi.

Because the consequences of the school closures – including compromised learning and reduced socialization – were borne primarily (and directly) by youth, these will be felt well into the future by both Alberta and Canada, across all dimensions of society, economy and country.

The mass school closures had some of the following key impacts on Alberta and other Canadian jurisdictions:

1. Large-scale ouster/defection from schooling by "third bucket kids" (where "first bucket" = physical/classical school, and "second bucket" = virtual/online school) – see the two-and-a-half-year-long work on "third bucket kids" led by the Canada-based Worldwide Commission to Educate All Kids Post-Pandemic.[6] (A wide variety of factors led to the "third bucket" ouster in Alberta and Canada and around the world, as soon as the schools shuttered, including lack of Internet/device access, abusive households, learning or linguistic difficulties when online, early defection to the labour force, household illness and leakage from the second bucket or online schooling once school standards disappeared and the costs of such leakage were a matter of turning off a Zoom call.)



2. Large-scale learning loss by students remaining in the school system[7]

3. Large-scale impacts on youth socialization and trust, as well as on the overall rhythm of Albertan and Canadian society

[6] https://www.i21cq.com/publications/worldwide-commission-to-educate-all-kids-post-pandemic/#:~:text=The%20Worldwide%20Commission%20to%20Educate%20All%20Kids%20(Post%2DPandemic),these%20ousted%20children%20into%20stable

[7] See, *inter alia*, the Final Report of the Alberta Child and Youth Well-Being Review (2021): https://open.alberta.ca/dataset/147b587f-5d12-48e1-9366-0dfce192e794/resource/b7f863bf-43af-44ec-8897-b0dafc341665/download/cs-child-youth-well-being-review-final-report-2021-12.pdf

4. Long-term impacts on the human capital, wealth and well-being of Alberta and Canada.

Countries that did not suffer the same large-scale consequences had the following advantages:

1. Very short school closures

2. Robust laws and norms in respect of compulsory education

3. Education was seen and understood as a national or regional priority

4. *Systems* understanding (and culture) that saw government compensate for systems closure with "energy" from other systems (i.e. Internet access and devices, energetic teaching, stanching of attendance leakage, check-in with students, economic and logistical support for students, etc.)

To avoid the schooling catastrophe of the pandemic period, Alberta's post-pandemic education framework must, in a pioneering sense, be amended, building on best legislatives moves around the world, and privileging a 'systems approach', to add the following, building on a basic new and deeply felt default posture of keeping its schools open at all times (barring *force majeure*):

1. Prohibition on *all* school closures except under the most exceptional circumstances – that is, making school closures as difficult and infrequent as possible, with such decision-making led by the head of government (i.e. head of *all* systems)

2. Minimization of the time periods of any and all school closures described in 1.

3. Enshrinement in law of the duty of Alberta to educate all of its children (complementary to, if not over and above, the right to education)[8]

4. Expansion and intensification of the requirements of compulsory attendance and penalties for dereliction thereof (incl. raising compulsory school terminus to 17 years of age, which is when high school normally ends)

5. Large-scale minimization of overall online learning in the system (express general preference for in-person learning in the system; elimination of any online learning as a post-pandemic legacy full-time option), while generalizing access to tablets, software and Internet access across the student body on a permanent basis (esp. in case of short-term closure) in order to stanch leakage into the "third bucket" in the event of school closures[9]

[8] Although Canada's constitutional and political traditions are more right-based than duty-based, when education is compromised or collapsed, it is children who must litigate for their "right to education". This children's right must therefore be complemented by an adult "duty to educate".

[9] Countries with near-perfect Internet coverage, wi-fi access and device access across the population and territory had minimal third bucket leakage, other things being reasonably equal – and esp. if the school closures were short.

6. Intensification of punctuality, behavioural and academic performance standards across the education system

7. One-off pandemic-related provisions to maximally find and reintegrate into education any and all students "lost" to education during the school closures[10]

8. One-off pandemic-related provisions to maximally make up for learning loss related to the 2020-2022 school closures

Alberta's Education-Related Legislative Framework:

Alberta's education-related statutory framework includes:

Education Act, SA 2012, c E-0.3

Child, Youth and Family Enhancement Act, RSA 2000, c C-12 *(change some of principles/preamble there?)*

Child First Act, SA 2013, c C-12.5

Family Law Act, SA 2003, c F-4.5

Protection of Sexually Exploited Children Act, RSA 2000, c P-30.3

Family Support for Children with Disabilities Act, SA 2003, c F-5.3

Early Learning and Child Care Act, SA 2007, c E-0.1

Child and Youth Advocate Act, SA 2011, c C-11.5

Teaching Profession Act, RSA 2000, c T-2

College of Alberta School Superintendents Act, SA 2021, c C-18.8

Proposed Amendments to the Education Act (to be read individually and as a whole):

Amendment 1: Change title of "Education Act" to "<u>Compulsory</u> Education Act"

[This will bring both strict and symbolic emphasis – including in the public consciousness – to Alberta's post-pandemic commitment to education as an obligatory and unavoidable "must" for all of its children.]

[10] Countries like Jamaica and Argentina did door-to-door searches for third bucket kids, further to the work of the Worldwide Commission to Educate All Kids (Post-Pandemic).

Amendment 2: Add "duty to educate" to preamble. New second paragraph of the preamble should read: "Whereas there exists a civilized, adult duty to educate all of Alberta's children"

[The existence of a right implies logically a duty. But the duty of the state is not made explicit in the current statutes. Students, parents and boards have "responsibilities". Alberta will now have an explicit duty to ensure that its children are educated.]

Amendment 3: Add "impact of children on future of society" to preamble. New third paragraph of the preamble should read: "Whereas the education of Alberta's children and youth is central to the future prosperity and social well-being of the province"

[This language is similar to – and complements – the existing preamble of Alberta's *Child First Act*. It aims to bring to bear a "futures orientation" in the thinking about education.]

Amendment 4: Add new fourth paragraph to preamble: "Whereas Alberta undertakes never to repeat the prolonged mass school closures of 2020-2022"

[Alberta here makes an historic statement, and a first among all provinces and territories, not to repeat the mistake of lengthy school closures of 2020-22 – lest this mistake be forgotten a decade hence. This also anticipates specific special amendments to the Act to reckon with some of the consequences of the school closures of 2020-2022 as a one-off.]

Amendment 5: Add new fifth paragraph to preamble: "Whereas Alberta, while acknowledging the opportunities presented by online learning, emphasizes in-person, in-school learning for children in order to ensure attendance and promote dynamic social interaction as cornerstones of a strong education."

[Alberta will minimize online learning as part of its curricular offering, as the easy default thereto during the pandemic closures led to large-scale leakage into the "third bucket" and learning loss for those remaining in the system. Emphasis on in-person learning in Alberta also asserts a commitment to "high energy" learning in the education system, with greater ability for quality control and monitoring of attendance and performance.]

Amendment 6: Amend "Part 1 – Access to Education" to read: "Part 1 – Right to Education and Duty to Educate"

[Let us be blunt. Not "access" to education, but rather "education" in a system in which education is now, more than ever, expressly compulsory.]

Amendment 7: Amend subtitle "Right of access to education" to read: "Right to education"

[Ibid]

Amendment 8: Add to the end of section 3(1) the underlined sentence, such that it now reads: "is entitled in that school year to an education program in accordance with this Act. <u>The Government of Alberta has a reciprocal duty to ensure that this entitlement is protected in accordance with this Act.</u>"

[Here we again assert the duty of state to educate, in support of the right to education.]

Amendment 9: Amend section 7(1)(c), which now reads: "subject to subsection (2), is younger than 16 years of age," to read: "subject to subsection (2), is younger than 17 years of age,"

[This will expand the compulsory education requirement to 17-year-olds (less a day), unless, as described in Amendment 10, the youth has already completed secondary school. Ontario and New Brunswick are currently at 18 years of age for compulsory schooling, as compared with 16 less a day in Alberta today. An extra year will also give one more year of academic preparation to the many students who suffered learning loss – or lost academic time – during the pandemic period.]

Amendment 10: Amend section 7(2), adding the underlined instead of "16", to read: "Subsection (1)(c) does not apply to a person who is younger than 17 years of age who has attained high school completion in accordance with the requirements prescribed in an order of the Minister under section 18."

[This language is consistent with/required by Amendment 10 above.]

Amendment 11: Add new section to read: "All schools shall remain open and operational during the school year, and may only close on scheduled school days on the joint express orders of the Premier and the Minister of Education. Where a school is closed, the Premier and the Minister of Education shall undertake to reopen it as quickly as possible, and shall publicly commit to the date of the reopening."

Add new subsection to this new section to read: "This section applies even if section 52.1 of the *Public Health Act* or section 18(1) of the *Emergency Management Act* is invoked."

Add new subsection to this new section to read: "The Government shall, on each day of any school closure, for the entire period of the closure, contact every student in the closed school(s) to enquire into their well-being and ensure that they have all necessary equipment (including any relevant electronic devices and Internet access), materials, means and accommodations for continuation of learning for the period of the school closure."

[This is a new, sui generis section relating to short-, medium- or long-term closures of the sort witnessed during the pandemic. This section is separate and distinct from the existing language on "Closure of schools" in section 62 of the *Education Act*, which appears to deal with traditional "closure" or retirement of school or school buildings, and which was nowhere invoked during the pandemic closures. The decision to close schools – for one day or many, *regardless of reason* – now goes to the head of government, jointly with the Minister of Education. This signals both the centrality of schools to Alberta's future and the gravity with which the potential closure of schools is taken. This also ensures that a system-wide, synoptic view of schools and the education is in place when the question of potential school closures is considered. Here we wish to avoid ever again allowing school closures to have a clerical, perfunctory or ancillary character, or for them to become instinctual under any given policy pressure or even emergency. The commitment to a firm, near-term return-to-school date militates

against the pandemic-period error of describing school closures as "indefinite" – something that would have suggested to young minds that this was a permanent state of affairs; the end of their studies, as it were. Finally, the stricture of having to enquire into the well-being of each and every student during any closure, as labour-intensive, creates systemic disincentive to close the schools except under the most exceptional circumstances – and for very short periods at that. Note that we do not enumerate the "exceptional circumstances" in this section or anywhere in the act. Instead, it is the Premier and Minister of Education who will, further to obvious consultation with colleagues and officials, make a synoptic determination as to whether exceptional circumstances are at play – in health, public safety, natural disaster or other terms.]

Amendment 12: Amend section 7(3) to remove "make all reasonable efforts to" before "ensure", so as to read: "A board shall ensure that a student who is a resident student of the board or who is enrolled in a school operated by the board attends school."

[The current "reasonable efforts" language is too weak.]

Amendment 13: Amend section 7(5) to add the underlined, so as to read: "Where a student is excused from attendance at school under subsection (4)(e), that student is excused from attendance at school only during the period of time prescribed by the board or the Minister, as the case may be. <u>The board or the Minister must expressly indicate the date of return to school, with such date being the soonest possible.</u>"

[We wish to avoid long or "indefinite" periods of absence from school, with explicit commitment to a return date.]

Amendment 14: Add new section on special Covid-19 period provisions – "Third Bucket (Missing) Students and Learning Loss." One new section will read: "The Ministry of Education (Alberta Education) shall undertake a comprehensive review of Alberta attendance records for the 2020-2022 period to identify all students whose attendance was materially affected by the school closures of the Covid-19 pandemic period. The Ministry of Education will make all reasonable efforts to reintegrate into schooling, with minimal delay, all students who left education prematurely during this period."

Amendment 15: The other new section will read: "The Ministry of Education will make all reasonable efforts to make up for any and all learning loss incurred by students during the Covid-19 pandemic period of 2020-2022, including as a result of school closures."

[This is critical, time-urgent work needed to triangulate attendance records and physical locations of (third bucket) students who defected or were ousted from schooling over the course of the pandemic and the school closures – for the many reasons discussed earlier in this paper. These two sections could also, in principle, be rolled up into regulations under the Act, but the symbolic import of them forming part of the body of the act trumps, in my submission.]

Two more amendments are proposed:

Amendment 16: Add two new sections on emergency decision-making (informed also by the international systems analysis discussed in Part 2 of this paper). The new first new

section reads: "The Minister of Education will be a full member of all Cabinet committees relating to emergencies in order to advance the interests of Alberta's children and their education."

Amendment 17: The second new section reads: "The Deputy Minister of Education will be a full member of all deputy ministerial committees relating to emergencies in order to advance the interests of Alberta's children and their education."

[Without wishing to impede on the Premier's prerogatives in establishing the committee structures and processes that she/he desires in order to reckon with any emergency, these new sections will make permanent the understanding of education and children's considerations as central to the management of all emergencies and the future of the province coming out of all emergencies. These two sections could also, in principle, be rolled into new regulations under the Act.]

Let me also propose that, shy of statutory amendments, three separate new regulations should be issued under the *Education Act* to signal the government's intention to inspect and review the quality and integrity of all home education (including "pod education") programs, charter schools and private schools twice a year to ensure alignment with provincial standards and the Act.

No relevant amendments are obviously required to any of the other statutes in Alberta's education-related statutory framework as a consequence of the *Education Act* amendments proposed herein.

Annex 1: Newfoundland & Labrador's Amendments to the Schools Act to Address Attendance Pressures.

7. Subsection 15(2) of the Act is repealed and the following substituted:

(2) A parent of a student who moves within the province or into the province shall present the student for enrolment in a school within one week of the move.

8. Section 16 of the Act is repealed and the following substituted:

Attendance

16. A parent of a child shall ensure that the child attends school unless the child is excused from attendance under this Act.

9. Subsection 17(1) of the Act is repealed and the following substituted:

Offence

17. (1) A parent of a child who neglects or refuses to enrol the child in school or does not make every reasonable effort to ensure that the child attends school is guilty of an offence.

10. (1) Subsection 18(1) of the Act is repealed and the following substituted:

Duty to report

18. (1) A person who has reason to believe that

(a) a child who is required to be enrolled under section 15 is not enrolled; or

(b) a child who is receiving instruction under section 6 is not receiving instruction in accordance with this Act,

shall report that belief to the superintendent or, in the case of a French first language school, to the director.

(2) Subsection 18(2) of the Act is amended by deleting the word "director" and substituting the words "superintendent or the director".

11. (1) Subsection 19(1) of the Act is repealed and the following substituted:

Regular attendance

19. (1) A teacher, a principal, the superintendent and the director shall make every reasonable effort to secure the regular attendance of students at school.

(2) Subsection 19(2) of the Act is amended by deleting the word "director" and substituting the words "superintendent or, in the case of a French first language school, to the director".

(3) Subsection 19(3) of the Act is repealed and the following substituted:

(3) Where the superintendent or the director receives a report under subsection (2) and is satisfied that every reasonable effort has been made to have the student return to regular attendance and these efforts have been

unsuccessful, the superintendent or the director shall refer that matter for investigation to the nearest detachment of the Royal Newfoundland Constabulary or of the Royal Canadian Mounted Police.

12. (1) Subsection 20(2) of the Act is repealed and the following substituted:

(2) A parent of a student attending school may request that a teacher, the superintendent or, in the case of a French first language school, the director consult with the parent with respect to the student's education program and that teacher, the superintendent or the director shall comply with that request unless the request is unreasonable in terms of frequency or other circumstances.

(2) Subsection 20(3) of the Act is repealed and the following substituted:

(3) A teacher, the superintendent or the director may request that a parent of a student consult with the teacher, the superintendent or the director with respect to that student's education program and that parent shall comply with that request.

Refusal to admit

35.1 (1) Where the superintendent or the director is of the opinion that the presence of a student in a school is detrimental to the physical or mental well-being of the students or staff, the superintendent or director may refuse to admit the student to the school.

(2) Where the superintendent or the director refuses to admit a student to a school under subsection (1), the superintendent or director shall

(a) notify the student and the student’s parent, in writing, of the refusal and the circumstances giving cause for the refusal;

(b) notify the student’s parent or, where the student is 19 years of age or older, the student, of the right to appeal the refusal; and

(c) direct the principal of the school to provide alternate delivery of the educational program for the student.

(3) The superintendent or the director shall review a decision under subsection (1) at least every 15 days and determine whether the student should be re-admitted to the school.

20. (1) Subsection 36(6) of the Act is repealed and the following substituted:

(6) Notwithstanding subsection (5), the superintendent or the director may approve the extension of a period of suspension if the principal can demonstrate that the presence of the suspended student in the school threatens the safety of board or conseil scolaire employees or students or frequently and seriously disrupts the classroom or the school.

(2) Subsection 36(7) of the Act is repealed and the following substituted:

(7) Where a period of suspension is extended under subsection (6), before reinstating the student, the superintendent or the director may require certification from a medical practitioner or other professional person whom the superintendent or director considers appropriate, that the student no longer threatens the safety of board or conseil scolaire employees or students.

Expulsion

37. (1) Where a student is persistently disobedient or defiant or behaves in a manner that is likely to injuriously affect the proper conduct of the school, the principal shall

(a) warn the student and record the date of and reason for the warning;

(b) notify the student's parent, in writing, that the student has been warned;

(c) send a copy of the notice referred to in paragraph (b) to the superintendent or, in the case of a French first language school, the director; and

(d) discuss with the student's parent the circumstances giving cause for the warning.

(2) Subsection 37(2) of the Act is repealed and the following substituted:

(2) Where, after a reasonable period and consultation with appropriate employees of the board or the conseil scolaire, it is determined that the student has not made a satisfactory effort to reform, the principal shall report in writing to the superintendent or the director and recommend to the superintendent or director that the student be expelled.

22. Section 41 of the Act is repealed and the following substituted:

Prohibition

41. A person shall not

(a) disturb or interrupt the proceedings of a school, a school council, a conseil d'école, a board, the conseil scolaire or the provincial advisory council;

(b) loiter or trespass in a school building or on property owned or used by a board or the conseil scolaire; or

(c) canvass, sell or offer to sell goods, services or merchandise to a teacher or a student in a school without the approval of the school council or the conseil d'école, and if there is no school council or conseil d'école, of the board or the conseil scolaire.

Annex 2: Considerations on the Relationship of Public Health and Emergency Management Systems to the Education System

In this section, I shall provide some short comments on the performance of the emergency and public health systems of a handful of countries that were more successful than Alberta and other Canadian provinces and territories in preserving the operational integrity and standards of their educational systems while performing at high levels in public health. The analysis is, for the most part, exercised by postural and policy considerations, rather than strictly statutory ones.

I conclude that the countries that did best in managing the relationship between education, emergency management and public health systems had the following in common:

- Greater sense of systems (approximating systems thinking), rather than episodic thinking (noting that such thinking could result in the polar-opposite extremes of tight policy choreography or even an overall *laissez-faire* approach)

- Forward strategic and policy posture – a national capacity to understand, at least impressionistically (but ideally in terms of scenario gaming and planning), the future consequences of collapse in any of these systems

- Considerable contingency (material) reserves and preplanned excess capacity in the systems of state and society (e.g. extra hospital beds, extra laptops and wi-fi cards for students and households, etc.)

- Strong or decisive centralized decision-making at political level (this is not an ideological point, but an empirical one: democratic federations and most federal jurisdictions appear to have done less well in managing all of these systems in tandem)

- High energy projected outward from government into society – i.e. government ramp-up capacity substitutes for a demobilized population

All countries and jurisdictions – democratic or not – appear to have struggled most with one key capability that I have flagged in past writing and discussions – to wit, feedback mechanisms and processes from the ground to the centre in order to refine or correct mistakes of emergency-period policy and administration across the systems. There is room here for Alberta to incorporate specific statutory amendments in both *Public Health Act* and *Emergency Management Act* in respect of the necessity of constantly seeking and, where useful, incorporating feedback from the public into emergency decision-making – especially as the emergency unfolds.

Countries and jurisdictions of interest here include Singapore, Vietnam, Japan, South Korea, Sweden, Australia and Israel. Let me emphasize that the pandemic experiences and records of all these jurisdictions was *far* from ideal – that is, all of them struggled and adjusted responses to different phases of the pandemic. Let us not create false hagiographies where the human comedy

is still at play. Our interest in these stylized descriptions is the essential structural-legal-bureaucratic framework that facilitated apparent *relative* success across the systems of state and society.

Singapore:

Singapore had very short school closures. Education is a clear national priority, and attendance discipline, as soon as schools went online, is very strict – for students and guardians alike. A Prime Minister-led interdepartmental task force led the management of the pandemic. Critically, and famously, Singapore had built up huge financial reserves in a national contingency fund to prepare exactly for future emergencies like the pandemic (or war, natural disasters or economic depression). The country deployed these contingency resources at scale to reckon with economic and health care pressures. Moreover, Singapore took an early political decision, driven by longstanding strategic-cultural instincts (and a reputational interest), to "stay open" as a country – that is, to maintain its hub position in Southeast Asia in particular, and Asia in general, which would require a national determination to reopen all systems as soon as possible. Finally, as with many Southeast Asian countries and *all* Northeast Asian countries, Singapore has a "high energy" government. As such, even during period of quarantine and isolation, Singapore deployed heavy human and technological resources to manage outbreaks, reach affected populations, and reckon with various systems at the same time. It never slept, and never glorified sleep.

Vietnam:

Vietnam, like Singapore, is a highly centralized country, except with a far larger population and territory. Public trust of government is high. Like Singapore, it has a high-energy executive, able to deploy significant human, fiscal and technological-scientific resources at scale across the country. It also has considerable experience with past pandemics and is well practiced in pandemic management – including in the use of technology and data management for purposes of public health decision-making. Large-scale, regular drills and population discipline, coupled with considerable ramp-up capacity in the health system, helped the country manage some of the pandemic waves. Like Singapore, education is a national priority (in Vietnam's case, explicitly in the constitution), so schools were closed for short periods. Migrant populations in the country's economic centres would have resulted in more third bucket kids than in Singapore, Japan and Vietnam. (Note that Vietnam, with a major border with China, had enough flexibility in its centralized decision-making to stand down from an early "Zero Covid" posture (as taken by China) and to adjust to more pragmatic targeting of outbreaks, while keeping other non-health systems ticking over.

Japan:

Japan had beds to spare in its health system, even in peak pandemic periods, due to considerable forward planning and ramp-up capacity. Schools were closed for short periods, but compulsory schooling norms held and wi-fi coverage was nearly perfect across the country. Critically, the public did not panic at any point in the pandemic, and the government maintained a sense of historic and systems proportions, without having to (and without having the power to) resort to

the more draconian command-and-control pandemic policy choreography of Vietnam, China and Singapore.

South Korea:

Like Japan, South Korea has considerable experience with emergencies in general (typhoons, industrial accidents, fires), and public health emergencies in particular (e.g. SARS in 2002-04, MERS-CoV in 2015). More globally, South Korea maintains an active war posture vis-à-vis North Korea, so its national state and society mobilization capabilities are significant. This means that its Covid-19 pandemic experience turned less on the "energy" and planning of government (which were significant), but rather on the initial problem definition (evolving from a Covid-Zero instinct to a more pragmatic posture) and coordination of ministries in Seoul and across the regions and major municipalities (issues of machinery of government and culture flagged in past critiques of the country's emergence preparedness and performance). Education has cultural pride of place in South Korea, so leakage into the third bucket was limited by virtue of short closures, strong attendance norms and near-perfect wi-fi coverage across the territory of the country.

Sweden:

Sweden barely closed its schools, having made a rapid determination to the effect that Covid-19 posed minimal apparent harm to children and youth. Sweden also bet on keeping most of its institutions and businesses open in order to promote herd immunity. The rhythm of the society, critically, was largely preserved.

Australia:

Australia, like Canada, has a federal democratic system. It assumed a near-Covid Zero posture in the early phases of the pandemic due to its island nature and longstanding cultural instincts in respect of infectious diseases. Australia's system has two cardinal emergency-related differences with that of Canada: first, it is more centralized in constitutional (incl. key constitutional jurisprudence) and political-cultural terms, with the Commonwealth (federal) government having non-trivial statutory and fiscal "ins" into education, health care and national security at state (provincial) levels; and second, a deeper "national security" or "emergency" culture stemming from direct experience of strategic abandonment in the Second World War and bombardment of its territory – leading to a national determination never again to suffer such vulnerability. As a result, the security and emergency machinery and personnel at the centre of government both at Commonwealth and state levels are more robust and practiced than in Canada.

Israel:

To an even greater extent than Australia, Israel has a national security and emergency culture across state and society. It is a high-energy society that mobilizes all national resources, across a small population and territory, to achieve its ends. In the case of the Covid-19 pandemic, these ends may have been more narrowly defined than Israel's more conventional "military planning" might have suggested for other major emergencies – including armed conflict and counter-terrorism. Israel's response was high energy but fairly uncoordinated across government and

society. Its health and tech sectors are large, so the ramp-up capacity for hospitals, vaccination and data management was high. On the other hand, education is highly valued in the society but school closures were not short and third bucket leakage were non-negligible – especially in marginalized communities and villages.

Annex 3: Considerations for Improving Relationships and Understanding Among Key Respondents to Public Emergencies in Alberta as they Affect the Educational System

As observed in Annex 2, the countries that did best in managing their response to COVID-19 in respect of education often tended to be those where there was a greater appreciation of the various systems of state and society, and of the importance of the education system among the systems and for the future of society.

While it is beyond the terms of reference of the Public Health Emergency Governance Review Panel to conduct an in-depth assessment of the relationships among those entities in Alberta, or to recommend policy or statutory changes to facilitate more systems-oriented responses to, and planning for, a public emergency affecting the education system and the well-being of children, the following observations may be helpful in developing such policy or statutory changes in the future:

1. As discussed in the proposed statutory amendments, *only* the Premier and Minister of Education can *jointly* close schools, under any conditions, emergency or not. Full stop. The Ministry of Health, strictly, should have no decision-making authority in respect of school closures. Nor should any other ministry.
2. Health, like all other ministries, may brief into any parts of decision-making processes in respect of education and schools, but it has no synoptic picture of all ministries, and so is only a source of input. Its brief is never dispositive.
3. The general *posture* of all ministries, in all emergencies, must be to keep schools open and operational – never the reverse. (Closure of any system leads to breakdown in all other systems – a key learning of the pandemic.) This posture is only to be disrupted in the most extreme circumstances, for the shortest period possible, with clear public and felt commitments to reopen the system on publicly stated dates (such being within the shortest possible period). This default posture will take time to insinuate into the culture of decision-making in Alberta, and will turn on sustained leadership in the system.
4. Leading countries understood that the closure of any system, however short, must be met with mobilization by other systems of state and society to quickly stanch "leakage" from that system. As such, if, under extreme circumstances (and in planning therefor), the Premier and Minister of Education close schools, the following moves are recommended, in both pre-planning and emergency response, for the ministries of the Government of Alberta, boards and municipalities:
    a. Ensuring that 100% of the provincial student body has a functioning laptop and access to wi-fi. (To be clear, this is for students, families, teachers, principals and boards to remain in communication, for general purposes, in the event of short-term closures. This is *not* to be understood as a substitute for learning within schools, when schools are open and properly operational. Attendance norms must be upheld fully during this period.)

   b. Ensuring that all students and families are contacted daily to enquire into the well-being of the student during physical school closures, and that remedial action be taken in the event the student is in distress as a consequence of the closure. (The Ministry of Health has a role in this respect, subordinate to the Ministry of Education. School boards, municipalities and families, too, have obvious key roles here.)
   c. Full mobilization of logistics and personnel, across the school boards, ministries, municipalities and all of society, to ensure the urgent physical reopening of the school.
   d. Detailed management of the reopening of the school, while fully upholding attendance norms. (All ministries, boards and municipalities have roles in this respect.) Critically, such reopening must be high energy in order to rapidly make up for any learning lost during the period of physical school closure.)
5. A broader question, beyond the scope of this report, is what "learning" ought to look like during any short-term physical school closures brought about by extreme circumstances.
6. Feedback to decision-makers is essential to the avoidance and correction of mistakes of policy and administration – especially in emergencies. As such, there must be constant upholding of feedback mechanisms from the public at large, and students, families, teachers and principals in particular, into decision-making processes. School boards and municipalities have key roles in facilitating these feedback processes from the ground up, and from decision-makers to the public.

APPENDIX 7

Mandating Impact Assessments

Research Memorandum

RRI CANADA

August 3, 2023

TO: Preston Manning, Chair
Public Health Emergencies Governance Review Panel

FROM: Gerard A. Lucyshyn, President/Executive Director

RE: Chapter VII - Mandating Impact Assessments

As per your email request and in accordance with EXC24-005 Schedule A.

> *"Comprehensive analysis of Chapter VII (Mandating Impact Assessments) with particular attention to regulatory aspects and securing examples of assessments at the three levels discussed in the chapter."*

We are pleased to submit the following research memorandum:

The Purpose and Need for Impact Assessments

> "Evidence-based policy making is a well understood and accepted principle of good governance. However, any sort of government intervention, whether by policy, law, regulation, or any other type of rule may not always fully consider all the effects of such intervention at the time the intervention is being developed. All government intervention has costs and there may be situations where such costs outweigh the anticipated benefits and/or may create some unintended consequences that negatively impact citizens, business, and/or society as a whole."
>
> - OECD 2019

Generally and more than not such negative impacts and unintended circumstances referred to above are more burdensome on smaller less organized, hard-to-reach, and marginalized citizens. Impact analysis is a crucial tool that ensures policy decision-makers have considered all options and information (available at the time) while documenting and making public the rationale, evidence, and analysis used in implementing government intervention. In addition, impact analysis holds decision-makers accountable and adds transparency to policy making.

Many decision-makers have found that over-procedural and "off-the-shelf" assessments impose challenging obstacles in the practical world of policy making, in particular in an emergency

situation or where a decision is required in a very short period of time. However, a *'state of urgency'* should not mean the principle of good governance can be neglected and regulations, especially those passed in response to an emergency situation, are exempt from scrutiny of their impact and effectiveness.

It is understood that decision makers may lack complete information or that certainty of evidence may not be available and not all outcomes cannot be fully anticipated, especially during emergency situations. However, once the immediate pressure from the emergency subsides, any regulations that were rapidly adopted or *fast-tracked* should be subjected to careful *post-implementation review.* Furthermore, once the emergency is over *fast-tracked* regulations should be subjected to a comprehensive *ex post evaluation* in order to examine their effectiveness, cost and benefits, and capture lessons learned. The objective is to improve better policy making decisions for future emergency situations, that is, upholding the principle of good governance even in emergency situations.

The COVID-19 crisis placed governments and their respective administrative structures under a great deal of pressure to rapidly adopt emergency regulations in order to respond to the epidemic. The objective of most of these measures focused on reducing the transmission rate, the death toll, and ensuring the sustainability of the healthcare system. Unfortunately, the measures froze many sectors of the economy, increased inequality in society, disrupted education, and undermined citizens' confidence in the future, as well as in the abilities of our governments and public institutions to handle emergency situations. We are only now starting to realize the costs of those policies. This clearly demonstrates the need for governments to consider mandating *ex ante impact assessments*, *post-implementation reviews* and *ex post evaluations*.

Three Types of Assessments to Consider in an Emergency Ssituation

***Ex Ante* Impact Assessment** refers to an evaluation or analysis conducted before the implementation of a policy or regulation. The objective of an *ex ante* impact assessment is to predict the potential impacts, risks, costs, and benefits of *different* courses of action to solve a problem. Available information is gathered, the data is weighed and the outcomes and consequences are estimated. *Ex ante* impact assessments aid in the planning and decision-making process and provide valuable insights into proposed actions. It assists decision makers in adjudicating and determining the best available option based on the best available information at the time while documenting the decision making process and rationale.

For example, the federal government of Canada mandates *ex ante* impact assessments for all subordinate legislation based on a *triage* system. The *triage* system determines how comprehensive the assessment needs to be and the appropriate analytical requirements. The *triage* system demonstrates the principle of proportionality by requiring a less comprehensive assessment on a lower impact policy proposal while requiring a more comprehensive assessment on a higher impact policy proposal. The *triage* system is generally based on costs and other determining factors. For example, under the *triage* system: LOW IMPACT are regulatory proposals that have a net present value of less than $10M over a 10 year period or less than an annual cost of $1M; MEDIUM IMPACT regulatory proposals have a net present value between $10M-$100M or an annual cost between $1M-$10M; and HIGH IMPACT regulatory proposals have a net present value of greater than $100M or an annual cost of greater than $10M.

Areas that are considered during an ex ante impact assessment include: impact on Canadians' well-being (health, safety, security), impact on Consumers (cost of living, prices, quality and variety of goods available), impact on income and employment opportunities, costs imposed on Canadian businesses in order to comply with regulatory requirements, changes in profit and revenues, and Canadian business opportunities and sustainability. Impact assessments also examine the cost to the government to implement and administer the regulatory program, such as cost of compliance and enforcement, outreach, data management, and impact on government revenues, etc. To see an example of a federal Regulatory Impact Assessment (ex ante impact assessment) click here.

Post Implementation Review (PIR) usually occurs after a policy has been implemented and aims at assessing whether or not the policy is achieving its objectives or measures its success rate. PIRs identify any unanticipated outcomes that were not known or that were not considered pre-implementation. PIRs provide decision makers with updated information on how successful the policy is and allows decision-makers the ability to modify a policy, if necessary, to ensure that the objective is being achieved.

The requirement for a post implementation review can be directly embedded into the primary legislation. For example in the United Kingdom, *The Small Business, Enterprise and Employment Act* 2015 requires the inclusion of a post implementation review clause in any secondary legislation that regulates business or voluntary and community bodies, or alternatively, that the primary legislation specifies why such a review is not necessary. Generally, a post implementation review is to be done every five years.

An example of the type of analytical questions asked during a post implementation review include: To what extent is the existing regulation working? Has the policy achieved its objective? Have there been any unintended consequences? What have been the actual costs and benefits of this policy and how do they compare to the estimated costs and estimated benefits? Is government intervention still required? What would happen if the regulation was removed? Is the existing regulation still the most appropriate approach? What refinements could be made? To see an example of a post implementation review by the government of Argentina click here.

Ex Post Evaluation*:* The ex post evaluation is a summative evaluation conducted after the completion of policy interventions. The objective of an ex post evaluation is to evaluate the achievements of policy objectives, impacts on the stakeholders and the general public. Ex post evaluations provide policy transparency and accountability, as well as the opportunity to learn how to do policy better in the future.

Ex-post evaluations are the present evaluations of past efforts to achieve policy goals that have passed through all stages of the policy cycle and decision-making. Ex-post evaluations can be based on the predetermined variables of interest and/or by comparing the achieved change or status with the original status and the anticipated impacts of the implemented intervention. To see an example of an ex post evaluation by the government of Australia click here.

Ex Ante Impact Assessments During a Time of Crisis

The federal government as well as provincial governments across the country struggled to design and implement regulatory measures in a race to mitigate the spread of COVID-19 and the death toll amongst their respective populations. One of the largest challenges they faced,

along with other governments around the world, was the lack of detailed and reliable information about the virus and tracking the effectiveness of containment measures.

Many administrations reduced their volume of non-COVID-19 legislation and reprioritized their legislative programmes to ensure resources, orders and regulations were focused on the COVID-19 response. Fast tracking regulations or legislation bypassed the ordinary procedures for making those regulations or legislation by leaving less time for scrutiny.

Since COVID-19 there has been a growing debate on *fast tracked* legislation. On one side, *fast tracked* regulation/legislation is viewed as a reflection of the government's ability to respond quickly and effectively during a crisis. However, on the other hand, *fast tracked* regulation/legislation circumvents 'normal' legislative scrutiny and can result in adverse effects on the rights of individuals.

Many governments that require impact assessments in 'normal times', decided to introduce exceptions to this requirement during the outbreak of COVID. However, others that were committed to the use of impact assessments, may have opted for a more simplified descriptive form of impact analysis due to time restrictions. For example, a qualitative description of costs and benefits and simplifying the identification of impacted stakeholders was required rather than a quantification of costs and benefits and full engagement of affected stakeholders, which would normally be required.

Much of the COVID-19 response regulation/legislation was intended to be temporary and many governments ensured that sunset clauses or expiry dates were introduced into their fast tracked regulations/legislation. But only few governments have mandated ex post evaluations be performed within a certain time frame following the expiry date to assess the effectiveness and the overall costs of the fast tracked regulation/legislation; even fewer have published or made public those results.

To ensure proportionality, accountability, transparency and overall good governance when developing regulatory/legislative responses to emergency situations, particularly to health emergencies like pandemics, governments must not lose sight of the health, economic and social impacts caused by their decisions to reduce mortality and transmission rates. During most emergency situations government intervention, while having good intentions, is more likely to have much more far-reaching impacts than during 'normal times'.

Keeping in mind that *traditional methodologies* of impact assessment may not be suitable in emergency or time sensitive circumstances, when evidence is most often incomplete or uncertain and/or the information is rapidly evolving. During those times, concentrated effort should be made to apply a simplified qualitative *ex ante impact assessment* based on the known evidence, imposition of periodical *post-implementation reviews* (as new information becomes available), and a comprehensive *ex post evaluation* to aid current decision-makers and future decision-makers to improve governance in times of crises in the future.

APPENDIX 8

An Economic Impact Assessment

September 3, 2023

TO: Preston Manning
Chair, Public Health Emergencies Governance Review Panel

FROM: Gerard A. Lucyshyn, President/Executive Director

RE: Economic Impacts on Alberta from COVID-19 Lockdown Measures

Further to your email on August 24, 2023, *to put together some thoughts to aid in*: sources to obtain macro economic data on the negative economic impacts of the lockdown measures, such as bankruptcies and the number of unemployed in 2019-2022. I am pleased to submit the following:

Economic Impacts of the Economic Lockdown Measures

Regarding potential sources for economic statistics, there are a variety of publicly available reputable sources, such as: Statistics Canada, Alberta Statistics, Alberta Treasury Branch, etc. However, to measure the economic impact of actions taken by governments across Canada during COVID-19 requires a determination of which statistics are important to the Panel, such as GDP, unemployment rates, financial bankruptcies, financial costs to the public, etc.

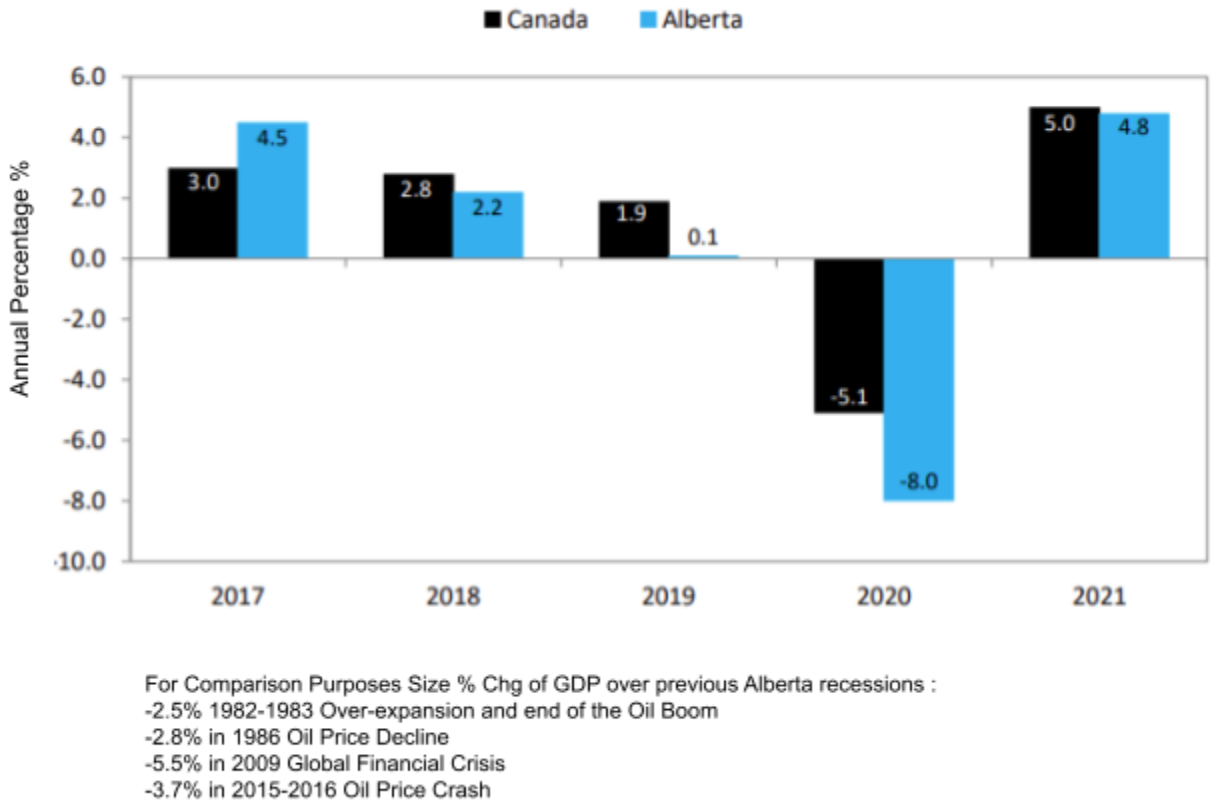
Regardless of which measures the Panel deems most important, it is certain that lockdown measures resulted in systemic changes in most metrics and indicators. However, to get a general sense of the economic impact on Albertans, one need not look much further than at some general indicators including Alberta's GDP, unemployment rate, and Alberta bankruptcies.

Alberta's Real Gross Domestic Product (GDP)

Alberta's GDP was declining year-over-year heading into the 2020 COVID-19 outbreak. However, a further decline in Alberta's GDP can be seen in 2020 as lockdown measures were implemented by Governments. To put this change into perspective, in 2020, Alberta's GDP fell *twice* as much as the *average* of the four previous worst recessions in Alberta over the last 40 years.

Another telling sign of the role the lockdowns played in the Alberta economy, is just how quickly the economy turned around once lockdown restrictions were relaxed by the end of 2020 and businesses and consumers were permitted to return to work. See Figure 1 for the annual percentage change in Alberta's real GDP 2017-2021.

Figure 1. Alberta Real Gross Domestic Product (GDP) at Market Prices, Annual % Change[1]



Source: Alberta Economic Dashboard

Alberta Unemployment Rate

Another simple common measurement of the impact lockdowns had on Alberta's economy is examining the unemployment rate. Again, standard economic theory predicts that a slowdown in GDP causes unemployment rates to rise. As the Alberta economy was slowing before the lockdowns we can anticipate there would have been a rise in unemployment. However, when comparing the rise in unemployment with Alberta historical rates during some of the worst economic downturns in the last 40 years, (such as the Global Financial Crisis of 2009 and the Oil Price Crash of 2015-2016), it is apparent that the lockdowns of 2020 caused unemployment rates to greatly exceed those of the previous significant recessions.

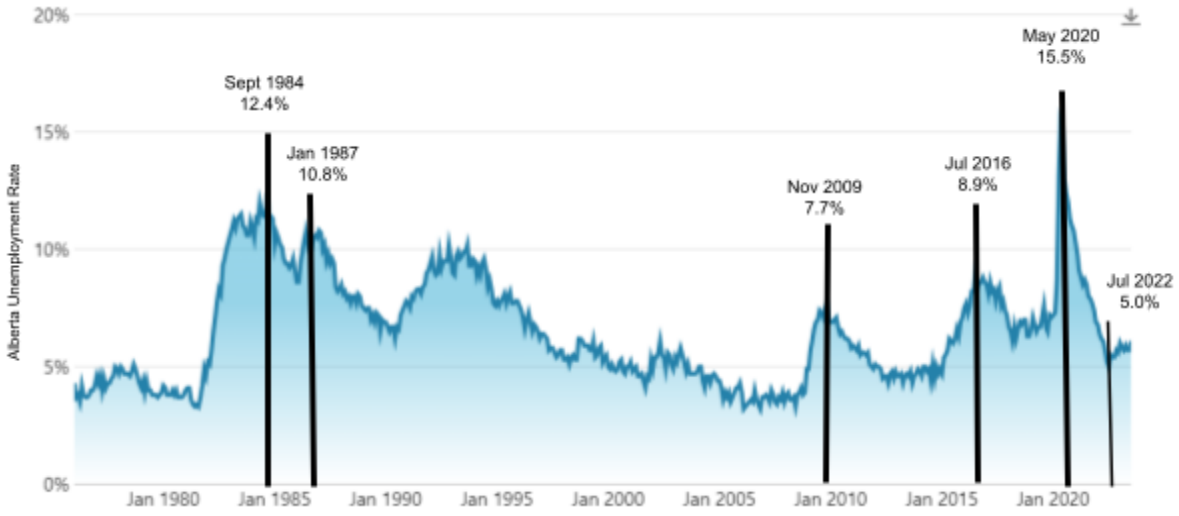
If businesses and industries are order closed, GDP will decline and unemployment will rise. During a *natural* economic slowdown the economy as a whole will be affected however some sectors of the

[1] Alberta Official Statistics. Real Gross Domestic Product, December 13, 2022.

economy are affected more than others whereas a lockdown specifically targets and affects particular industries. Consider : shutting down restaurants while allowing professional hockey organizations to operate or closing churches but keeping liquor stores open, etc.

Figure 2 provides a historical view of Alberta's unemployment rate between 1980 - 2022. Note that the lockdowns began on March 15, 2020 (Alberta's unemployment rate in Feb 2020 was 8.7%) and by May 2020, the unemployment rate nearly doubled reaching a 40+ year high of 15.5%. On May 25, 2020 the Government of Alberta announced the "Open for Summer Plan" that would remove all public health restrictions by July 1, 2020. The unemployment rate dropped 2% between June-July 2020 and continued to decline by approximately 1% per month until reaching pre-lockdown level in April 2021.

Figure 2. Alberta Unemployment Rate Historical



Source: Alberta Economic Dashboard

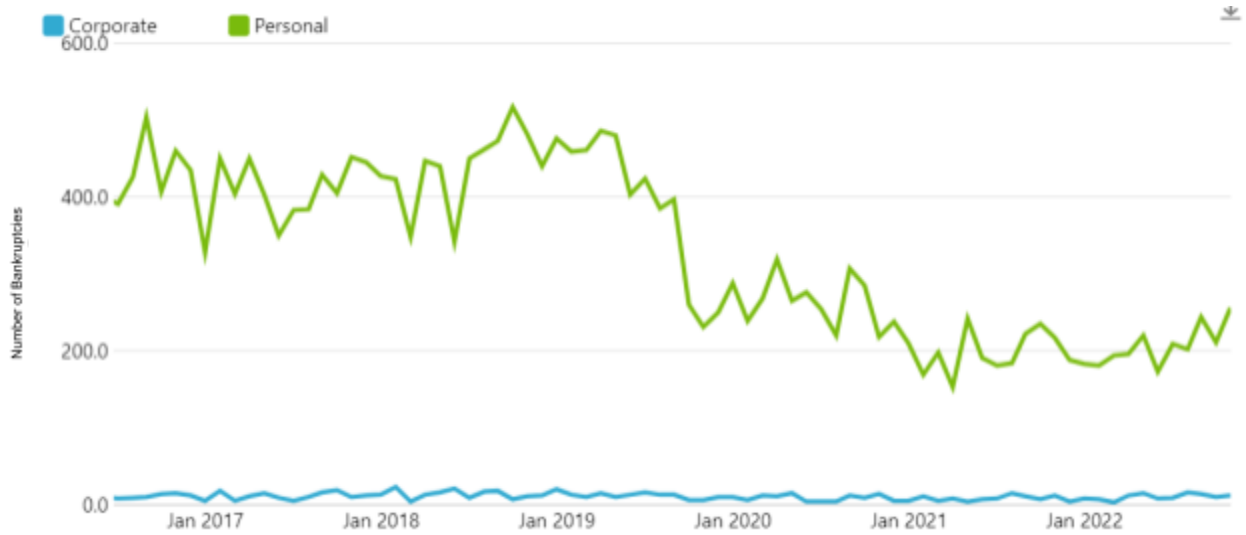
For a further perspective as to how bad the decline in GDP and the increase in unemployment were for Albertans, one can compare those indicators during the Great Depression of the 1930s. National unemployment rate peaked at 19.3% while the GDP plummeted by 15% (June 1933). Recall during the lockdown measures Alberta's unemployment peaked in May 2020 at 15.5% while its GDP diminished by 8%. That is half the fall in GDP and twice the amount of unemployment than during the Great Depression.

Alberta Bankruptcies

While Alberta's GDP dropped significantly and its unemployment rate topped record levels, the number of personal bankruptcies, interestingly, actually *declined* between 2017 and 2021 (see Figure 3). While I reiterate the importance of conducting a more comprehensive economic analysis to determine a fulsome explanation for this reduction, one *may* postulate that some reasons may included: Albertans adjusting their spending habits (e.g. travel, eating out, personal expenditures, etc.), Albertans (and Canadians) possessed higher than usual levels of savings before the pandemic, very low interest rates, assistance from the Canada Emergency Response Benefit (CERB), and CERB loans for small businesses at risk.

Again, I would urge caution in jumping to any conclusions without an in depth study of these areas and the importance such reasons played into the number of bankruptcies, however, with certainty one can say that not all industries and workers were affected in the same manner (some negatively, some positively, some not at all) by the lockdown measures and this should taken into consideration when examining the economic impacts of the lockdowns.

Figure 3. Alberta Personal and Business Bankruptcies 2017-2022[2]



Source: Alberta Economic Dashboard

Lastly there are several other economic indicators the panel may wish to consider when assessing the extent of economic disruption such as: (1) the *Labor Force Participation Rate* which measures the percentage of the working-age population that is either employed or actively seeking employment. A drop in participation can indicate discouraged workers; (2) changes in *Consumer Spending* especially in sectors like hospitality and entertainment, can reflect the impact on consumer confidence; (3) reviewing *Business Investment* in capital goods, machinery, and technology can show the extent to which businesses are delaying or canceling investments due to uncertainty; and (4) the *Debt Levels* of private individuals and government pre- and post-lockdown measures.

[2] "Economic Dashboard - Alberta." Accessed September 3, 2023. URL: https://economicdashboard.alberta.ca/.

APPENDIX 9

A Path Towards an Improved Protection of Rights and Freedoms in the Context of Crises and Emergencies

Draft Report by Michel Kelly-Gagnon, Presented to the Public Health Emergencies Governance Review Panel (PHEGRP) – June 26, 2023 (v.38)

A path towards an improved Protection of Rights and Freedoms in the context of Crises and Emergencies

TABLE DES MATIÈRES

1. INTRODUCTION

The purpose of this Chapter is to identify the strengths and weaknesses in Alberta's legislation, regulations and case law with respect to the protection of fundamental rights and freedoms ("**R&F(s)**") in the context of a public emergencies.

Drawing lessons from our collective experience of 2020-2023, this Chapter proposes specific and detailed solutions, primarily through legislative amendments, to provide a clear, simple and predictable framework for the mechanisms by which legitimate legislation and government action can either limit, protect or accommodate the exercise of R&Fs.

Due to the paramountcy of R&Fs and their transversality (across all domains of State action, not exclusively public health matters), we argue for bringing amendments to statutes of general application rather than to health-specific legislation.

2. EXECUTIVE SUMMARY

Existing legislation already protects, on paper, most if not all of the R&Fs that were arguably trampled by Covid measures. The two main obstacles to the actual preservation and vindication of R&Fs rather emerged from *process* and, in the end, the *Courts' approach* to the balancing of R&Fs with State objectives. I accordingly suggest amendments in terms of ***procedure*** (in court and in administrative decision making), and ***substance*** (content of R&F and other legislation).

The suggested amendments to procedural elements in the ***Judicature Act***[1] and in the ***Administrative Procedures and Jurisdiction Act***[2] would make it simpler,

[1] RSA 2000, c. J-2.
[2] RSA 2000, c. A-3.

faster and more affordable for Albertans to obtain interim and final remedies to alleged R&F breaches, and to be provided with justificatory evidence by the State.

The suggested amendments to substantive elements in legislation would ensure that the notion of "emergency" is not stretched beyond recognition by a government intent on using emergency powers. They would also add explicit protections in R&F legislation (namely the ***Alberta Bill of Rights***[3] and the ***Alberta Human Rights Act***[4]):

- For medical consent and the right to choose in medical matters;
- For professional and academic freedom;
- Against invasive technologies and profiling by the State;
- Against abusive takings and limitations on private property;
- Against discrimination on the basis of medical status or history;
- For ensuring that Courts and decision makers give R&Fs sufficient weight and value, rather than lip service.

3. HOW ALBERTA'S COVID-19 MEASURES HAVE LIKELY INFRINGED ON R&Fs

As we shall explain below in a more detailed fashion, the courts' analysis of R&F cases generally follows two steps:

1º determining whether State law or State action infringed upon a protected right or freedom, and

2º determining whether the State has justified said infringement.

[3] RSA 2000, c. A-14.
[4] RSA 2000, c A-25.5.

Section 3 of this Chapter only deals with step one, as step two is better addressed in the context of assessing how judges handled Covid litigation (see Section 5 below).

3.1. FREEDOM OF RELIGION, EXPRESSION, AND PEACEFUL ASSEMBLY

Freedom of religion is the right to entertain such religious beliefs as a person chooses, the right to declare religious beliefs openly and without fear of hindrance or reprisal, and the right to manifest religious belief by worship and practise or by teaching and dissemination[5].

Freedom of expression, or free speech, is the right of everyone to search for, receive and communicate information, ideas and opinions of all kinds, without interference by the State[6].

Freedom of peaceful assembly protects the physical gathering together of people. The limited existing case law on the issue indicates that this right, in the current state of case law, is largely subsumed in or consubstantial to freedom of expression[7].

Freedoms of religion, expression, and peaceful assembly are protected under s. 2 of *Canadian Charter of Rights and Freedoms*[8] ("**Charter**"):

> *2 Everyone has the following fundamental freedoms:*
>
> *(a) freedom of conscience and religion;*
>
> *(b) freedom of thought, belief, opinion and expression, including freedom of the press and other media of communication;*
>
> *(c) freedom of peaceful assembly;* […]

[5] *R. v. Big M Drug Mart Ltd.*, [1985] 1 SCR 295.
[6] *R. v. Keegstra*, [1990] 3 SCR 697.
[7] *Bérubé v. Ville de Québec*, 2019 QCCA 1764.
[8] In *The Constitution Act 1982*, Schedule B to the Canada Act 1982 (UK), 1982, c 11.

The *Alberta Bill of Rights*[9] also protects freedoms of religion, expression, and peaceful assembly:

> *1 It is hereby recognized and declared that in Alberta there exist without discrimination by reason of race, national origin, colour, religion, sexual orientation, sex, gender identity or gender expression, the following human rights and fundamental freedoms, namely:*
>
> *[…]*
>
> *(c) freedom of religion;*
>
> *(d) freedom of speech;*
>
> *(e) freedom of assembly and association;*

Bans and restrictions on the attendance to religious services and other gatherings, namely for public protesting, started in March of 2020 in Alberta. Obviously, they curtailed individual rights to freedom of religion, expression and peaceful assembly. Same can be said about vaccine passports, which, starting from September of 2021, limited the right of Albertans to gather, protest or otherwise have access, for expressive purposes, to several premises usually available for such activities.

Many regulated professionals who publicly criticized the management of the Covid situation by government, or the safety or efficacy of the Covid vaccines, were targeted by their regulators[10]. Similar instances in the academia have been reported[11]. Again, without entering into the justification or lack thereof, it appears that the rights of academics and professionals to free speech and free inquiry were undermined indeed.

[9] RSA 2000, c. A-14.
[10] E.g., see https://www.jccf.ca/professional-misconduct-accusations-withdrawn-against-nurse-who-shared-information-about-covid-19-vaccinations/
[11] E.g., see the case of professor Patrick Provost of Université Laval's Faculty of Medicine : https://www.cbc.ca/news/canada/montreal/quebec-university-professor-suspended-anti-vax-comments-1.6507928

3.2. Personal Security and Informed Consent

The right of a person to **security** has physical and mental components. It protects bodily and psychological integrity and one's control over same[12]. Where State action would have the probable effect of seriously impairing a person's mental health or causing severe psychological harm, the right to security also comes into play[13]. The use of force by State agents and the infliction of physical suffering also engage the right to security[14].

Security of the person is protected by s. 7 of the Charter:

> *7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.*

The *Alberta Bill of Rights* also protects a person's right to security:

> *1 It is hereby recognized and declared that in Alberta there exist* […] *the following human rights and fundamental freedoms, namely:*
>
> *(a) the right of the individual to liberty, security of the person and enjoyment of property, and the right not to be deprived thereof except by due process of law;*

Informed consent to medical care is protected by the Charter to a certain extent, whenever a person's control over their bodily integrity is at stake. It is also protected by common law: a medical professional must establish that the patient has a reasonable understanding of the information provided in the process of obtaining consent to medical care, such as a vaccine. The amount of information must be contextually appropriate, as it would usually be unreasonable to mention every possible risk, however improbable and benign. Relevant risks can be identified to a professional standard (what other caregivers would disclose), a subjective standard (what the patient wishes to know), or

[12] *R. v. Morgentaler*, [1988] 1 SCR 30.
[13] *Chaoulli v. Quebec (Attorney General)*, 2005 SCC 35.
[14] *Fleming v. Ontario*, 2019 SCC 45; *Suresh v. Canada (Immigration)*, 2002 SCC 1.

an objective standard (what a reasonable person in similar circumstances would want to know)[15]. For a non-legal, but comprehensive and useful summary of most of the declensions of informed consent in a medical setting, see also the webpage that the Canadian Medical Protective Association has devoted to this topic[16].

Covid vaccines were rolled out in Alberta, starting in late December of 2020. To my knowledge, no policy in the Province ever physically forced persons to take the shot. It is possible that court orders were issued in specific cases, e.g., for inapt individuals, but that type of scenario is beyond the scope of this Chapter.

Taken at face value, the current version of Alberta Health Services' standard form for *Consent for COVID-19 Immunization*[17] may well include most of the information relevant to the average patient, including contraindications as well as common and less common side effects. I assume that prior versions of the form, if any, were similar. In the context of the urgent, mass roll-out of the vaccines, it is doubtful, however, that the verbal communications between caregivers and individual patients, and correlative verification of the patient's understanding, reflected the

[15] *Reibl v. Hughes*, [1980] 2 SCR 880.

[16] https://www.cmpa-acpm.ca/en/advice-publications/handbooks/consent-a-guide-for-canadian-physicians : "[…] *For consent to treatment to be considered valid, it must be an "informed" consent. The patient must have been given an adequate explanation about the nature of the proposed investigation or treatment and its anticipated outcome as well as the significant risks involved and alternatives available. The information must be such as will allow the patient to reach an informed decision. In situations where the patient is not mentally capable, the discussion must take place with the substitute decision maker.*
The obligation to obtain informed consent must always rest with the physician who is to carry out the treatment or investigative procedure. This obligation may be delegated in appropriate circumstances (to a PGY trainee for example) but before assigning this duty to another, the treating physician should be confident the delegate has the knowledge and experience to provide adequate explanations to the patient.
In special circumstances, an obligation of pre-treatment disclosure may fall to more than one physician involved in the care. For example, a radiologist carrying out an invasive diagnostic procedure would likely be seen as responsible for explaining how the test will be done and the risks attendant upon it. The physician who ordered the test might also be expected to tell the patient, in general terms, about the nature and purpose of the test and alternatives which might be employed.
The bottom line: The patient must have been given an adequate explanation about the nature of the proposed investigation or treatment and its anticipated outcome as well as the significant risks involved and alternatives available. […]"

[17] Attached hereto as **Appendix A**.

level of detail of the standard form. One could also argue that the novelty, and the streamlined regulatory approval process by the federal Minister of Health[18], both demanded a higher standard of care from doctors and nurses with respect to informed consent[19].

Vaccine passports, on the other hand, became a matter of government policy in September of 2021, for access to several venues and services. Although it is unclear how vaccine passports may, in and of themselves, breach a person's right to security, they could amount *in practice*, in many cases, to a level of compulsion triggering the Charter's protection. Indeed, vaccine passport regulations that would almost neutralize one's ability to function socially, financially and familywise – unless one consents to a medical treatment they either do not need or do not want – may breach that person's right to security. Case law offers no useful guidance on the issue, although by analogy an argument could be made under *R. v. Smith*[20].

3.3. Privacy and Professional Confidentiality

Information about an individual's health and health care history are private and protected under statute pursuant Alberta's ***Freedom of Information and Protection of Privacy Act***[21]*,* and the ***Health Information Act***[22]. Doctor-patient communications are also privileged at common law[23].

Without regard to any alleged justification for compulsory disclosure, contact tracing by Alberta health authorities, starting in March of 2020, and vaccine

[18] See the *Interim Order respecting clinical trials for medical devices and drugs relating to COVID-19*: https://www.canada.ca/en/health-canada/services/drugs-health-products/covid19-industry/interim-order-respecting-clinical-trials-medical-devices-drugs.html
[19] This Chapter is not an inquiry into medical malpractice, but one can expect that the issue of informed consent in tort litigation will come up at some point in time.
[20] [2015] 2 S.C.R. 602; see contra *Siemens v. Manitoba (Attorney General)*, [2003] 1 S.C.R. 6, excluding economic rights from s. 7 protection.
[21] RSA 2000, c. F-25.
[22] RSA 2000, c. H-5.
[23] *M. (A.) v. Ryan*, [1997] 1 SCR 157.

passports, starting in September of 2021, entailed the communication of private and confidential medical information.

3.4. Enjoyment and Free Disposition of Property

Property is a "bundle of rights"[24] that attach to the thing owned and may be regulated by the State or taken away to a certain extent, as provided by law. The line between regulating and confiscating or expropriating is a fine one, and we will not undertake to settle the debate in this Chapter.

It is a trite remark to say that the Charter does not protect private property *per se*. By comparison, the ***Canadian Bill of Rights***[25], which applies in federal matters only, offers some protection against takings of and limitations on private property:

> *1 It is hereby recognized and declared that in Canada there have existed and shall continue to exist* […] *the following human rights and fundamental freedoms, namely,*
>
> *(a) the right of the individual* […] *enjoyment of property, and the right not to be deprived thereof except by due process of law;*

The *Alberta Bill of Rights* does afford some protection to private property:

> *1 It is hereby recognized* […] *the following human rights and fundamental freedoms, namely:*
>
> *(a)* […] *enjoyment of property, and the right not to be deprived thereof except by due process of law;*

The ***Alberta Personal Property Bill of Rights***[26], offers some protection against takings of and limitations on private property:

> *2 Subject to section 3, where*
>
> *(a) personal property is owned by a person other than the Crown, and*

[24] *Saulnier* v. *Royal Bank of Canada*, 2008 SCC 58.
[25] SC 1960, c. 44.
[26] RSA 2000, c. A-31.

> *(b) a provincial enactment contains provisions that authorize the acquiring of permanent title to that personal property by the Crown,*
>
> *those provisions are of no force or effect unless a process is in place for the determination and payment of compensation for the acquiring of that title.*
>
> *3 Section 2 does not apply in respect of the following:*
>
> *(a) any taxes, levies or royalties that are payable to the Crown under a provincial enactment;*
>
> *(b) where personal property is acquired or retained by the Crown following a conviction for contravention of a provincial enactment, if*
>
> *(i) the acquiring of that personal property is in whole or in part the penalty or an addition to a penalty provided for under that enactment,*
>
> *(ii) the possession of that personal property by its owner constitutes the contravention of that enactment, or*
>
> […]
>
> *4 Subject to section 3, every provincial enactment, whether enacted before or after the coming into force of this Act, shall be construed and applied so as not to abrogate, abridge or infringe on, and so as not to authorize the abrogation or abridgment of or infringement on, any of the rights or benefits provided for under this Act unless an Act of the Legislature expressly declares that that enactment operates notwithstanding the Alberta Personal Property Bill of Rights.*

Leaving aside any alleged justification, exemption or sufficient compensation by government in the context of Covid, the closing of so-called “non-essential” businesses and services, starting in March of 2020, certainly encroached on the freedom of property in Alberta.

3.5. Non-Discrimination

The Charter does not prohibit discrimination by the State on the basis of a person’s medical status or history (such as being vaccinated against Covid), short of handicap or “disability”:

> *15 (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.*

Neither does the *Alberta Human Rights Act*[27] prohibit discrimination against medical status or history (short of disability) in publications and notices, advertisements, provision of goods, services, accommodation and facilities, benefits, occupancy, tenancy, pay, employment[28].

Vaccine passports started being implemented in the Fall of 2021 in Alberta. Employers and local authorities were notoriously passport enthusiasts. Since medical status, such as not being vaccinated against Covid, is not an illicit ground for discrimination, one cannot argue that vaccine passports breached anti-discrimination statutes under the current state of the law. But considering the open hostility – verging on hatred – of major figures in Canadian media and politics[29], regarding the so-called "unvaccinated", a valid argument could be made in favour of adding medical status and history to prohibited grounds of discrimination, subject to the usual, stringent "limitation, specification or preference based on a *bona fide* occupational requirement", or similar reasonable justification.

NOTE TO THE PANEL	**The Panel has raised the issue of potential conflict between Alberta law and federal emergency legislation. I have chosen not to address it in this Chapter, as Privy Council (UK JCPC), then Supreme Court (SCC) case law have consistently upheld the principle of paramountcy of federal law over provincial law, subject to Parliament acting within its jurisdiction pursuant to the division of powers (under sections 91 *et sequens* of the *Constitution Act 1867*). For a recent example, see *Quebec***

[27] RSA 2000, c A-25.5.
[28] Note that the *Alberta Human Rights Act* applies to private matters (i.e., between persons) as well as the State's relations with Albertans.
[29] E.g., Prime Minister Trudeau saying protesters demonstrating against him were "anti-vaxxer mobs" launching "racist, misogynistic attacks" : https://www.washingtonexaminer.com/news/justin-trudeau-protesters-anti-vaxxer-mobs-racist

	***(Attorney General)* v. *Canadian Owners and Pilots Association*, 2010 SCC 39.** **I believe that dwelling on the issue of federal-provincial conflict of law in this Chapter would further the objective and mission of the Panel. As Wittgenstein wrote in the *Tractatus*, "what we cannot speak about we must pass over in silence"…**

4. LIMITING R&Fs: BASIC NOTIONS

The Charter applies to all kinds of State action (i.e., statutes, regulations, other enactments, government policy decisions, individualized decisions or actions, etc.), on all levels (i.e., federal, provincial, territorial):

> *32 (1) This Charter applies*
>
> *(a) to the Parliament and government of Canada in respect of all matters within the authority of Parliament including all matters relating to the Yukon Territory and Northwest Territories; and*
>
> *(b) to the legislature and government of each province in respect of all matters within the authority of the legislature of each province.*

Pursuant to s. 52 of the *Constitution Act 1982*, any law that is inconsistent with the Charter is of no force or effect. Such a law will nonetheless be presumed valid until a Court judgment says otherwise[30]. Same goes for State action (e.g., administrative decision) taken pursuant an enabling provision in legislation.

[30] *Nova Scotia Board of Censors* v. *McNeil*, [1978] 2 S.C.R. 662, at pp. 687-688; note that s. 24(1) of the Charter allows courts of law to issue an array of remedies in addition to constitutional invalidation: declarations of right, Charter damages, etc.

Note that the *Alberta Bill of Rights* also contains a provision approximating a "supremacy" clause, albeit weak and antiquated[31]:

> *2 Every law of Alberta shall, unless it is expressly declared by an Act of the Legislature that it operates notwithstanding the Alberta Bill of Rights, be so construed and applied as not to abrogate, abridge or infringe or to authorize the abrogation, abridgment or infringement of any of the rights or freedoms herein recognized and declared.*

The State may lawfully limit protected R&Fs either :

- by a rule of law, through reasonable justification,
- by properly balancing it in the context of an administrative decision,
- or via a specific provision in a statute, overriding the Charter.

We will elaborate on those mechanisms below.

4.1. Reasonable Justification via Rule of Law

However broad and generous, the Charter's protection of R&Fs is subject to "*reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society*". That is a direct quote from section 1 of the Charter.

Courts of justice are the arbiters of the State's alleged justification for R&Fs. The applicable criteria here are called the "*Oakes* test", by reference to the Supreme Court of Canada judgment[32] that first laid it out, in 1986.

First, for the State to claim any justification at all, the limitation brought to a protected right or freedom must be found in a "rule of law", i.e., the limitation must be based on some written provision in legislation[33] or, in rare cases, on a common law power. The State may not justify limitations that come from the mere whim or

[31] Much like the similarly worded "supremacy clause" in the *Canadian Bill of Rights*, which courts historically ignored.
[32] *R.* v. *Oakes*, [1986] 1 SCR 103.
[33] *Irwin toy Ltd*. v. *Quebec (Attorney General)*, [1989] 1 SCR 927.

individual endeavour of an agent or officer of the State, e.g. a policeman or a city mayor.

Once it is demonstrated that the alleged "rule of law" limits a right, either in by "purpose" or "effect", it becomes the State's onus (burden) to justify it:

- The purpose for which the limit is imposed must be "pressing and substantial" (i.e., important, serious enough);
- The means by which the State's goal is served must be "proportionate", i.e.:
    - rationally linked;
    - minimally impairing the right or freedom at issue;
    - not causing deleterious (bad) effects that would outweigh the salutary (good) ones[34].

Note that the tendency of judges has been, in the decades following the 1986 Oakes case, to apply the "proportionality" requirements in an increasingly lenient manner, making the State's demonstration of justification correspondingly easier[35].

4.2. Proper Balancing in Administrative Decision-Making

Very often, Charter values such as free speech will not be directly limited by a written rule of law, but rather indirectly impacted by an individualized (punctual, in a given case) decision made by an administrative decision maker in the normal course of discharging their statutory duties[36]. A modified version of the *Oakes* test will apply: State agents, when exercising their discretion, are expected to "properly balance" the objectives of the law or programme they are applying with the "value" of any affected fundamental right, such as freedom of expression. If they fail to do

[34] *Alberta* v. *Hutterian Brethren of Wilson Colony*, [2009] 2 SCR 567.
[35] Compare *R.* v. *Oakes*, [1986] 1 SCR 103 with, for instance, *Alberta* v. *Hutterian Brethren of Wilson Colony*, [2009] 2 SCR 567.
[36] *Loyola High School* v. *Quebec (Attorney General)*, [2015] 1 SCR 613.

so, courts may strike down (invalidate, annul) their decision as being "unreasonable"[37].

4.3. Override Provision

The override provision, also known as "notwithstanding clause", could be described as the "nuclear option" for limiting fundamental rights.

Section 33 of the Charter allows Parliament or a Legislature to insert in legislation an express (explicit, precise, clear) declaration stating that the said Act or provision "shall operate notwithstanding sections [*insert here a reference to one or more of ss. 2 or 7 to 15 of the Charter*]"[38]. Such an overriding provision has a limited, 5-year duration, after which it ceases to have effect unless it is then re-enacted by Parliament or the Legislature[39].

Overriding provisions are seldom used, as they come at a heavy political and social price. They remain, nonetheless, perfectly legal, and it is worth mentioning that the override mechanism was instrumental in the Provinces striking a deal with Ottawa and bringing about the 1982 constitutional reform.

5. APPROACH TAKEN BY THE COURTS DURING COVID

Persons aggrieved by governmental Covid measures basically had two civil recourses available to them: 1) on an **interim basis**, seeking stays or injunctions against said measures, and 2) on **the merits**, seeking judicial review, i.e., asking the Court to strike down the impugned Covid measures on either legal (common law, statutory) bases or constitutional bases (*Charter* or federal division of powers).

[37] *Doré* v. *Barreau du Québec*, [2012] 1 SCR 395.
[38] Charter, s. 33(1); see also *Ford* v. *Québec (Attorney General)*, [1988] 2 SCR 712.
[39] Charter, s. 33(3).

The technical availability of such recourses did not entail that court challenges would be met with any degree of success for the applicant. In fact, quite the opposite happened. The "Covid case law" in Alberta does not significantly depart from the "Covid case law" in the rest of Canada: Courts denied provisional/interim remedies, and dismissed permanent remedies either on technical bases (mainly "mootness") or on the merits (based on the full evidence and arguments presented).

5.1. Provisional (Interim) Remedies

Pursuant to the criteria set out in *RJR-MacDonald Inc. v. Canada (Attorney General)*, [1994] 1 SCR 311, the issuance of interlocutory injunctions and stays against allegedly unconstitutional enactments or administrative decisions requires that the applicant demonstrate that : 1) there is a serious issue to be tried, in the sense that the Applicants' claims are not frivolous or vexatious, 2) there is a likelihood of irreparable harm if the injunctive relief the applicant seeks is refused, 3) the balance of convenience or inconvenience favours granting the injunction the Applicants seek. At the third stage of the *RJR* test, the State benefits from a strong presumption of "public interest" in favour of the impugned State rule or decision[40].

In Covid cases, Courts relied heavily on that third stage of the *RJR* test, stressing that the presumed benefits of Covid measures in preventing the spread of the disease outweighed the individual (and community) interest in maintaining the free exercise of fundamental rights such as religion and peaceful assembly, even where the breach of such protected rights was proven *prima facie*[41].

[40] See *Harper v. Canada (Attorney General)*, 2000 SCC 57, para. 9, and *RJR-MacDonald Inc. v. Canada (Attorney General)*, [1994] 1 SCR 311, para. 85.
[41] *Ingram v. Alberta (Chief Medical Officer of Health)*, 2020 ABQB 806; *Lachance c. Procureur général du Québec*, 2022 QCCS 161; *Monsanto v. Canada (Health)*, 2020 FC 1053; *Wojdan v. Canada (Attorney General)*, 2021 FC 1341; *Neri v. Canada*, 2021 FC 1443.

That trend favouring the government's position did not originate from Covid case law. Indeed, there are only five examples from the Supreme Court of Canada in the post-Charter era where injunctions have been sought to stay legislation pending a constitutional determination. In all five cases, the Court denied the injunction based on the assumption of public interest[42]. The bar is set very high.

In other words, judges felt that their hands were tied when it came to deciding whether to issue provisional remedies against Covid measures that infringed Charter-protected freedoms. They referred the debate to the merits, i.e., when the records would be complete and would include extensive expert evidence respecting the alleged science backing Covid measures.

5.2. Permanent Remedies (on the Merits)

Few applicants had the resources and perseverance to bring their Covid challenges to the merits. For months, they jumped through the hoops of various motions, discovery, filing of expert reports, etc. By then, due to normal judicial delays (albeit excessive by any reasonable human standard), most of the impugned Covid measures had been repealed or had ceased to be in effect.

The Attorneys General involved in those cases sought to have the judicial reviews struck down on the ground of "mootness", i.e., that the debate had become theoretical. Courts across the country were receptive to that argument. Whenever they were presented with the opportunity of striking out cases based on mootness, they did[43].

[42] *Manitoba (A.G.) v. Metropolitan Stores Ltd.*, [1987] 1 SCR 110; *RJR-MacDonald Inc. v. Canada (Attorney General)*, [1994] 1 S.R 311; *Harper v. Canada (Attorney General)*, [2000] 2 SCR 764; *Thomson Newspapers Co. v. Canada (Attorney General)*, [1998] 1 SCR 877; *Gould v. Canada (Attorney General)*, [1984] 2 SCR 124.
[43] *Lavergne-Poitras v. Canada (Attorney General)*, 2022 FC 1391; *Nassichuk-Dean v University of Lethbridge*, 2022 ABKB 629; *Ben Naoum v. Canada (Attorney General)*, 2022 FC 1463; *Boucher-Roy c. Procureur général du Québec*, 2022 QCCS 4657; *M. S. v Newfoundland and Labrador (Child and Youth Services)*, 2020 NLCA 43; *Spencer v. Canada (Attorney General)*, 2023 FCA 8.

In rare instances, cases went to trial on the merits before mootness became an issue. Those judicial review applications were roundly dismissed. Trial judges essentially copy-pasted the AG's evidence and paid little to no heed to the cross-examinations and adverse evidence[44].

6. REFORM PROPOSALS

For the sake of clarity, I will divide my reform proposals into two categories: substantive and procedural – both being necessary for proper vindication of R&Fs.

6.1. PROCEDURE: *JUDICATURE ACT*

The current rules of civil procedure and related case law have destroyed, for plaintiffs and applicants, the benefit of the *Oakes* test, which shifts the burden of justification on the State for Charter breaches[45], as in practice the aggrieved party must file its expert evidence first – even though "in theory" it remains the State's burden to justify infringements of fundamental rights or freedoms.

Amendments to the *Judicature Act*[46] would allow courts to 1) more quickly and easily issue injunctions, safeguard or stay orders for the benefit of persons whose fundamental freedoms are allegedly infringed by emergency measures, and 2) require the concerned State entities to promptly provide the courts with a documented justification for *prima facie* infringements, failing which the government measures could be stayed indeterminately pending final determination (*res judicata*).

Section 24(1) of the *Judicature Act* currently reads as follows:

> *24(1) If in a proceeding the constitutional validity of an enactment of the Parliament of Canada or of the Legislature of Alberta is brought into question, the*

[44] *Syndicat des métallos, section locale 2008 c. Procureur Général du Canada*, 2022 QCCS 2455*; Taylor v. Newfoundland and Labrador*, 2020 NLSC 125.
[45] Under s. 1 of the Charter or its equivalent in other quasi-constitutional statutes; see, e.g., *R. v. Oakes*, [1986] 1 SCR 103, and *Alberta v. Hutterian Brethren of Wilson Colony*, 2009 SCC 37.
[46] RSA 2000, c. J-2.

enactment shall not be held to be invalid unless 14 days' written notice has been given to the Attorney General of Canada and the Minister.

(2) When in a proceeding a question arises as to whether an enactment of the Parliament of Canada or of the Legislature of Alberta is the appropriate legislation applying to or governing any matter or issue, no decision may be made on it unless 14 days' written notice has been given to the Attorney General of Canada and the Minister.

(3) The notice shall include what enactment or part of an enactment is in question and give reasonable particulars of the proposed argument.

(4) The Attorney General of Canada and the Minister are entitled as of right to be heard, either in person or by counsel, notwithstanding that the Crown is not a party to the proceeding.

(5) No person other than the Minister or counsel designated by the Minister shall, on behalf of His Majesty in right of Alberta or on behalf of an agent of His Majesty in right of Alberta, appear and participate in any proceeding within or outside Alberta in respect of a question referred to in subsection (1) or (2).

(6) If the Minister or counsel designated by the Minister appears in a proceeding within Alberta in respect of a question referred to in subsection (1) or (2), the Minister is deemed to be a party to the proceeding for the purpose of an appeal from an adjudication in respect of that question and has the same rights with respect to an appeal as any other party to the proceeding.

I suggest replacing s. 24 of the *Judicature Act* (supra) by the following set of provisions:

24 (1) In any civil, administrative, regulatory, quasi-criminal or criminal case, a person intending to question the operability, the constitutionality or the validity of a provision of an Act of the Legislature of Alberta or the Parliament of Canada, of any regulation made under such an Act, of a government or ministerial order or of any other rule of law must give notice to the Attorney General of Alberta.

(2) Such notice is also required when a person seeks reparation from the State, a state body or a legal person established in the public interest for an infringement or denial of their fundamental rights and freedoms under the Alberta Bill of Rights (RSA 2000, c. A-14), the Alberta Human Rights Act (RSA 2000, c A-25.5), the Alberta Personal Property Bill of Rights (RSA 2000, c A-31), the Canadian Bill of Rights (SC 1960, c. 44), or the Constitution of Canada.

(3) Such a notice is not required if the reparation sought relates to the disclosure or exclusion of evidence or to the period of time elapsed since the accusation, or in the cases determined by order of the Minister of Justice of Alberta.

(4) The words "to question the operability, the constitutionality or the validity" at paragraph (1), and "seeks reparation from the State" at paragraph (2), presuppose that the person is formally seeking a remedy pursuant to the Alberta

Bill of Rights (RSA 2000, c. A-14), the Alberta Human Rights Act (RSA 2000, c A-25.5), the Alberta Personal Property Bill of Rights (RSA 2000, c A-31), Canadian Bill of Rights (SC 1960, c. 44), or the Constitution of Canada.

(5) The words "to question the operability, the constitutionality or the validity" at paragraph (1), and "seeks reparation from the State" at paragraph (2), do not concern mere interpretation arguments grounded in the Alberta Bill of Rights (RSA 2000, c. A-14), the Alberta Human Rights Act (RSA 2000, c A-25.5), the Alberta Personal Property Bill of Rights (RSA 2000, c A-31), the Canadian Bill of Rights (SC 1960, c. 44), or the Constitution of Canada, in which case notice to the Attorney General of Alberta is not required.

(6) To be validly given, the notice to the Attorney General of Alberta must summarily and intelligibly state the contentions the person intends to assert and the constitutional or quasi-constitutional grounds on which they are based, and be served on the Attorney General at least 30 days before the trial. The Attorney General becomes a party to the proceeding without further formality and may submit conclusions to the court, in which case the court must rule on them.

(7) The notice must also be served on the Attorney General of Canada if the provision or rule of law concerned comes under federal jurisdiction.

24.1 (1) Upon prima facie evidence, adduced by affidavit along with the originating process or application, of the infringement of a right or freedom protected under the Alberta Bill of Rights (RSA 2000, c. A-14), the Alberta Human Rights Act (RSA 2000, c A-25.5), the Alberta Personal Property Bill of Rights (RSA 2000, c A-31), the Canadian Bill of Rights (SC 1960, c. 44), or the Constitution of Canada, the Court shall issue a stay, injunction, order or any other remedy for the benefit of the applicant, as needed to restore status quo ante pending final determination.

(2) Said stay, injunction, order or remedy shall issue on the 60th day after filing of the evidence of infringement, unless the Attorney General, in the meantime, adduces evidence which, on the balance of probabilities, demonstrates that the impugned enactment or State action is prescribed by law, reasonable and is demonstrably justified in a free and democratic Alberta.

(3) Judgment on the merits shall issue within 120 days of the filing of the aforementioned notice, failing which the Court shall issue, on the 121st day, a stay, injunction, order or any other interlocutory remedy for the benefit of the applicant, as needed to restore status quo ante pending final determination, notwithstanding any prior interlocutory judgment or evidence adduced by the Attorney General.

(4) If the applicant has adduced prima facie evidence of damage, the Court shall not strike an originating process or application on the ground of mootness of the constitutional or quasi-constitutional issues raised in the notice.

(5) No costs, including compensation for expert fees if any, may be awarded against the applicant unless the Attorney General demonstrates that the notice was manifestly frivolous or vexatious, or otherwise constituted an abuse of process.

(6) The applicant shall neither be ordered to post a suretyship as a precondition to the issuance of an interlocutory remedy, nor be liable in damages to the opposite party if he is unsuccessful on the merits, except where the Court finds that the application was manifestly frivolous or vexatious, or otherwise constituted an abuse of process.

6.2. PROCEDURE: *ADMINISTRATIVE PROCEDURES AND JURISDICTION ACT*

Nothing in the *Administrative Procedures and Jurisdiction Act*[47] guarantees that a person's R&Fs will be considered by the decision maker, although that is a constitutional requirement. The current process for actively raising constitutional issues before administrative decision makers exercising statutory powers[48] in Alberta is formal, complex, court-like. "Statutory powers", here, means administrative, quasi-judicial or judicial powers conferred by statute, other than powers conferred on a court of record of civil or criminal jurisdiction or powers to make regulations (rule-making function).

Here are the current provisions governing constitutional questions in administrative procedures in Alberta – note that the Act severely restricts the jurisdiction of decision makers to make determinations on constitutional questions of law[49]:

Jurisdiction to Determine Questions of Constitutional Law

Definitions

10 In this Part,

(a) "court" means the Court of King's Bench of Alberta;

(b) "decision maker" means an individual appointed or a body established by or under an Act of Alberta to decide matters in accordance with the authority given under that Act, but does not include

(i) the Alberta Court of Justice or a judge of that Court,

[47] *Administrative Procedures and Jurisdiction Act*, RSA 2000, c A-3.
[48] *Idem,* s. 1(c).
[49] *Idem*, s. 11.

(ii) a justice of the peace conferred with the authority to determine a question of constitutional law under the Court of Justice Act,

(iii) the Court of King's Bench of Alberta or a judge or applications judge of that Court, or

(iv) the Court of Appeal of Alberta or a judge of that Court;

(c) "designated decision maker" means a decision maker designated under section 16(a) as a decision maker that has jurisdiction to determine one or more questions of constitutional law under section 16(b);

(d) "question of constitutional law" means

(i) any challenge, by virtue of the Constitution of Canada or the Alberta Bill of Rights, to the applicability or validity of an enactment of the Parliament of Canada or an enactment of the Legislature of Alberta, or

(ii) a determination of any right under the Constitution of Canada or the Alberta Bill of Rights.

Lack of jurisdiction

11 Notwithstanding any other enactment, a decision maker has no jurisdiction to determine a question of constitutional law unless a regulation made under section 16 has conferred jurisdiction on that decision maker to do so.

Notice of question of constitutional law

12(1) Except in circumstances where only the exclusion of evidence is sought under the Canadian Charter of Rights and Freedoms, a person who intends to raise a question of constitutional law at a proceeding before a designated decision maker that has jurisdiction to determine such a question

(a) must provide written notice of the person's intention to do so at least 14 days before the date of the proceeding

(i) to the Attorney General of Canada,

(ii) to the Minister, and

(iii) to the parties to the proceeding,

and

(b) must provide written notice of the person's intention to do so to the designated decision maker.

(2) Until subsection (1) is complied with, the decision maker must not begin the determination of the question of constitutional law.

(3) Nothing in this section affects the power of a decision maker to make any interim order, decision, directive or declaration it considers necessary pending the final determination of any matter before it.

(4) The notice under subsection (1) must be in the form and contain the information provided for in the regulations.

Referral of question of constitutional law

13(1) With respect to a question of constitutional law over which a designated decision maker has jurisdiction and in respect of which a notice has been given under section 12, if the designated decision maker is of the opinion that the court is a more appropriate forum to decide the question, the designated decision maker may, instead of deciding the question,

(a) direct the person who provided the notice under section 12 to apply to the court to have the question determined by that court, or

(b) state the question of constitutional law in the form of a special case to the court for the opinion of the court.

(2) Before acting under subsection (1)(a) or (b), the designated decision maker may conduct any inquiries the designated decision maker considers necessary.

(3) Where the designated decision maker acts under subsection (1)(a) or (b), the designated decision maker must, unless otherwise directed by the court, suspend the proceeding, or any part of the proceeding, as it relates to the question to be heard by the court under subsection (1) until the decision of the court has been given.

(4) A question of constitutional law in respect of which an application has been directed to be made to the court under subsection (1)(a) must be brought on for hearing as soon as practicable.

(5) The court must hear and determine the question of constitutional law submitted to it under this section and give its decision as soon as practicable.

(6) The designated decision maker may and, at the request of the court, shall provide the court with any record and documentation that may assist the court in determining the question of constitutional law submitted to it under this section.

Attorney General of Canada and Minister

14 In any proceeding relating to the determination of a question of constitutional law before a decision maker or before the court under this Part, or in any subsequent proceeding on appeal or judicial review,

> *(a) the Attorney General of Canada and the Minister are entitled as of right to be heard, in person or by counsel,*
>
> *(b) no person other than the Minister or counsel designated by the Minister shall, on behalf of His Majesty in right of Alberta, or on behalf of an agent of His Majesty in right of Alberta, appear and participate, and*
>
> *(c) if the Minister or counsel designated by the Minister appears, the Minister is deemed to be a party and has the same rights as any other party.*

That procedure, where available[50], is leaden. At least two elements are in stark contrast with settled constitutional case law:

- Since the 2003 Supreme Court of Canada judgment in *Parry Sound*,[51] we know that tribunals, not only courts of law, can apply R&Fs legislation. Unlike courts, they will make determinations, such as constitutional inapplicability (rather than invalidity), for the parties only (rather than *erga omnes*, for the public at large). In that context, there is no valid reason to "prohibit" decision makers from using R&Fs legislation and making determination in compliance therewith. After all, R&Fs statutes are the "supreme law" of the land, and they ought to benefit persons in all settings, not just before courts of law.

- Since the 2012 Supreme Court of Canada judgment in *Doré*,[52] we know that when applying Charter values (and, by extension, values protected by R&Fs legislation) in the exercise of statutory discretion, an administrative decision maker must balance those values with the statutory objectives by asking how the values at issue will best be protected in light of those objectives. This goes to the core of the proportionality exercise, and requires the decision maker to balance the severity of the interference of the R&Fs protections with the statutory objectives.

[50] See s. 11 of the Act.
[51] *Parry Sound (District) Social Services Administration Board v. O.P.S.E.U., Local 324*, 2003 SCC 42.
[52] *Doré v. Barreau du Québec*, 2012 SCC 12.

The principles in *Parry Sound* and *Doré* lead me to infer that R&Fs must as a rule, be considered in administrative decision-making, and that the process for raising a constitutional argument in that context ought to be simple, cheap and speedy. In any event, administrative decisions are all reviewable by a higher tribunal or court of law, thus having administrative decision makers apply the "supreme laws" of Alberta and Canada does not threaten the legitimate interests of the State. Consequently, I suggest the following amendments to the *Administrative Procedures and Jurisdiction Act* (in tracked changes below):

> ***Definitions***
>
> *10 In this Part,*
>
> *(a) "court" means the Court of King's Bench of Alberta;*
>
> *(b) "decision maker" means an individual appointed or a body established by or under an Act of Alberta to decide matters in accordance with the authority given under that Act, but does not include*
>
> *(i) the Alberta Court of Justice or a judge of that Court,*
>
> *(ii) a justice of the peace conferred with the authority to determine a question of constitutional law under the Court of Justice Act,*
>
> *(iii) the Court of King's Bench of Alberta or a judge or applications judge of that Court, or*
>
> *(iv) the Court of Appeal of Alberta or a judge of that Court;*
>
> *(c) "designated decision maker" means a decision maker designated under section 16(a) as a decision maker that has jurisdiction to determine one or more questions of constitutional law under section 16(b);*
>
> *(d) "question of constitutional law" means*
>
> *~~(i) any~~ challenge, by virtue of the Constitution of Canada or the the Alberta Bill of Rights (RSA 2000, c. A-14), the Alberta Human Rights Act (RSA 2000, c A-25.5), or the Alberta Personal Property Bill of Rights (RSA 2000, c A-31), to the applicability or validity of an enactment of the Parliament of Canada or an enactment of the Legislature of Alberta~~, or~~.*

~~*(ii) a determination of any right under the Constitution of Canada or the Alberta Bill of Rights.*~~

(e) "question of constitutional law" does not mean:

(i) a determination of right under the Constitution of Canada or the Alberta Bill of Rights RSA 2000, c A-25.5), the Alberta Human Rights Act (RSA 2000, c A-25.5), or the Alberta Personal Property Bill of Rights (RSA 2000, c A-31), except if such determination entails a challenge to the applicability or validity of an enactment of the Parliament of Canada or an enactment of the Legislature of Alberta within the meaning of paragraph (d);

(ii) the mere interpretation of enactments in compliance with the Alberta Bill of Rights (RSA 2000, c. A-14), the Alberta Human Rights Act (RSA 2000, c A-25.5), the Alberta Personal Property Bill of Rights (RSA 2000, c A-31), or the Constitution of Canada.

(iii) balancing the severity of any interference with fundamental rights and freedoms or values protected by the Alberta Bill of Rights (RSA 2000, c. A-14), the Alberta Human Rights Act (RSA 2000, c A-25.5), the Alberta Personal Property Bill of Rights (RSA 2000, c A-31), or the Constitution of Canada, with statutory objectives;

Lack of jurisdiction

11 Notwithstanding any other enactment, a decision maker has ~~***no***~~ *jurisdiction to determine a question of constitutional law unless a regulation made under section 16 has* ~~***conferred***~~ *taken away jurisdiction* ~~***on***~~ *from that decision maker to do so.*

11.1 Section 11 and regulations made under section 16 cannot limit the inherent jurisdiction and duty of a decision maker to balance the severity of any interference with fundamental rights and freedoms, or values, under the Alberta Bill of Rights (RSA 2000, c. A-14), the Alberta Human Rights Act (RSA 2000, c A-25.5), the Alberta Personal Property Bill of Rights (RSA 2000, c A-31), or the Constitution of Canada, with statutory objectives.

Notice of question of constitutional law

12(1) Except in circumstances where only the exclusion of evidence is sought under the Canadian Charter of Rights and Freedoms, the decision maker shall provide notice of ~~*a person who intends to raise*~~ *a question of constitutional law in accordance with section 24 of the Judicature Act, with all necessary changes and adaptations*. ~~*at a proceeding before a designated decision maker that has jurisdiction to determine such a question*~~

~~*(a) must provide written notice of the person's intention to do so at least 14 days before the date of the proceeding*~~

~~*(i) to the Attorney General of Canada,*~~

~~(ii) to the Minister, and~~

~~(iii) to the parties to the proceeding,~~

~~and~~

~~(b) must provide written notice of the person's intention to do so to the designated decision maker.~~

~~(2) Until subsection (1) is complied with, the decision maker must not begin the determination of the question of constitutional law.~~

(3) Nothing in this section affects the power of a decision maker to make any interim order, decision, directive or declaration it considers necessary pending the final determination of any matter before it.

~~(4) The notice under subsection (1) must be in the form and contain the information provided for in the regulations.~~

~~**Referral of question of constitutional law**~~

~~13(1) With respect to a question of constitutional law over which a designated decision maker has jurisdiction and in respect of which a notice has been given under section 12, if the designated decision maker is of the opinion that the court is a more appropriate forum to decide the question, the designated decision maker may, instead of deciding the question,~~

~~(a) direct the person who provided the notice under section 12 to apply to the court to have the question determined by that court, or~~

~~(b) state the question of constitutional law in the form of a special case to the court for the opinion of the court.~~

~~(2) Before acting under subsection (1)(a) or (b), the designated decision maker may conduct any inquiries the designated decision maker considers necessary.~~

~~(3) Where the designated decision maker acts under subsection (1)(a) or (b), the designated decision maker must, unless otherwise directed by the court, suspend the proceeding, or any part of the proceeding, as it relates to the question to be heard by the court under subsection (1) until the decision of the court has been given.~~

~~(4) A question of constitutional law in respect of which an application has been directed to be made to the court under subsection (1)(a) must be brought on for hearing as soon as practicable.~~

~~(5) The court must hear and determine the question of constitutional law submitted to it under this section and give its decision as soon as practicable.~~

~~(6) The designated decision maker may and, at the request of the court, shall provide the court with any record and documentation that may assist the court in determining the question of constitutional law submitted to it under this section.~~

Attorney General of Canada and Minister

14 In any proceeding relating to the determination of a question of constitutional law before a decision maker or before the court under this Part, or in any subsequent proceeding on appeal or judicial review,

(a) the Attorney General of Canada and the Minister are entitled as of right to be heard, in person or by counsel,

(b) no person other than the Minister or counsel designated by the Minister shall, on behalf of His Majesty in right of Alberta, or on behalf of an agent of His Majesty in right of Alberta, appear and participate, and

(c) if the Minister or counsel designated by the Minister appears, the Minister is deemed to be a party and has the same rights as any other party.

[…]

Regulations

16 The Lieutenant Governor in Council may make regulations

(a) designating decision makers as having <u>no</u> jurisdiction to determine questions of constitutional law;

~~(b) respecting the questions of constitutional law that decision makers designated under a regulation made under clause (a) have jurisdiction to determine;~~

~~(c) respecting the referral of questions of constitutional law to the court;~~

~~(d) respecting the form and contents of the notice under section 12(1).~~

Note that this process, set out in the *Administrative Procedures and Jurisdiction Act*, would be binding, *inter alia*, on the Public Health Appeal Board established under sections 3 *et seq* of the ***Public Health Act***[53], which read as follows:

Board established

[53] *Public Health Act*, RSA 2000, c P-37.

3(1) There is hereby established a Public Health Appeal Board consisting of not more than 5 members who shall be appointed by the Lieutenant Governor in Council.

[…]

Duties of Board

4(1) The Board shall hear appeals pursuant to section 5.

(2) The Board may engage the services of persons having special technical, professional or other knowledge to assist it in the hearing of appeals.

Appeal to Board

5(1) In this section, "decision of a regional health authority" means

(a) an order issued under section 62, and

(b) a decision to issue or to cancel, suspend or refuse to issue a licence, permit or other approval provided for in the regulations, and any other decision in respect of which an appeal to the Board is permitted under the regulations, whether any of those decisions is made by the regional health authority itself or one of its employees or agents.

(2) A person who

(a) is directly affected by a decision of a regional health authority, and

(b) feels himself or herself aggrieved by the decision may appeal the decision to the Board.

(3) The person referred to in subsection (2) shall commence the appeal by serving a notice of appeal in the prescribed form on the Board and the regional health authority within 10 days after receiving notice of the decision complained of, and the notice of appeal is sufficiently served if it is left at an office of the Board or regional health authority.

(4) Subject to subsections (5) and (6), the Board shall, if it is satisfied that the requirements of subsection (2) have been met, hear the appeal within 30 days after receiving the notice of appeal.

(5) Where the Board is satisfied that the appellant and the regional health authority, or either of them, have not made a reasonable effort to resolve the matters in dispute between them, it may refer the matter to the regional health authority for further consideration and redetermination.

(6) Where the Board refers a matter to the regional health authority under subsection (5), the Board may prescribe a time period within which the regional

health authority must deal with the matter and may give to the regional health authority any other directions it considers appropriate.

(7) The Board shall provide the appellant, the regional health authority and, in a case where the decision or order appealed from was made by an employee or agent of the regional health authority, that employee or agent, an opportunity to appear and make representations orally or in writing, or both orally and in writing.

(8) The appellant, the regional health authority and, where the decision or order appealed from was made by an employee or agent of the regional health authority, that employee or agent, may be represented by counsel.

(9) Notwithstanding subsections (3) and (4), the Board may, if it considers it appropriate to do so, extend the time within which an appeal may be taken under subsection (3) or within which the Board must act under subsection (4).

(10) For the purposes of conducting an appeal under this section, the Board has all of the powers, privileges and immunities of a commissioner appointed under the Public Inquiries Act.

(11) The Board may confirm, reverse or vary the decision of the regional health authority and shall give written notice of its decision to the appellant and the regional health authority.

Stay pending appeal

6 An appeal taken pursuant to section 5 does not operate as a stay of the decision appealed from except so far as the chair or vice-chair of the Board so directs.

6.3. Substantive Law: "Emergency" Legislation

It may be in the public interest to include in all of Alberta's "emergency legislation" an objective definition of "emergency" that would not depend upon a potentially far-fetched interpretation[54] or on a discretionary declaration of emergency made by a government official. Emergency legislation should require that truly dire circumstances exist before government can invoke exceptional powers. I favour a wording the amendments in objective terms, with a high threshold that could be reviewed on a correctness standard by an independent and impartial court of law:

[54] For an example, see the *Final Report* of the Public Emergency Commission on the February 2022 events : https://publicorderemergencycommission.ca/final-report/ .

> *"**Emergency**": An urgent, temporary, and critical situation that objectively[55], demonstrably, immediately, and seriously threatens to cause, beyond a reasonable doubt, major and widespread increases in public displacements, disorder, injuries, death, destruction of property, or a fatal impairment in the ability of the Government or Legislature of Alberta to preserve the Rule of Law in the Province.*
>
> *A reviewing Court, tribunal or decision maker owes no deference to any prior determination made in this respect by the Government or Legislature of Alberta, or by the Government or Parliament of Canada.*

For example, the definition of "emergency" in the ***Emergency Management Act***[56] could be amended along the following lines (subject to a number of harmonization amendments in the Act):

> *1(1) In this Act,*
>
> […]
>
> *(e) "disaster" has the same meaning as "emergency", with all necessary adaptations ~~means an event that results in serious harm to the safety, health or welfare of people or in widespread damage to property or the environment~~;*
>
> *(f) "emergency" means ~~an event that requires prompt co-ordination of action or special regulation of persons or property to protect the safety, health or welfare of people or to limit damage to property or the environment~~ an urgent, temporary, and critical situation that objectively, demonstrably, immediately, and seriously threatens to cause, beyond a reasonable doubt, major and widespread increases in public displacements, disorder, injuries, death, destruction of property, or a fatal impairment in the ability of the Government or Legislature of Alberta to preserve the Rule of Law in the Province.*
>
> *(f.1) A reviewing Court, tribunal or decision maker owes no deference to any prior determination made in this respect by the Government or Legislature of Alberta, or by the Government or Parliament of Canada.*

The *Public Health Act* could also be amended to reflect a high threshold:

> *(hh.1) "public health emergency" means an urgent, temporary, and critical occurrence or threat of an illness, a health condition, an epidemic or pandemic disease, a highly infectious agent or biological toxin, or the presence of a chemical agent or radioactive material, that objectively, demonstrably, immediately, and seriously threatens to cause, beyond a reasonable doubt major*

[55] I.e., based on observable facts, in the opinion of any reasonable person.
[56] *Emergency Management Act*, RSA 2000, c E-6.8.

and widespread increases in the incidence of disease, injuries, disabilities, deaths, or a fatal impairment in the ability of the Government or Legislature to preserve the Rule of Law in Alberta.

~~*(i) an illness,*~~

~~*(ii) a health condition,*~~

~~*(iii) an epidemic or pandemic disease,*~~

~~*(iv) a novel or highly infectious agent or biological toxin, or*~~

~~*(v) the presence of a chemical agent or radioactive material*~~

~~*that poses a significant risk to the public health;*~~

(hh.2) A reviewing Court, tribunal or decision maker owes no deference to any prior determination made with respect to the existence of a "public health emergency" by the Government or Legislature of Alberta, or by the Government or Parliament of Canada.

NOTE TO THE PANEL	**I am mindful of the Panel's request that additional amendments be brought to health legislation so as to provide explicit, fact-pattern-based protections that would "illustrate" the broad amendments we suggested for the *Alberta Bill of Rights*, namely: i) the right to personal inviolability and bodily integrity, ii) informed consent to medical, psychological or any other type of care; iii) the right to choose to receive, or not to receive, medical, psychological or any other type of State-sanctioned care or treatment; iv) the right not to be coerced, either directly or indirectly, into submitting to medical, psychological or any other type of State-sanctioned care or treatment.** **Although I wholeheartedly favour the statutory *codification and illustration* of the aforementioned R&Fs in ordinary enactments, it would bring me away from the purpose of this Chapter, and squarely into a domain where technical expertise and experience in the medical field – which I do not have – are absolutely**

	necessary. I will thus remain available to work on this separate, but important task, should the Government of Alberta wish me to do so and provide the needed resources.

Any taking or substantial limitation, by the State, of a property or economic right purportedly based on emergency should be swiftly and completely compensated. I have yet to obtain third-party expert advice on the optimal wording of a compensation clause or mechanism. The latter will either be part of the final version of this Chapter, or constitute a separate memo. For the time being, I am contemplating amendments to the *Emergency Management Act* along the following lines :

> *Dispute re compensation ~~amount~~*
>
> *25 (0.1) The taking or substantial limitation of a person's proprietary, contractual or other economic rights, or the losses caused by any measure whith similar effects, due to the implementation of this Act or the regulations under a state of emergency, shall be compensated in full by the Crown, at fair market value, with interests at the legal rate, within 90 days.*
>
> *(1) If any dispute arises concerning the ~~amount of~~ compensation payable under ~~section 19(3) or 24(1.1)~~ this Act or the regulations, the matter shall be determined by arbitration and the* Arbitration Act *applies.*
>
> *(1.1) Upon* prima facie *proof of a taking or substantial limitation of a person's proprietary, contractual or other economic right, or of losses caused by any measure with similar effects, the Crown shall pay the allegedly aggrieved party a non-refundable provision for the costs of litigation, including reasonable attorney and expert fees.*
>
> *(1.2) No costs or fees shall be awarded in favour of the Crown, notwithstanding the outcome of arbitration, except on grounds of abuse of process.*
>
> *(2) ~~For greater certainty, a~~rbitration is ~~not~~ available to contest eligibility for compensation under this Act or the regulations.*

Note that the amended s. 25(0.1), above, is a very preliminary attempt at stating principles. I realize that it will require careful consideration and rewording before a "final" amendment proposal can be made. I do not purport to have expertise in

expropriation law. Obviously, I would not recommend enacting a provision that would expose Alberta to crippling economic liability, for instance.

NOTE TO THE PANEL	**My external consultant on matters of expropriation law, Mtre Guillaume Pelegrin, is currently working on a memo respecting these suggested amendments. I should be able to relay a fine-tuned position within six to eight weeks.** **I have noted the importance of avoiding provisions that would make Alberta liable to i) overcompensate admissible claims, or ii) compensate for losses that are usually the province of private insurance.**

The purpose of this Chapter is not to propose detailed amendments respecting issues of reporting and notice by public officials in times of emergency. I will nevertheless suggest a few broad policy items that are conducive to a better vindication of R&Fs – mainly because such amendments would make it easier for litigants in R&F cases to access to relevant documents and evidence. Naturally, I will remain available to provide draft amendments upon request, should the need arise, in light of the entire Report and after consultation with our colleagues.

Where the Government of Alberta declares a state of emergency, or where a court of law concludes that a state of emergency (as defined above) exists, **all government communications with experts, and related documents**[57], should be made entirely public on Internet within 5 days, including mandatory stenographic transcripts of meetings between elected officials, government officials and experts, notwithstanding cabinet privilege or any other kind of privilege. Also, the responsible government officer(s) should be statute-bound to **appear weekly before an all-party committee** of elected members of the Legislature of Alberta to answer all questions and provide all documents requested

[57] Including expert reports and the resources and data on which experts and politicians rely.

by these elected members within 72 hours, notwithstanding cabinet or other privilege[58].

As to **publication and notice** of emergency orders, I agree with the conclusion of my colleague Gerard Lucyshyn in his Memo dated April 20, 2023, titled *Where the Regulations Act does not apply*. I quote:

> *There appears to be a number of areas where the Regulations Act does not apply within the Emergency Management Act, the Public Health Act, and the Regional Autorities Act. This may impact the overall criteria of accountability and transparency and openness and may require a closer examination. Note that while the above orders are exempt from the Regulations Act, this means there is no requirement to publish such orders which may make it more challenging for public access and inspection of them.*

The requirement of notice – and, by extension, intelligibility of enactments for the laymen – is closely tied to principles of fundamental justice in Canadian constitutional law[59]. While I recognize that complying with all the filing and publication requirements of the ***Regulations Act***[60] may not be feasible under emergency circumstances, modern means of communications[61] make it cheap, fast and easy for any governmental authority to provide instant notice of their orders.

Many options are open. An amendment to the *Regulations Act* could be brought, for instance, to create a separate, provisional, streamlined process of electronic filing and publication of such orders within, say, one hour of their *de facto* issuance, and pending their "standard" publication in the *Alberta Gazette*. It could even be a new Part added to the *Gazette*.

[58] Either under pein of contempt of court, with all the due process and defences available in contempt proceedings, or of some other sufficiently deterring sanction.
[59] See case law dealing with s. 7 of the Charter, e.g. *R. v. Nova Scotia Pharmaceutical Society*, [1992] 2 SCR 606.
[60] RSA 2000, c. R-14.
[61] Namely Internet websites, so-called "Amber Alerts" on cellular networks, and "apps" on mobile devices.

Finally, in terms of amendments to “emergency legislation”, I would strongly support enacting statutory provisions ensuring that, within five days of a declaration of public emergency (or of a court ruling on same), the Government of Alberta be bound to **provide courts, tribunals and administrative decision makers** directly involved in issuing decisions relative to the emergency situation, with all the human, material and financial **resources** reasonably required to discharge their duties in the circumstances. Also, I would advocate for **extending publicly funded Legal Aid** for all R&F applicants who present a case that is neither frivolous, vexatious or abusive.

6.4. Substantive Law: *Alberta Bill of Rights* and *Alberta Human Rights Act*

Assuming it is the intention of the Legislature of Alberta to significantly amend the provincial R&Fs legislation to avoid that the infringement of rights seen under Covid conditions be repeated in a future situation of emergence, I believe that it would be advisable to 1) add explicit rights and freedoms to existing R&F legislation, and 2) add more robust supremacy clauses, in order to avoid any watering down by judges.

The *Alberta Bill of Rights* is quite succinct. I will copy it below, in its entirety, with all suggested amendments in tracked changes:

> *ALBERTA BILL OF RIGHTS*
>
> *Chapter A-14*
>
> *Preamble*
>
> […]
>
> *Recognition and declaration of rights and freedoms*
>
> *1 It is hereby recognized and declared that in Alberta there exist without discrimination by reason of race, national origin, colour, opinion, disability, medical status or history, religion, sexual orientation, sex, gender identity or gender expression, the following human rights and fundamental freedoms, namely:*

(a) the right of the individual to life, liberty, autonomy, security of the person, personal inviolability, bodily integrity, and enjoyment, use and disposition of property~~, and the right not to be deprived thereof except by due process of law~~;

(a.1) the right of the individual not to be deprived of the means of earning a living, caring for their family, or functioning in society;

(a.2) the right of the individual to privacy, including the inviolability of the home and of personal electronic devices, and the right not to be monitored, tracked, traced or profiled;

(a.2.1) Without limiting the generality of the foregoing, the right to be free from the collection and use of personal information to assess certain characteristics of a natural person, in particular for the purpose of analyzing that person's work performance, economic situation, health, personal preferences, interests or behaviour.

(a.3) informed consent to medical, psychological or any other type of care;

(a.4) the right of the individual to choose to receive, or not to receive, medical, psychological or any other type of State-sanctioned care or treatment;

(a.5) the right of the individual not to be coerced, either directly or indirectly, into submitting to medical, psychological or any other type of State-sanctioned care or treatment, except upon the order of a court of law of competent jurisdiction, on proof of immediate danger of serious injury or loss of life to another;

(a.6) the right of the individual to the absolute confidentiality of their health information and records, except where i) a medical doctor or other health care provider, in the context of providing care to the patient, has a valid medical reason for inquiring about prior medical history, or ii) a court of law of competent jurisdiction determines that disclosure is necessary to prevent imminent death or serious injury, or to protect the rights of an accused person;

(b) the right of the individual to equality before the law and (…) *equal benefit of the law without discrimination;*

(c) freedom of religion and freedom of conscience;

(d) freedom of speech;

(d.1) academic freedom, which is the right of every member of the higher education community to engage freely and without doctrinal, ideological or moral constraint, such as institutional

censorship, in an activity through which that person contributes to carrying out the mission of their institution;

(d.2) professional freedom, which is the right of:

(d.2.1) every regulated professional to engage without doctrinal, political, ideological or moral constraint, such as institutional censorship, in the exercise of their profession, and in free inquiry and public debate in connection with their profession or in other contexts, and

(d.2.2) every regulatory body, college or association, not to be constrained doctrinally, politically, ideologically or morally, in the carrying out of its duties;

(e) freedom of assembly, recognizing the intrinsic and irreplaceable value of human physical presence, and the freedom of association;

(f) freedom of the press;

(g) the right of parents to make informed decisions respecting the education and care of their children;

(h) the right of minors to primary and education and to face-to-face, in-person learning.

Fundamental duties and responsibilities

1.1 Every person is bound to exercise their rights and freedoms in accordance with the requirements of good faith.

1.2 No right or freedom under this Bill of Rights may be exercised with the intent of injuring another or in an excessive and unreasonable manner, and therefore contrary to the requirements of good faith.

Construction of law

2 (1) Every law of Alberta shall, unless it is expressly declared by an Act of the Legislature that it operates notwithstanding the Alberta Bill of Rights, be so construed and applied as not to abrogate, abridge or infringe or to authorize the abrogation, abridgment or infringement of any of the rights or freedoms herein recognized and declared.

(2) The Charter binds the State, and all natural and legal persons subject to the jurisdiction of the Laws of Alberta; it governs those matters that come under the legislative authority of Alberta, including, but not limited to, private law and civil rights and obligations.

Enforcement

2.1 Anyone whose rights or freedoms, as guaranteed by this Bill of Rights, have been infringed or denied may apply to a court of competent jurisdiction to obtain a just and appropriate remedy, such as a stay, an injunction, a declaration, damages, or punitive damages.

2.2 Any Act of the Legislature of Alberta, or any decision made or action taken under the authority thereof, that directly or indirectly witholds a benefit, or attaches punitive or seriously disadvantageous consequences to the exercise of a right or freedom set out in this Bill of Rights, shall be presumed to unjustifiably infringe said right or freedom; such Act, decision or action shall also be presumed to be irrational, abusive and in bad faith until proven otherwise.

Exclusion of evidence bringing administration of justice into disrepute

2.3 Where a Court, tribunal or administrative decision maker concludes that evidence was obtained in a manner that infringed or denied any rights or freedoms guaranteed by this Bill of Rights, the evidence shall be excluded.

Exception where express declaration

2.4 (1) The Legislature of Alberta may expressly declare, in an Act of the Legislature, that the Act or a provision thereof shall operate notwithstanding a provision included in this Bill of Rights.

(2) An Act or a provision of an Act in respect of which a declaration made under this section is in effect shall have such operation as it would have but for the provision of this Bill of Rights referred to in the declaration.

(3) A declaration made under subsection (1) shall cease to have effect five years after it comes into force or on such earlier date as may be specified in the declaration.

(4) The Legislature may re-enact a declaration made under subsection (1).

(5) Subsection (3) applies in respect of a re-enactment made under subsection (4).

Supremacy

2.5 This Bill of Rights is integral to the Constitution of Alberta, which is the supreme law of Alberta, and any law that is inconsistent with the provisions of this Bill of Rights is, to the extent of the inconsistency, of no force or effect.

2.6 A right or freedom set out in this Bill of Rights shall be presumed to be paramount and of superior importance to other objectives put forward by the Government or Legislature of Alberta.

2.7 This Bill of Rights guarantees the rights and freedoms set out in it, subject only to such limits prescribed by a rule of law, as can be demonstrably and manifestly justified in a free and democratic Alberta.

Saving

3(1) Nothing in this Act shall be construed to abrogate or abridge any human right or fundamental freedom not enumerated herein that may have existed in Alberta at the commencement of this Act.

(2) In this Act, "law of Alberta" means an Act of the Legislature of Alberta enacted before or after the commencement of this Act, any order, rule or regulation made thereunder, and any law in force in Alberta at the commencement of this Act that is subject to be repealed, abolished or altered by the Legislature of Alberta.

(3) The provisions of this Act shall be construed as extending only to matters coming within the legislative authority of the Legislature of Alberta.

~~*Notice to Minister of Justice*~~

~~*4(1) If in any action or other proceeding a question arises as to whether any law of Alberta abrogates, abridges or infringes, or authorizes the abrogation, abridgment or infringement, of any of the rights and freedoms herein recognized and declared, no adjudication on that question is valid unless notice has been given to the Minister of Justice.*~~

~~*(2) When the Minister of Justice has notice under subsection (1), the Minister may, in person or by counsel, appear and participate in that action or proceeding on such terms and conditions as the court, person or body conducting the proceeding may consider just.*~~

The experience of the Covid years makes it quite clear that employers ought not to discriminate employees or prospective employees by asking them about, or requiring proof of, their medical history, including medical treatments they may have received or not received – unless, of course, they meet a stringent justification standard. Easing social tensions in situations of emergency or crises also warrants additional protection, in the public and private sectors, against discrimination based on opinions, conscientious objection, or the exercise of other R&Fs.

"[M]edical status or history" and a person's "lawful exercise of a right or freedom set out in the Alberta Bill of Rights" should be inserted as prohibited grounds for discrimination in the *Alberta Human Rights Act*:

Preamble

WHEREAS recognition of the inherent dignity and the equal and inalienable rights of all persons is the foundation of freedom, justice and peace in the world;

WHEREAS it is recognized in Alberta as a fundamental principle and as a matter of public policy that all persons are equal in: dignity, rights and responsibilities without regard to race, religious beliefs, colour, gender, gender identity, gender expression, physical disability, mental disability, medical status or history, age, ancestry, place of origin, marital status, source of income, family status, ~~or~~ sexual orientation,or lawful exercise of a right or freedom set out in the Alberta Bill of Rights;

[…]

Discrimination re publications, notices

3(1) No person shall publish, issue or display or cause to be published, issued or displayed before the public any statement, publication, notice, sign, symbol, emblem or other representation that

(a) indicates discrimination or an intention to discriminate against a person or a class of persons, or

(b) is likely to expose a person or a class of persons to hatred or contempt

because of the race, religious beliefs, colour, gender, gender identity, gender expression, physical disability, mental disability, medical status or history, age, ancestry, place of origin, marital status, source of income, family status, ~~or~~ sexual orientation of that person or class of persons, or exercise by that person or class of person of a right or freedom set out in the Alberta Bill of Rights.

(2) Nothing in this section shall be deemed to interfere with the free expression of opinion on any subject.

[…]

4 No person shall

(a) deny to any person or class of persons any goods, services, accommodation or facilities that are customarily available to the public, or

(b) discriminate against any person or class of persons with respect to any goods, services, accommodation or facilities that are customarily available to the public,

because of the race, religious beliefs, colour, gender, gender identity, gender expression, physical disability, mental disability, medical status or history, age, ancestry, place of origin, marital status, source of income, family status, ~~or~~ sexual orientation of that person or class of persons, or exercise by that person or class of person of a right or freedom set out in the Alberta Bill of Rights.

[…]

Discrimination re tenancy

5(1) No person shall

(a) deny to any person or class of persons the right to occupy as a tenant any commercial unit or self-contained dwelling unit that is advertised or otherwise in any way represented as being available for occupancy by a tenant, or

(b) discriminate against any person or class of persons with respect to any term or condition of the tenancy of any commercial unit or self-contained dwelling unit,

because of the race, religious beliefs, colour, gender, gender identity, gender expression, physical disability, mental disability, medical status or history, age, ancestry, place of origin, marital status, source of income, family status, ~~or~~ sexual orientation of that person or class of persons, or exercise by that person or class of person of a right or freedom set out in the Alberta Bill of Rights.

[…]

Discrimination re employment practices

7(1) No employer shall

(a) refuse to employ or refuse to continue to employ any person, or

(b) discriminate against any person with regard to employment or any term or condition of employment,

because of the race, religious beliefs, colour, gender, gender identity, gender expression, physical disability, mental disability, medical status or history, age, ancestry, place of origin, marital status, source of income, family status, ~~or~~ sexual orientation of that person or any other person, or exercise by that person or any other person of a right or freedom set out in the Alberta Bill of Rights.

(2) Subsection (1) as it relates to age and marital status does not affect the operation of any bona fide retirement or pension plan or the terms or conditions of any bona fide group or employee insurance plan.

(3) Subsection (1) does not apply with respect to a refusal, limitation, specification or preference based on a bona fide occupational requirement.

Applications and advertisements re employment

8(1) No person shall use or circulate any form of application for employment or publish any advertisement in connection with employment or prospective employment or make any written or oral inquiry of an applicant

(a) because of the race, religious beliefs, colour, gender, gender identity, gender expression, physical disability, mental disability, medical status or history, age, ancestry, place of origin, marital status, source of income, family status, ~~or~~ sexual orientation of that person or any other person, or exercise by that person or any other person of a right or freedom set out in the Alberta Bill of Rights.

(b) that requires an applicant to furnish any information concerning race, religious beliefs, colour, gender, gender identity, gender expression, physical disability, mental disability, medical status or history, age, ancestry, place of origin, marital status, source of income, family status or sexual orientation.

(2) Subsection (1) does not apply with respect to a refusal, limitation, specification or preference based on a bona fide occupational requirement.

Membership in trade union, etc.

9 No trade union, employers' organization or occupational association shall

(a) exclude any person from membership in it,

(b) expel or suspend any member of it, or

(c) discriminate against any person or member,

because of the race, religious beliefs, colour, gender, gender identity, gender expression, physical disability, mental disability, medical status or history, age, ancestry, place of origin, marital status, source of income, family status, ~~or~~ sexual orientation of that person, or exercise by that person of a right or freedom set out in the Alberta Bill of Rights.

Ameliorative policies, programs and activities

10.1 It is not a contravention of this Act to plan, advertise, adopt or implement a policy, program or activity that

(a) because of their race, religious beliefs, colour, gender, gender identity, gender expression, physical disability, mental disability, medical status or history, age, ancestry, place of origin, marital status, source of income, family status, ~~or~~ sexual orientation, or their exercise of a right or freedom set out in the Alberta Bill of Rights, and

(b) achieves or is reasonably likely to achieve that objective.

Reasonable and justifiable contravention

11 A contravention of this Act shall be deemed not to have occurred if the person who is alleged to have contravened the Act shows that the alleged contravention was reasonable and justifiable in the circumstances.

The generality of the amendment pertaining to the "exercise of a right or freedom set out in the *Alberta Bill of Rights*" would be sufficiently balanced by the broad justification clause, at section 11 of the *Alberta Human Rights Act*, which allows for proper adjustments and defence in particular situations, especially in an employment setting.

7. CONCLUSION

While many parts of the Canadian federation continue to drift toward statism and soft authoritarianism, it is time that R&Fs be restored to their proper place in a free and democratic Alberta: right at the top.

It goes without saying that any eventual amendment to such fundamental enactments as the *Alberta Bill of Rights* or the *Alberta Human Rights Act* will require fine-tuning and further consideration and analysis, in order to ensure adequate adjudication by courts and administrative authorities, as well as positive outcomes for all Albertans. I look forward to the Panel's comments and suggestions on this Draft.

APPENDIX 10

Improving the Capacity and Performance of the Alberta Healthcare System

System Capacity, Surge Capacity, and Incremental Changes to Alberta's Health Care System to Improve System Performance

A report written by the Montreal Economic Institute (MEI).

Introduction

During the COVID-19 crisis, a persistent concern for Canadian policy-makers has been the ability of the long-overburdened Canadian health care system to handle surges in health care needs. In fact, many public health and safety measures, including stay-at-home orders, were put in place in order to preserve public health system capacity.[1] Surge capacity, essentially, permits the management of a sudden influx of patients that would otherwise severely challenge or exceed the present capacity, and is dependent on a well-managed system, complete with adequate supplies and equipment (stuff), infrastructure needed to treat patients (space), health workforce (staff), and policies and procedures (systems).[2]

In the context of a system that struggles perennially with shortages of stuff, space, and staff, the deployment of adequate surge capacity is difficult. In fact, the Canadian Federation of Nurses Unions and other stakeholders have reported that "surge capacity is difficult to create when there are shortfalls in resources for usual public health and personal health service needs."[3] Chapter One of this report assesses the province of Alberta's surge response, and health system deficits in Alberta and Canada more broadly. Ultimately, the health care system in Alberta struggled to deploy adequate surge capacity due to the lack of health system resilience and adaptive capacity pre-COVID.

For the province to be better prepared to respond to future public health emergencies and other crises, the capacity of the province's health care system ***must*** be improved. Yet this is not just a question of increasing funding – per capita health care spending has been steadily increasing for years, outpacing that of most other provinces and of many comparable peer countries. Rather, the development of robust surge capacity will require incremental changes to certain features of the health system to embed flexibility and competition, and foster patient choice.

Chapter Two of this report discusses incremental changes that can be made to the province's health care system to increase efficiency, foster flexibility and adaptability, and utilize health care resources to their fullest extent. These recommended patient-centred changes can be made to Alberta's health system without diminishing universal access or violating the *Canada Health Act* (CHA), while also constraining spending.

Incremental reform, by definition, is not big or bold, yet harness the potential for enormous impact and large results. The Alberta Quality Matrix for Health indicates six dimensions of quality: acceptability, accessibility, appropriateness, effectiveness, efficiency, and safety.[4] But in

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[1] Government of Ontario, "Ontario Enacts Provincial Emergency and Stay-at-Home Order," News Release*,* April 7, 2021.
[2] American College of Emergency Physicians, "Health Care System Surge Capacity Recognition, Preparedness, and Response" *Advancing Emergency Care Policy Statement,* October 2017, p. 1.; Canadian Institute for Health Information, *Health System Capacity: Measures to Support System-Level Monitoring in Canada*, 2022, p. 7.
[3] Government of Canada, "Chapter 5: Learning from SARS: Renewal of public health in Canada – Building Capacity and coordination" *Learning from SARS: Renewal of public health in Canada – Report of the National Advisory Committee on SARS and Public Health,* November 8, 2004, p. 102.

order for health care services to be appropriate, effective, and safe, they need to be accessible in an efficient manner. The recommendations made in Chapter Two focus on the dimensions of accessibility and efficiency.

The incremental recommendations contained in this report include:

1. Implement activity-based funding for hospitals,
2. Expand the use of nurse practitioners (NPs),
3. Expand the use of licensed practical nurses (LPNs),
4. Reduce the health care administration burden,
5. Reduce or eliminate barriers to labour mobility for health care workers,
6. Utilize pharmacists to their full scope of practice,
7. Expand the use of telemedicine,
8. Gradually increase medical school admissions and residency positions,
9. Incentivize medical school graduates to practice family medicine, and
10. Expand and improve the organization of home care services.

Alberta does not need to reinvent the wheel when it comes to health care, and in addition to the recommendations noted, should look to what can be learned from better-performing, universal systems that have superior accessibility and efficiency.

[4] Health Quality Council of Alberta, "Alberta Quality Matrix for Health," June 2005.

Chapter One: System Capacity and Surge Capacity in Health Care

Health System Capacity

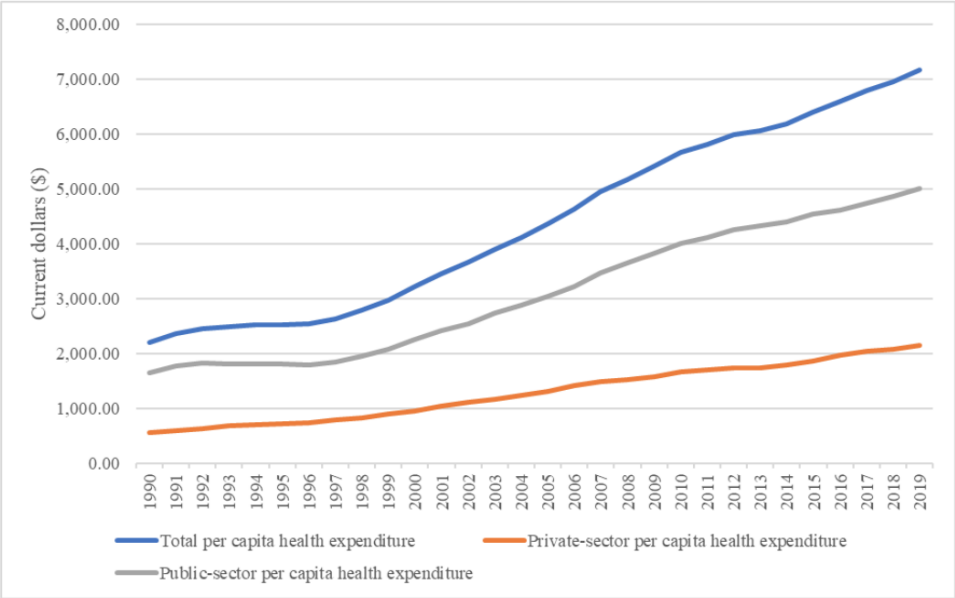
a) Canada's Health System Capacity

Health system capacity is a complex notion that includes adequate supplies and equipment (stuff), the infrastructure and space to treat patients (space), personnel that are adequately trained (staff), and policies and procedures (systems).[5] Canadian health care is based on the core principle of access according to need rather than ability to pay, and the structural features of this system ultimately result in increased demand, resource shortages, and increased health system costs that are managed through rationing. With global budgets dictating hospital financing and expenditure caps to contain health care spending, rationing takes the form of wait lists to allocate care.

As a result, health care systems across Canada have struggled with capacity issues for decades, despite increased spending. In fact, since the 1990s, real per capita spending has increased significantly (see Figure 1.1), yet a lack of capacity – "stuff," "space," and "staff" – has all but enshrined hallway medicine as an outcome of Canadian health care.[6] This lack of capacity is evidenced by outdated equipment, shortages of staff and facilities, and lengthy wait times in emergency departments (EDs), and confirmed by a range of measures related to health care capacity.

[5] Canadian Institute for Health Information, *Health System Capacity: Measures to Support System-Level Monitoring in Canada,* 2022, p 7.
[6] Peter St. Onge and Patrick Dery, "Canada's Health Care System Woes: Waiting Lists, Outdated Equipment, Staff Shortages," MEI*,* Economic Note, December 2019, p. 1; Hamid Sadri and Neil D. Fraser, "Déjà vu: Seventy years of hallway medicine in Canada," *Longwoods.com,* April 2022.

Figure 1.1. Per capita health expenditure, Canada, 1990 - 2019.



Source: Canadian Institute for Health Information, "National health expenditure trends, 2022," *Data Tables – Series B,* November 3, 2022

The percentage of certain scheduled surgeries completed within the Canadian Institute for Health Information (CIHI) benchmark can also serve as an illustration of system capacity through its response to demand. Lengthy wait lists for priority procedures are commonplace and another visible indicator that Canadian health care capacity is below that of other universal systems.

For instance, the percentage of hip replacement and knee replacement surgeries meeting the benchmark have decreased since 2018 (see Figure 1.2 and Figure 1.3). The cancellation or postponement of scheduled surgeries like these to free capacity for the treatment and management of COVID-19 patients undeniably impacted wait times, however, it's evident this problem predates the pandemic. The percentage of surgeries meeting the pan-Canadian benchmark for these procedures was, at most, 75% pre-COVID.[7]

As benchmarks are the amount of time that clinical evidence shows is appropriate to wait for a particular procedure,[8] the extension of a patient's wait time is likely to have a cascading effect on other areas of health system functioning, not to mention the impact on a patient's quality of life.

[7] Canadian Institute for Health Information, Explore wait times for priority procedures in Canada, consulted August 29, 2023.
[8] Canadian Institute for Health Information, "Wait Times for Priority Procedures in Canada, 2014," March 2014, p. 2.

Figure 1.2. Percent of hip replacement surgeries meeting benchmarks, 2018 - 2022, Canada.

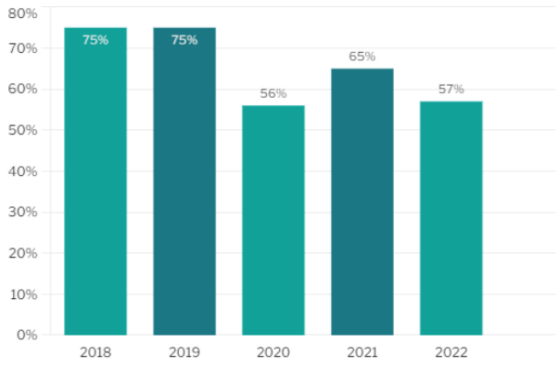
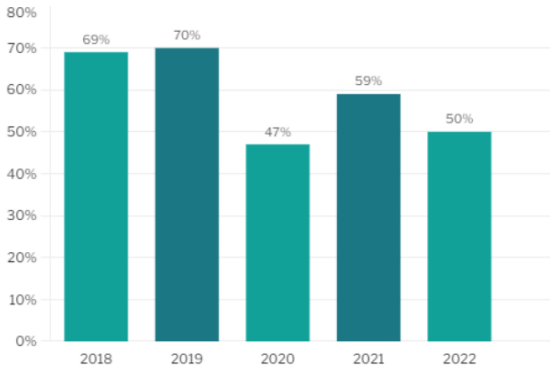


Figure 1.3. Percent of knee replacement surgeries meeting benchmarks, 2018 - 2022, Canada.

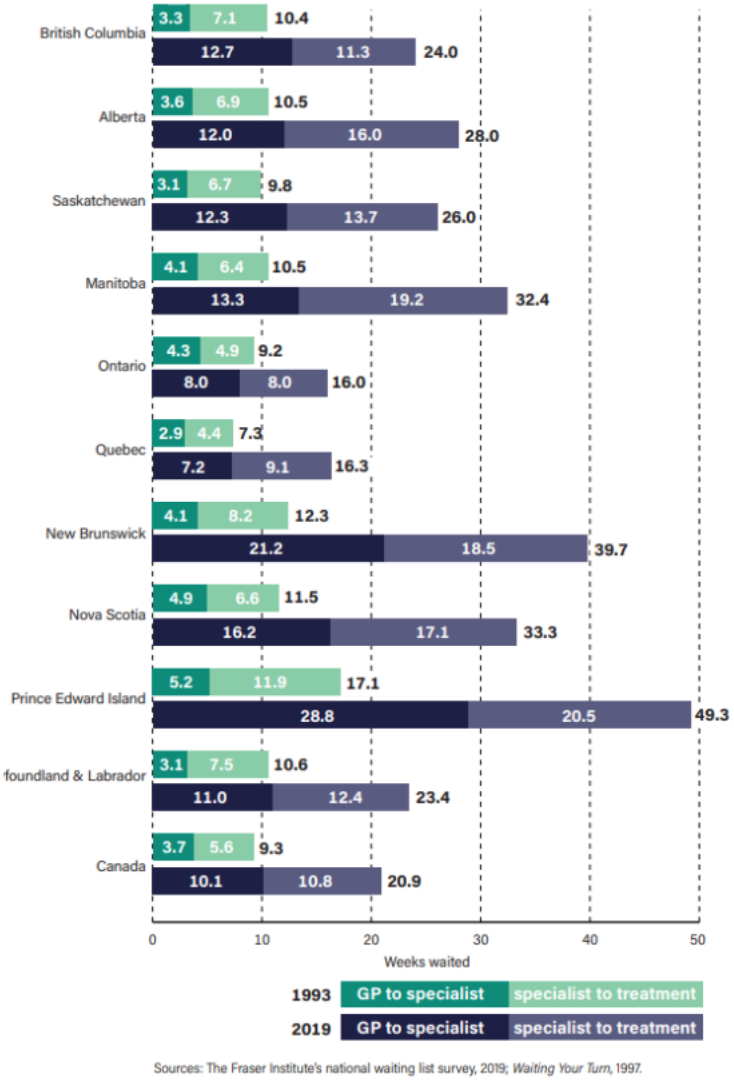


Source: Canadian Institute for Health Information, Explore wait times for priority procedures in Canada, consulted August 29, 2023.

Canada-wide, the wait times built into getting to the point of surgery have also increased considerably. The wait time from referral by a general practitioner (GP) to consultation with a specialist increased by a whopping 173% between 1993 and 2019 (from 3.7 weeks to 10.1 weeks, see Figure 1.4).[9] The wait time from the consultation with a specialist to the point at which the patient receives treatment has also increased drastically – from 5.6 weeks in 1993 to 10.8 weeks in 2019, a wait time 93% longer.

[9] Bacchus Barua and Mackenzie Moir, "Waiting Your Turn: Wait Times for Health Care in Canada, 2019 Report," Fraser Institute, 2019, p. iii.

Figure 1.4. Median wait from referral by GP to treatment, by province, 1993 and 2019.



Sources: The Fraser Institute's national waiting list survey, 2019; *Waiting Your Turn*, 1997.

When compared against other high-income OECD countries with universal health care systems, Canada constantly underperforms (see Appendix A, Table A.1), especially with respect to the factors which govern wait times for essential health care services. In fact, the latest Commonwealth Fund analysis ranked Canada 10th out of the 11 countries examined related to its performance over 71 indictors related to access to care, care process, administrative efficiency, equity, and health care outcomes.[10]

b) Comparative Snapshot

[10] Eric C. Schneider *et al.*, "Mirror, Mirror 2021 Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries," The Commonwealth Fund, August 2021, p. 2.

While a complete forensic comparative analysis and multi-jurisdictional evaluation of health system capacity is outside the scope of this report, a benchmarking of metrics relevant to universal health system capacity is both appropriate and situational. Analyzing pre-COVID country-level data allows for an understanding of capacity *before* the crisis, which can help to situate relative performance *during* the pandemic.

For this comparative "snapshot," Australia, Canada, Germany, Japan, Korea, the Netherlands, Sweden, and the United Kingdom (UK) are compared on a number of health care capacity indicators as well as wait times, where possible (see Appendix A for Table A.1 - OECD metrics for Australia, Canada, Germany, Japan, Korea, the Netherlands, Sweden, and the UK). These countries are all high-functioning universal systems which have similar per capita costs.

i. Indicators

Canada was the worst performer in half of the indicators analysed (not including cost) (see Table 1.1). In fact, Canada was not the highest-ranking jurisdiction for any indicator, yet was in the middle of the pack when it came to expenditure per capita. Despite spending more than Australia, Canadian health care performed worse on all indicators. Canada spent 11.7% more per capita than Japan, 37.0% more than Korea, and 16.0% more than the UK per capita yet performed similarly or worse (Table 1.1).

Table 1.1 Select OECD metrics for Australia, Canada, Germany, Japan, Korea, the Netherlands, Sweden, and the UK (Data are from 2019 or if unavailable, the latest available year in parentheses). Green cells indicate the best performing jurisdiction per indictor, red indicates the worst performing.

	Expenditure on health - all financing schemes - per capita ($USD)	Practicing physicians (per 1,000)	Practicing nurses (per 1,000)	Medical graduates (per 1,000 practicing physicians)	Nursing graduates (per 100,000)	Number of hospitals (per 1,000,000 population)	Total hospital beds (per 1,000)	Total acute care beds (per 1,000)	Total ICU beds (average, per 100,000)	CT Scanners (per 1,000,000)	MRI units (per 1,000,000)
Australia	$ 5,126.65	3.83	12.23	41.45	109	52.76	n/a	n/a	n/a	69.81	14.8
Canada	$ 5,222.64	2.74	9.98	27.77	52.71 (2017)	18.86	2.52	1.97	16.99	14.60	10.05
Germany	$ 6,418.32	4.40	11.79	28.01	43.92	36.42	7.91	5.95	31.67	35.26	34.71
Japan	$ 4,610.79	2.49 (2018)	11.76 (2018)	27.75 (2018)	52.25	65.79	12.84	n/a	18.71	111.49 (2017)	55.21 (2017)
Korea	$ 3,290.83	2.46	7.93	30.07	100.16	77.66	12.43	7.08	19.97	39.58	31.99
Netherlands	$ 5,643.59	3.75	10.77	40.23	58.58	32.75	3.02	2.56	n/a	14.87	13.84
Sweden	$ 5,387.73	4.29	10.86	31.43	43.22	n/a	2.07	n/a	n/a	26.17	16.64
United Kingdom	$ 4,389.04	2.95	8.2	44.36	44.77	29.61	2.45	n/a	n/a	n/a	n/a

Source: OECD Data, Topic, Health, Healthcare Resources, Health expenditures and financing, consulted August 29, 2023.
Note: Beware of differences in methdology and estimated values vs final reports in some cases.

Hospital capacity is another indicator that can be used to illustrate health system capacity, and Canada is one of the OECD countries least likely to have an acute care hospital bed available for use when needed. Indeed, pre-COVID, 91.6% of Canadian acute care beds already had someone in them – of the OECD countries, only Israel and Ireland fared worse. The rate in the UK, for comparison, was 84.3%.[11]

An analysis of 169 Ontario hospitals published just before the first COVID-19 case was reported in Canada found that in the preceding six months, nearly half (83) were beyond full capacity for more than 30 days, while nearly a quarter (39) had hit 120% capacity or higher for at least one day, and about the same number (40) averaged 100% capacity or higher.[12]

According to the CAEP:

> The COVID-19 pandemic has rightly called into question the ability of Canadian emergency departments—and the healthcare system as a whole—to handle any potential large surge of patients presenting to our doors.[13]

The CAEP specifically criticized the lack of a "buffer" due to existing overcrowding, and pleaded that, post-crisis, we do not go back to being complacent about capacity. They note that these problems long predated the pandemic; the occupancy rate of a hospital, according to mathematical models, should be 85%, yet in Canadian hospitals pre-COVID, it habitually exceeded 100%.[14]

The latest Commonwealth Fund analysis of 71 performance indicators across five areas (access to care, care process, administrative efficiency, equity, and health care outcomes) ranked Canada 10th out of the 11 countries included.[15] The top three performing countries were Norway, the Netherlands, and Australia. Only the United States fared worse (see Figure 1.5).

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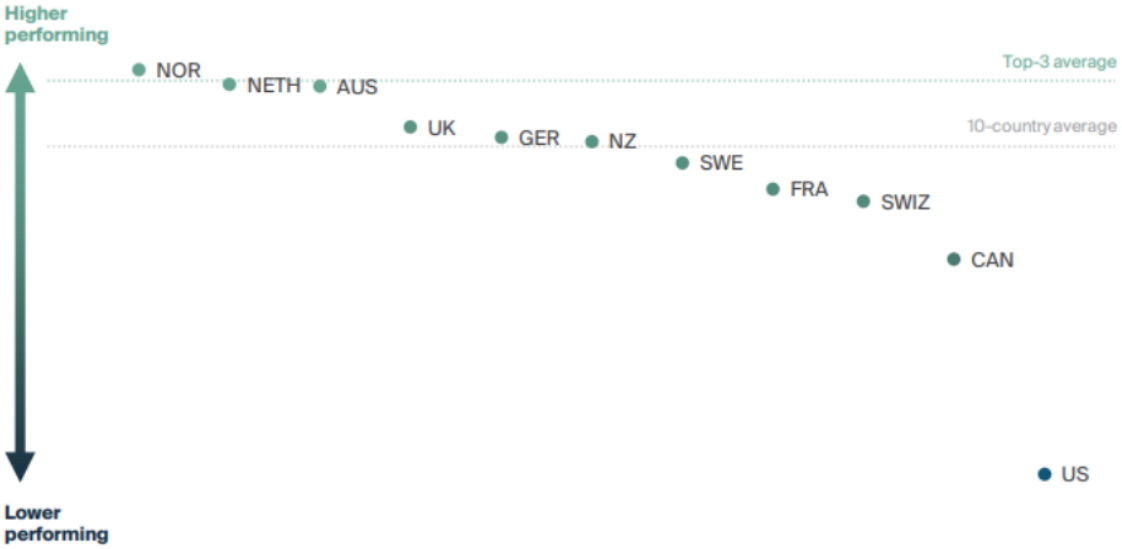
[11] Tristin Hopper, "Why Canada's hospital capacity was so easily overwhelmed by the COVID pandemic," *National Post,* January 17, 2022.
[12] Catherine Varner, "The end of hallway medicine?" *Healthy Debate*, June 3, 2020.
[13] Canadian Association of Emergency Physicians, "Surge Capacity and the Canadian Emergency Department," March 24, 2020, p. 1.
[14] *Idem.*
[15] Eric C. Schneider *et al*., *op. cit.,* note 10, p. 2.

Figure 1.5. Comparative Health Care System Performance Scores.



Note: To normalize performance scores across countries, each score is the calculated standard deviation from a 10-country average that excludes the US. See How We Conducted This Study for more detail.

Data: Commonwealth Fund analysis.

Their analysis of equity is particularly interesting: As the foundation of Canadian Medicare is access according to need, not ability to pay, one might expect a relatively high ranking in this domain, which focused on income-related disparities. In this domain, Australia, Germany, and Switzerland ranked highest, meaning these countries had the smallest income-related disparities in performance based on the measures included.[16] Canada, on the other hand, demonstrated the second largest disparities between income groups overall, including in the affordability indicators.[17]

ii. Wait Times for Priority Procedures (Elective Surgeries)

In 2019 the median wait times for hip replacement surgery in Canada was 17.0% longer than in the UK and 48.1% longer than in Sweden (see Table 1.2). For knee replacement surgery, patients were waiting a median of 23.1% longer in Canada than in the UK, and 42.1% longer than in Sweden.

The most recent data indicates increasing wait times over the COVID-19 pandemic. In Canada, the median wait time for hip replacement grew 54.7% between 2019 and 2022, compared to a growth of 43.6% in Sweden over the same time period. For knee replacement surgery, between 2019 and 2022 patients were waiting a median of 63.6% longer in Canada, compared to a 60.0% increase in Sweden (see Table 1.2). The wait times for these procedures has been growing since

[16] *Ibid,* pp. 29-30.
[17] *Ibid,* p. 7.

2014 due to several factors, such as the prevalence of conditions like osteoarthritis and obesity as well as an aging population.[18]

Table 1.2. Median wait time (days) for hip replacement and knee replacement surgeries for Canada, Sweden, and the UK, 2019 and latest available year.

	Median wait time (days) for hip replacement		Median wait time (days) for knee replacement	
	2019	Latest available year	2019	Latest available year
Canada	106	164 (2022)	121	198 (2022)
Sweden	55	79 (2022)	70	112
United Kingdom	88	176 (2020)	93	207 (2020)

Source: OECD Data, Topic, Healthcare Utilisation, consulted August 29, 2023.
Note: Beware of differences in methdology and estimated values vs final reports in some cases.

Thus, wait times for patients in Canada for these two priority procedures indicate a lack of capacity when compared with Sweden and the UK, which respectively spent 3.2% more and 16.0% less per capita than Canada on health care in 2019 (see Table 1.1).

It's vital to note that the wait times for these surgeries reflect only a fraction of the total time spent waiting by the patient as they reflect the time from the booking date of the surgery to when the surgery actually occurs.[19] There are other necessary appointments to arrive at the decision for surgery. For starters, GP/family physician visits are required to receive referral to a specialist, who then performs the surgery. Frequently, there is a wait time to get in to see the GP/family physician in the first place, if one is available, which adds to this considerably. In 2016 over 60% of people waited one month or more for a specialist appointment in Canada, compared to about 25% in Germany and the Netherlands.[20] Figure 1.4 shows the increasing wait times between 1993 and 2019 across Canada.

According to the OECD, waiting times is not considered to be a significant policy issue in a number of countries, including Germany, Korea, and Japan.[21] As a result, data availability is not sufficient to make an adequate comparison as we did with indicators in the previous section, other than that shown in Figure 1.6, below.

[18] OECD, "Waiting Times for Health Services: Next in Line," *OECD Health Policy Series,* May 2020, p. 36.
[19] Canadian Institute for Health Information, *op. cit.,* note 7.
[20] OECD, *op. cit.,* note 18, pp. 15-16.
[21] Reported in 2020 based on 2019 survey. Quote: "none of these countries report any statistics on waiting times except for Japan." *Ibid,* p. 12.

Figure 1.6. Waiting times are considered to be an issue across different types of health services, 2019.

Source: Based on responses from the OECD Waiting Times Policy Questionnaire 2019.
OECD, "Waiting Times for Health Services: Next in Line" OECD Health Policy Series 28 May 2020

As Chief Justice Beverley McLachlin said in *Chaoulli v. Quebec:* "Access to a wait listing list is not access to health care."[22] In Canada at least 53,215 patients have died on a wait list since 2018-2019 waiting for various surgeries, diagnostics, and treatments.[23] Capacity must be significantly scaled up to at least be in the same arena as per capita spending.

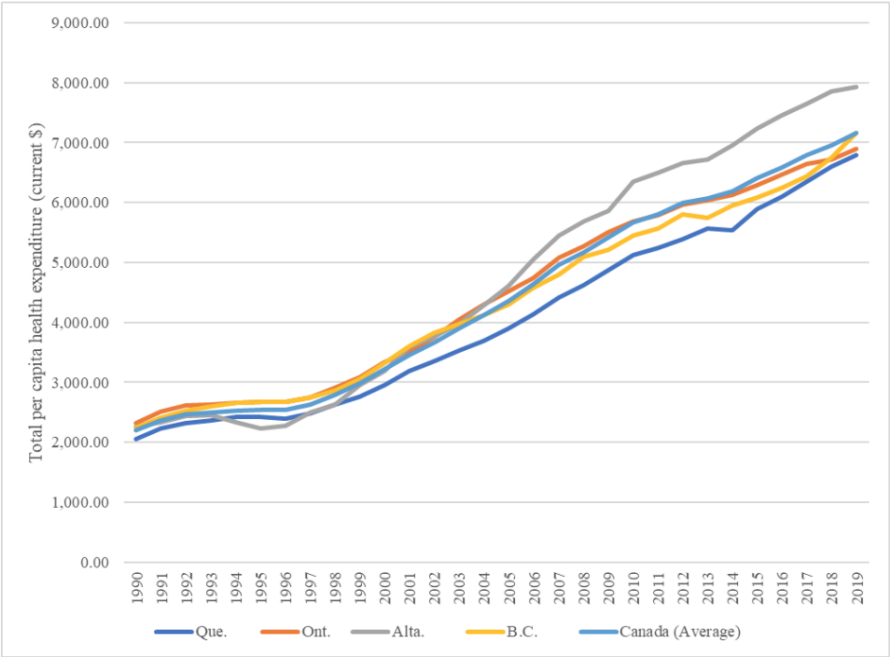
Health System Capacity in Alberta

Alberta's health care spending has historically been increasing at a faster rate than government revenue, in addition to spending more per capita than other comparable provinces.[24] In fact, in 1995, Alberta spent less than British Columbia, Ontario, Quebec, and the Canadian average, but

[22] Chaoulli *v.* Quebec (Attorney General), [2005] 1 S.C.R. 791, 2005 SCC 35
[23] SecondStreet.org, "Canadians Waiting for Health Care," consulted September 3, 2023.
[24] Canadian Institute for Health Information, "National health expenditure trends, 2022," *Data Tables – Series B,* November 3, 2022.

within 10 years had surpassed all comparators and has remained a high spender since (see Figure 1.7). In 2019 Alberta had the second most expensive provincial health care system in the country after Newfoundland and Labrador.[25]

Figure 1.7. Total per capita health expenditure, current $, Alberta, British Columbia, Ontario, Quebec, and Canadian average, 1990 - 2019.



Source: Canadian Institute for Health Information, "National health expenditure trends, 2022," *Data Tables – Series B,* November 3, 2022.

a) Indicators

Alberta's higher spending on health has not produced better outcomes and the province consistently underperforms in a country that underachieves relative to its peers (see Table 1.3). Strikingly, of the indicators analysed, Alberta performed the worst on a third, was in the middle of the pack on a third, and led on a third. Quebec, on the other hand, spends considerably less per capita than Alberta, and outperformed Alberta, British Columbia, and Ontario on half of the listed indicators.

[25] Not including the territories. Canadian Institute for Health Information, "National Health Expenditure Trends 1975 to 2019," 2019, p. 20.

Table 1.3. Comparing health indicators across Canada, 2019. Green cells indicate the best performing jurisdiction per indictor, red indicates the worst performing.

	Alberta	British Columbia	Ontario	Quebec
Number of family medicine physicians (per 100,000)	128	131	116	127
Number of medical specialists (per 100,000)	129	119	118	126
Number of surgical specialists (per 100,000)	26	29	29	31
Number of total physicians (per 100,000)	257	250	234	253
Acute care hospital beds* (per 100,000**)	137.42	124.54	112.01	151.94
ICU beds (per 100,000**)	8.76	9.42	12.26	14.83

Notes: *Does not include obstetrics, pediatrics, mental health and addictions, rehabilitation, or long-term care beds; **Bed count from 2019-2020 fiscal year, population count from July 1, 2019
Source: Canadian Institute for Health Information, "Hospital Beds Staffed and in Operation, 2019 – 2020," 2021; Statistics Canada, "Population estimates on July 1st, by age and sex," Table 17-10-0005-01 (21 December 2022); Canadian Institute for Health Information, "Supply, Distribution and Migration of Physicians in Canada, 2021 — Historical Data," 2022.

In 2019 Alberta had 40.9% fewer ICU beds per capita than Quebec and 16.1% fewer surgical specialists per capita. In addition, in July of this year the Alberta Medical Association called the family physician shortage in Alberta an "urgent crisis."[26]

b) Wait Times

i. General Practitioner and Specialist

In 2019, the wait time between GP referral and treatment was longer in Alberta (28.0 weeks) than in British Columbia (24.0 weeks), Ontario (16.0 weeks), and Quebec (16.3 weeks) (see Figure 1.4).[27] The rate of increase in the province was also higher: Between 1993 and 2019, wait times increased 2.7-fold in Alberta, compared to 2.3-fold in British Columbia, 1.7-fold in Ontario, and 2.2-fold in Quebec (see Figure 1.4).[28]

These increased wait times are cause for concern: research has repeatedly indicated that wait times for medically necessary treatment often have serious consequences such as increased pain and suffering and a decreased quality of life. At times they can also result in poorer medical

[26] Global News, "AMA calls Alberta family doctor shortage an 'urgent crisis'," *Global News,* July 6, 2023.
[27] Bacchus Barus and Mackenzie Moir, *op. cit.,* note 9, p. iii.
[28] *Idem.*

outcomes for the patient, which translates then to higher system costs and overall economic loss for the economy as patients wait for treatment.[29]

Fast forward to 2022, and wait times have reached 33.3 weeks in Alberta, 25.8 weeks in British Columbia, 20.3 weeks in Ontario, and 29.4 weeks in Quebec (see Table 1.4).[30] This is not unexpected given the cancellation or postponement of elective surgeries due to COVID-19. While BC has been able to start driving down its wait times from their highest report in 2020, the other provinces continue to soar, with Alberta leading.

Table 1.4. Median wait times from referral by GP to treatment by specialist, selected Canadian jurisdictions and years.

	Median wait time from referral by GP to treatment by specialist (weeks)			
	2019	2020	2021	2022
Alberta	28.0	29.4	32.1	33.3
British Columbia	24.0	26.6	26.2	25.8
Ontario	16.0	17.4	18.5	20.3
Quebec	16.3	18.8	29.1	29.4

Source: Bacchus Barua and Mackenzie Moir, "Waiting Your Turn: Wait Times for Health Care in Canada, 2019 Report," Fraser Institute, 2019, pg. iii; Bacchus Barua and Mackenzie Moir, "Waiting Your Turn: Wait Times for Health Care in Canada, 2020 Report," Fraser Institute, 2020, pg. iii; Bacchus Barua and Mackenzie Moir, "Waiting Your Turn: Wait Times for Health Care in Canada, 2021 Report," Fraser Institute, 2021, pg. iii; Bacchus Barua and Mackenzie Moir, "Waiting Your Turn: Wait Times for Health Care in Canada, 2022 Report," Fraser Institute, 2022, pg. iii.

ii. Priority Procedures (Elective Surgeries)

Alberta's current wait times (2022) for hip replacement and knee replacement exceed the pan-Canadian benchmarks, and the province fares worse than others in this regard (see Table 1.5).

[29] *Idem.*
[30] Bacchus Barua and Mackenzie Moir, "Waiting Your Turn: Wait Times for Health Care in Canada, 2022 Report," *Fraser Institute,* 2022, p. iii.

Table 1.5. Wait times for priority procedures.

	Knee Replacement	Hip Replacement
Alberta		
Percentage meeting benchmark, 2022	27%	38%
Median wait (days)	284	232
Canada		
Percentage meeting benchmark, 2022	50%	57%
Median wait (days)	198	164
British Columbia		
Percentage meeting benchmark, 2022	56%	62%
Median wait (days)	165	149
Ontario		
Percentage meeting benchmark, 2022	68%	72%
Median wait (days)	117	108
Quebec		
Percentage meeting benchmark, 2022	32%	45%
Median wait (days)	266	203

Source: Canadian Institute for Health Information, Explore wait times for priority procedures in Canada, consulted August 29, 2023

Of the four provinces, Alberta has the lowest percentage of patients receiving surgery within the pan-Canadian benchmarks for both surgeries. Compared with Ontario, the median wait in Alberta is more than twice as long for both knee replacement surgery and hip replacement surgery (see Table 1.5).[31]

The Lieutenant Governor of Alberta, in the November 2022 Speech from the Throne, committed to a "health care reform action plan"[32] that would reduce surgery wait times (in addition to decreasing ED wait times, improving EMS response times, and developing long-term reforms).[33] The plan includes "maximizing the use of all surgical facilities across the province while using

[31] Canadian Institute for Health Information, *op. cit.,* note 7.
[32] Government of Alberta, Speech from the Throne: November 29, 2022, Healthcare, consulted September 3, 2023.
[33] Jason Copping, Minister of Health, "Health Care Action Plan: Update to Albertans," *Government of Alberta,* February 27, 2023, p. 2.

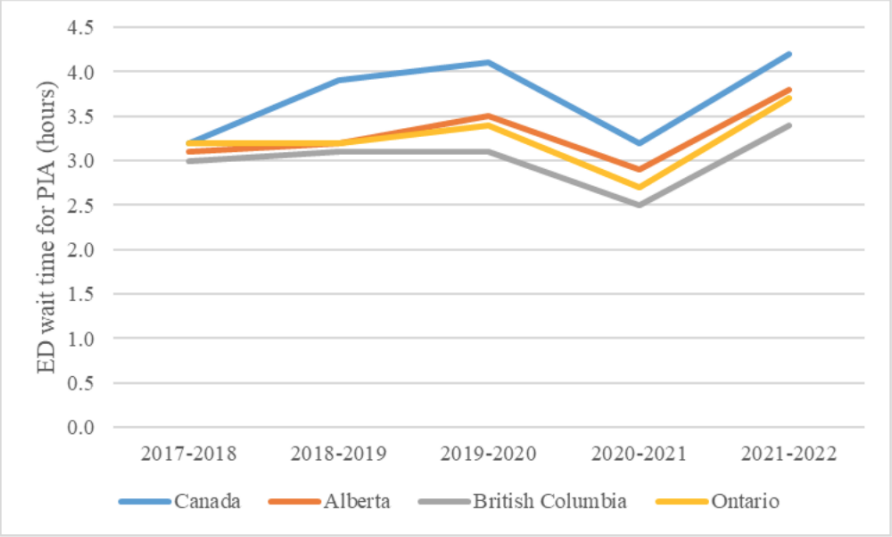
chartered facilities to deliver more needed surgeries more quickly for more Albertans."[34] In a February 2023 update, the Minister of Health indicated that the number of patients waiting longer for surgery than clinically recommended has dropped by 9.4% since November 2022.[35] No updates have been provided since February 27, 2023.

iii. Emergency Department

Prolonged wait times in the emergency department (ED) are associated with increased morbidity and mortality, as well as decreased patient satisfaction.[36] As Alberta's population grows and ages, ED attendance increases. This is compounded by greater disease complexity, infrastructural and staffing limitations (lack of "space," "staff," and "stuff").[37]

While wait times in the ED are growing rapidly across Canada, they have been higher in Alberta than British Columbia or Ontario since the 2018-2019 fiscal year (see Figure 1.8).[38]

Figure 1.8. Emergency department wait time for physician initial assessment (90% spent less, in hours).



Source: Canadian Institute for Health Information, Your Health System, Emergency Department Wait Time for Physician Initial Assessment (90% Spent Less, in Hours) details for Alberta, consulted September 3, 2023.

In December 2022, a CTV report indicated that wait times in Edmonton EDs were the longest they have been in seven years [39] (see Figure 1.9).

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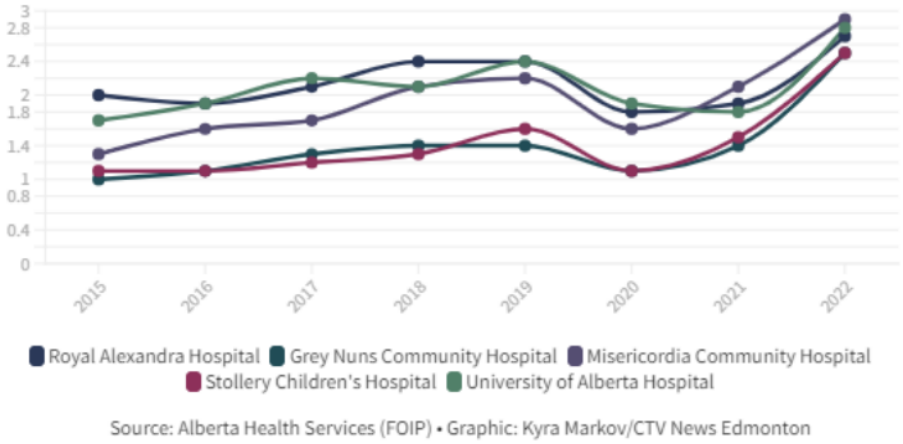
[34] Government of Alberta, *op. cit.,* note 32.
[35] Jason Copping, Minister of Health, *op. cit.,* note 33, p. 4.
[36] See R. W. Derlet, 2002; and Hoot and Aronsky, 2008 as cited in Yuzeng Shen and Lin Hui Lee, "Improving the wait time to consultation at the emergency department," *BMJ Quality Improvement Report,* Vol. 7, No. 1, 2018, p. 1.
[37] Yuzeng Shen and Lin Hui Lee, *ibid,* p. 2.
[38] Canadian Institute for Health Information, Your Health System, Emergency Department Wait Time for Physician Initial Assessment (90% Spent Less, in Hours) details for Alberta, consulted September 3, 2023.
[39] CTV News, "Edmonton emergency wait times the longest they have been in 7 years: FOIP documents," *CTV News,* December 14, 2022.

Figure 1.9. Average yearly emergency department wait times (in hours) at hospitals in Edmonton (2015-2022)



Note: ED wait times reflect the length of time in emergency department before being seen by a physician. Median is calculated as the median time which means that 50 per cent of patients wait this length of time or less to be seen by a physician. 2022 only includes data up until September inclusive.
Source: CTV News, "Edmonton emergency wait times the longest they have been in 7 years: FOIP documents," *CTV News,* December 14, 2022.

Pressure on EDs continued to build through the spring of 2023, with media reports outlining lengthy wait times.[40] The health care reform action plan announced in 2022[41] also committed to decreasing ED wait times.[42] Four months later the Minister of Health indicated that wait times had decreased about 10%.[43] No updates have been provided since February 27, 2023.

iv. Other

In addition, the province monitors measures related to primary care, continuing care, cancer wait times, acute care, and mental health.[44] Many of these measures indicate a deterioration in capacity. For instance, during the 2021-2022 fiscal year, 78% of Albertans were enrolled in a Primary Care Network, down from 80% in 2020-2021, and 81% in 2019-2020.[45] This metric is important as it is an indicator of accessibility[46] and the decline year after year indicates a gap in access, and fewer Albertans who have access to primary care programs and services. The impact of primary care in reducing health disparities, better outcomes, and lower costs is well established in the literature. As Alberta's population continues to grow, so too do concerns about accessibility.

[40] Jennifer Lee, "Some Calgarians met with 15-hour waits as ER bottlenecks grow," *CBC News,* May 5, 2023.
[41] Government of Alberta, *op. cit.* note 32.
[42] Jason Copping, Minister of Health, *op. cit.,* note 33, p. 2.
[43] *Ibid,* p. 3.
[44] Alberta Health Services, "Monitoring Measure Definitions: Quarterly Report," Data and Analytics Reporting Services, May 2022, p. 6.
[45] *Ibid,* p. 2.
[46] Alberta Health Services & Government of Alberta, "Access to primary care through Primary Care Networks: Percentage of Albertans enrolled in a primary care network," Indicator Definition, October 31, 2012, p. 1.

Health System Resiliency

Health system capacity is centered on resilience, a concept that is inconsistent in the literature in terms of its nomenclature and scope of definitions.[47] Essentially, a resilient system is able to deliver necessary care in times of increased demand while also ensuring minimal impact on other services and care (see Box 1.1).

Box 1.1. Features of health system resiliency.

- **Absorptive:** resist, prepare, or withstand the unforeseen shock of the emergency or impact of the disaster without loss of function.
- **Adaptive:** respond or can use alternate reserves or processes to maintain essential functions and meet immediate and acute community needs (ensure continuity of efficient, safe, high-quality, and person-centred health services).
- **Transformative:** recover from the disruption rapidly and at a sensible cost and reduce vulnerability to risk and improve readiness for future emergencies.
- **Learning:** Reflect and review past actions and their effectiveness to inform future actions, question assumptions, challenge and change existing learning structures

Source: Merette Khalil *et al.*, "What is 'hospital resilience'? A scoping review on conceptualization, operationalization, and evaluation," *Frontiers in Public Health*, Vol. 10, 2022, p. 7.

A resilient health system, therefore, is underpinned by adaptive capacity. Fluid in situations of risk, a resilient system can successfully adjust its functioning in times of crisis, such as during the COVID-19 pandemic.[48]

According to a recent study on Sweden's pandemic response, "resilience could be used as the optimal surge capacity response to the wavering needs during a pandemic."[49] It should come as no surprise, then, that a system struggling with capacity and resilience in times of normal demand and functioning will undoubtedly have difficulty meeting excess demand in times of increased need.

Surge Capacity

[47] Merette Khalil *et al.*, "What is "hospital resilience"? A scoping review on conceptualization, operationalization, and evaluation," *Frontiers in Public Health,* Vol. 10, 2022, p. 5.
[48] Karl Blanchet *et al*, "Governance and Capacity to Manage Resilience of Health Systems: Towards a New Conceptual Framework," *International Journal of Health Policy and Management,* Vol. 6, No. 8, 2017, p. 431.
[49] Ritva Rosenbäck, Björn Lantz, and Peter Rosén, "Hospital Staffing during the COVID-19 Pandemic in Sweden," *Healthcare,* Vol. 10, No. 10, 2022, p. 2.

In the absence of a standardized definition of surge capacity, a multitude of definitions exist from governments, academic institutions, and healthcare organizations in Canada and around the world, making the establishment of clear criteria for its study and measurement challenging.[50] The Public Health Agency of Canada has acknowledged that "there is a great deal of variability across Canada in knowledge about, and capacity for, surge response."[51]

Most definitions of surge capacity are presented in the context of preparedness and emergency response and are centred on the ability of a healthcare system to rapidly expand its capacity to handle a sudden influx of patients or increased demand during emergencies or disasters. This is rooted in the foundational capacity of the health care system, which includes physical resources such as human resources ("staff"), equipment and supplies ("stuff"), and infrastructure ("space"), as well as the strategies and ability to maintain essential services while handling increased patient loads.

For the purposes of this report, the definition of surge capacity employed has been adapted from that used by the American College of Emergency Physicians, presented in Box 1.2 below.

Box 1.2. Surge capacity.

> Surge capacity is the mobilization of a health system's capacity and is a measurable representation of ability to manage a sudden influx of patients that would otherwise severely challenge or exceed the present capacity. It is dependent on a well-functioning incident management system and the variables of space, stuff, staff, and systems.

Source: Adapted from: American College of Emergency Physicians, "Health Care System Surge Capacity Recognition, Preparedness, and Response" *Advancing Emergency Care Policy Statement,* October 2017, p. 1.

Surge capacity has multiple components, each of which can vary in different ways at different times. This makes measurement difficult. Given the varying definitions employed worldwide, a meaningful comparison of responses is also challenging. Many empirical studies assessing surge capacity have measured the availability of beds at a certain level (facility, regional, and/or national) or use staff numbers as a proxy.[52]

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[50] Md. Khalid Hassan *et al*., "Hospital Surge Capacity Preparedness in Disasters and Emergencies: Protocol for a Systematic Review," *International Journal of Environmental Research and Public Health,* Vol. 19, No. 20, 2022, p. 2.
[51] Public Health Agency of Canada, "Advice to the Minister, Surge Health Capacity in Canada," February 18, 2010, p. 84.

According to David Redman, former Head of Emergency Management Alberta, a written surge capacity plan should be made for all critical system aspects, including:

- Surge staff of all types
- Surge infrastructure
- Surge equipment
- Surge supplies
- Surge Information Communication Technology (ICT).[53]

According to the Canadian Association of Emergency Physicians (CAEP), during a pandemic, institutional surge capacity targets should be, at minimum, 20% beyond usual capacity. Further:

> With a major pandemic, "contingency care" may be required which represents 100% of the usual capacity or twice as many ICU beds. This will require the use of alternate treatment areas within the hospital including the operating theatres, post anesthetic recovery rooms and clinic areas. At this point, regional planning and the use of regional resources become necessary. In a national "crisis", communities will require greater than 200% usual capacity and three times the number of the usual ICU beds.[54]

Surge Capacity in Alberta

For the purposes of this report, the assessment of Alberta's surge capacity utilized a concurrent triangulation mixed methods study design as inspiration (see Figure 1.10). We analyzed data provided by Alberta Health Services (AHS) and the Canadian Institute for Health Information

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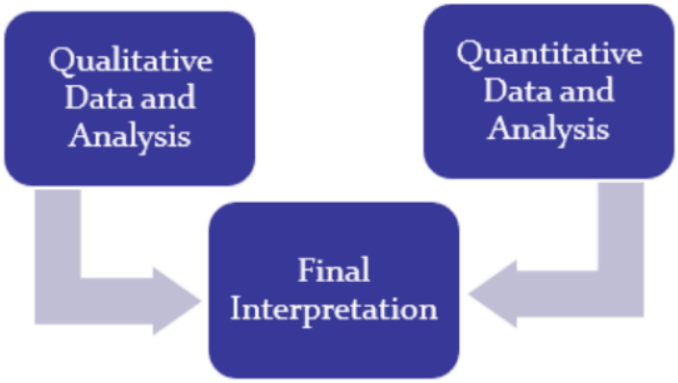
[52] Samantha K. Watson, James W. Rudge, and Richard Coker, "Health Systems' 'Surge Capacity': State of the Art and Priorities for Future Research," *The Milbank Quarterly*, Vol. 91, No. 1, 2013.
[53] Personal communication, August 23, 2023.
[54] Canadian Association of Emergency Physicians, *op. cit.,* note 13, p. 1.

(CIHI) on intensive care unit (ICU) beds and acute care hospital beds in 2019, 2020, 2021, and 2022, where available.

While not an exhaustive inspection of surge capacity, the acute care and ICU capacities available at different stages of the pandemic provide insight into the province's ability to scale up as needed to respond to a real (or anticipated) surge in patients requiring treatment. As no official definition of surge capacity, or its official evaluation by the province, was obtainable,[55] these figures were used as a proxy for surge capacity due to the uneven health care burden throughout the pandemic, which initially fell more heavily on ICUs due to high admission rates and long lengths of stay. This data allowed for quantitative evaluation against the CAEP benchmark.

In addition, the frontline health care workforce and its surge capacity was also briefly assessed using data from the College of Licensed Practical Nurses of Alberta and the College of Registered Nurses of Alberta for 2019, 2020, 2021, and 2022 (where available).

Figure 1.10. A concurrent triangulation mixed methods study design.



Source: Georgia State University Library, GSU Library Research Guides, Mixed Methods, Mixed Methods Designs, March 30, 2023.

Alongside this analysis, a qualitative content analysis of the media coverage during the first year of the pandemic was conducted to explore and understand the prevailing narrative related to Alberta's surge capacity from March 2020 – March 2021. As this is the onset of the crisis and the initial period of urgency, the need for developing and deploying surge capacity was arguably highest in this period. This assessment enabled another layer to the exploration of the adaptive ability of the Alberta health care system, concurrent with limited early knowledge of the virus and the need for early capacity expansion at the system level.

It must be noted that the province modeled varying scenarios – "probable," "elevated," and "extreme" – to quantify what they determined as adequate surge capacity based on the models.[56] While these values are useful for decision making and resource allocation, the use of an

[55] A request was sent on August 23, 2023, regarding information on how surge capacity was evaluated in Alberta to date (either with COVID or previous influenza pandemics or crises) to align indicators and metrics. No response was received as of September 29, 2023.
[56] KPMG LLP, "Review of Alberta's COVID-19 Pandemic Response: March 1 to October 12, 2020," *Final Report to the Government of Alberta,* January 2021, p. 34.

overarching metric, such as that provided by the CAEP, allowed for an objective evaluation of surge capacity irrespective of scenario modelling for the purposes of this report.

a) Baseline

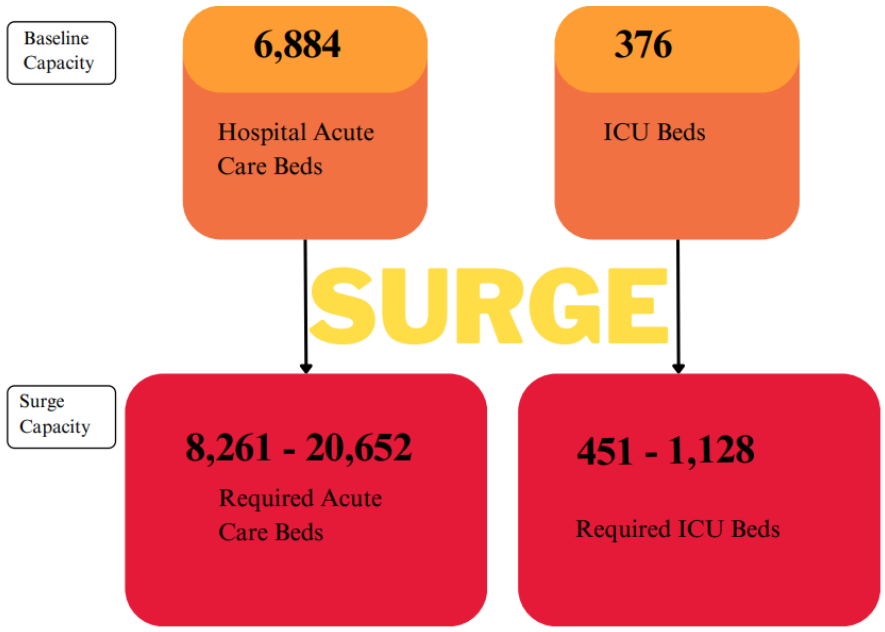
Prior to COVID-19, there were 6,884 acute care hospital beds[57] and 376 ICU beds[58] in the province of Alberta. This number of ICU beds, however, is at odds with other estimates, particularly that of AHS, who has a listed baseline of 173 beds.[59] This is further discussed in a recent Preprints manuscript:

> The authors in Bagshaw et al. wrote that there was "a baseline of 173 funded ICU beds" in Alberta," as asserted by Alberta Health Services later in the pandemic ([2] p. 1402). However, previous publications, by some of the same authors, gave different figures, ranging from 351 to 430 funded adult ICU beds in Alberta [32,33]. In 2015 the authors published an estimate of 268 publicly funded adult ICU beds in the year 2010 [34]. Checking publicly available websites for each ICU in Alberta gave a figure for publicly funded adult ICU capacity of 281 beds.[60]

The number of beds, acute and ICU, and their calculation, can be a complex and sometimes controversial area. For the purposes of this report, and to ensure comparability and continuity, the values provided by CIHI will be used as baseline. To align with the CAEP's suggested benchmarks for adequate surge capacity in the context of COVID-19, Alberta would require a minimum of 8,261 acute care beds and 451 ICU beds (see Figure 1.11).[61]

[57] According to Alberta Health Services (AHS), as of March 31, 2019. Alberta Health Services, "Alberta Health Services: Annual Report 2018-19," May 31, 2019, p. 145.
[58] According to Canadian Institute for Health Information, as of April 1, 2019. The number of ICU beds relates to those only found in general hospitals and does not include specialty (pediatric), cancer treatment, specialty (mental health and addictions), specialty (other), rehabilitation, and extended care/chronic. Canadian Institute for Health Information, Hospital Beds Staffed and In Operation, 2019–2020, 2021. AHS reports 398 intensive care beds, but this number includes ICU, SCU, CCU, CVICU, and PICU and cannot be disentangled. As a result, the number of ICU beds from CIHI is used for consistency and precision.
[59] This data, available from January 2021 through May 2022 details the ICU and non-ICU bed use, daily, by COVID and non-COVID patients. The baseline provided is dated January 28, 2021, which unfortunately doesn't provide the pre-COVID baseline prior to the year 2020. City of Edmonton, "Historical: COVID-19 in Alberta: Intensive Care Unit (ICU) bed and non-ICU bed capacity and utilization," consulted September 29, 2023.
[60] Ari Joffe and Chris Milburn, "Avoidable Intensive Care Resource Use of Unvaccinated COVID-19 Patients: Interpretation and Policy Implications," *Preprints.org,* April 18, 2023, p. 2.
[61] If 173 was used at ICU baseline, the minimum surge requirement would be 208 ICU beds.

Figure 1.11. Baseline acute care hospital bed and ICU capacity in Alberta, 2019, and estimated surge capacity at 20% - 200% increase to baseline.



Source: Alberta Health Services, "Alberta Health Services: Annual Report 2018-19," May 31, 2019, pg. 145; Canadian Institute for Health Information, Hospital Beds Staffed and In Operation, 2019–2020, 2021.

b) 2020: Media and Official Reports

In Alberta, plans for increasing surge capacity were first developed at a site and unit level to include all spaces able to accommodate patient care and staffing options (including alternative staffing models). These site level plans were subsumed in larger zone level plans and ultimately the provincial plan, which identified all space that could be made available across the province.[62]

As of March 31, 2020, there were officially 6,911 provincial acute care beds[63] and 374 ICU beds[64] – a paltry net gain of 27 acute care beds (0.4% increase) and a **net loss** of 2 ICU beds (0.5% decrease) from the baseline year before. This is in contrast to a spokesperson from AHS' claim on March 18, 2020 that there were 207 ICU beds in the province (see Figure 1.3).[65]

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[62] Data provided by the province, August 22, 2023.
[63] According to AHS. Alberta Health Services, "Annual Report 2019-20," June 24, 2020, p. 122.
[64] According to CIHI. The number of ICU beds relates to those only found in general hospitals and does not include specialty (pediatric), cancer treatment, specialty (mental health and addictions), specialty (other), rehabilitation, and extended care/chronic. Canadian Institute for Health Information, Hospital Beds Staffed and In Operation, 2020–2021, 2022. AHS reported 391 beds, but for consistency's sake and as this includes SCU, CCU, CVICU and PICU beds the value as reported by CIHI for ICU beds is once again used.
[65] This refers to adult ICU beds. The article also mentions that there are 704 ICU beds available in the province but this includes special units like burn units, coronary care units, NICU, etc. The CIHI figures refer only to adult ICU beds. Sarah Plowman, "How many ventilators and ICU beds does Alberta have?" *CTV News,* March 18, 2020.

The first case of COVID-19 was identified in Canada on January 25, 2020,[66] and in late February 2020 in Alberta,[67] so while there hadn't been much time to scale up before this measurement was taken, but there had been some. The context must also be considered – by mid-March 2020, the Premier had been authorized by the Emergency Management Cabinet Committee to "use all powers necessary" to keep Albertans safe (March 16)[68] and the province had declared a state of public health emergency and notable orders had been issued under the *Public Health Act* (March 17).[69] Thus, in this context and when compared to CIHI's baseline, the surge capacity of hospital beds in the first months of the pandemic was without a pulse.

During this period, there were fewer ICU beds per capita in Alberta than in other provinces. In fact, according to a recent study, per 100,000, Alberta had 9.7 ICU beds, British Columbia had 10.5, Manitoba 11.2, Ontario 14.2, and the Canadian average was 13.5.[70] There were also fewer ventilators.

In April 2020, reports of additional capacity were made public, with a new temporary structure ("field hospital") at the Peter Lougheed Hospital in Calgary to become operational by the end of the month and provide 100 additional acute care beds.[71] Provincial modeling data indicated expected ICU demand and expected ICU expansion was to reach 1,081 beds by the end of April.[72] In May 2020, AHS announced that the field hospital, called a Sprung Pandemic Response facility, was complete but only had room for two-thirds its original stated capacity.[73]

In mid-September 2020 there were a reported 272 ICU beds, with the Premier still promising up to 1,081 beds (see Figure 1.12).[74] Yet, the numbers kept moving, as do the way they were reported: In October 2020, media reported on Alberta's "dedicated COVID-19 ICU beds," implying there were 70 ICU beds solely for use by COVID patients, but no mention of other non-COVID-related ICU beds.[75] And then by late November 2020 it was stated that there were over 8,000 acute care beds in Alberta, but only 173 adult ICU beds, although an anticipated 2,250 acute-care beds and 425 ICU beds were to be added for patients with COVID-19 in the following weeks (see Figure 1.12).[76]

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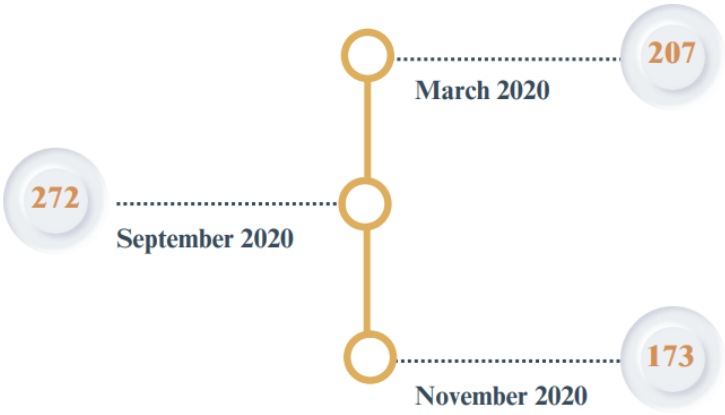
[66] Canadian Institute for Health Information, "Canadian COVID-19 Intervention Timeline," October 13, 2022.
[67] CTV News, "Alberta's first presumptive case of COVID-19 is in the Calgary Zone," *CTV News,* March 6, 2020.
[68] Kelly Cryderman, "Alberta declares state of emergency in response to COVID-19," *The Globe and Mail,* March 17, 2020.
[69] Lynne Golding and Sophie MacRae, "Canadian Health Sector: Updates Related to COVID-19 in March 2020," *Health Law Bulletin,* Fasken, March 31, 2020.
[70] This number is again at odds with what is reported elsewhere. Sean M. Bagshaw et al., "Association Between Pandemic Coronavirus Disease 2019 Public Health Measures and Reduction in Critical Care Utilization Across ICUs in Alberta, Canada," *Critical Care Medicine,* Vol. 50, No. 3, 2022, Supplementary Table 6.
[71] CBC News, "100 acute care beds coming to Peter Lougheed Centre, province says," *CBC News,* April 9, 2020.
[72] KPMG LLP, *op. cit.,* note 56, p. 35.
[73] With 67 patient care spaces and support space for staff and physicians. Alberta Health Services, "Construction of temporary healthcare facility complete," May 2, 2020.
[74] Robson Fletcher, "What we know (and what we don't) about Alberta's ICU capacity amid COVID-19," *CBC News,* September 16, 2020.
[75] The article states that 16 ICU beds were in use, which is 23% of Alberta's dedicated COVID-19 beds. Emily Mertz, "Hospital beds versus staff: Is COVID-19 overwhelming the human side of Alberta's health system?" *Global News,* October 22, 2020.

Figure 1.12. Acute care hospital bed and ICU bed capacity in Alberta, select media reports, 2020.



Source: Sarah Plowman, "How many ventilators and ICU beds does Alberta have?" *CTV News*, March 18, 2020; Robson Fletcher, "What we know (and what we don't) about Alberta's ICU capacity amid COVID-19," *CBC News*, September 16, 2020; Jason Herring, "As ICU beds fill up with COVID-19 patients, Alberta scrambles to free up space," *Calgary Herald*, November 26, 2020.

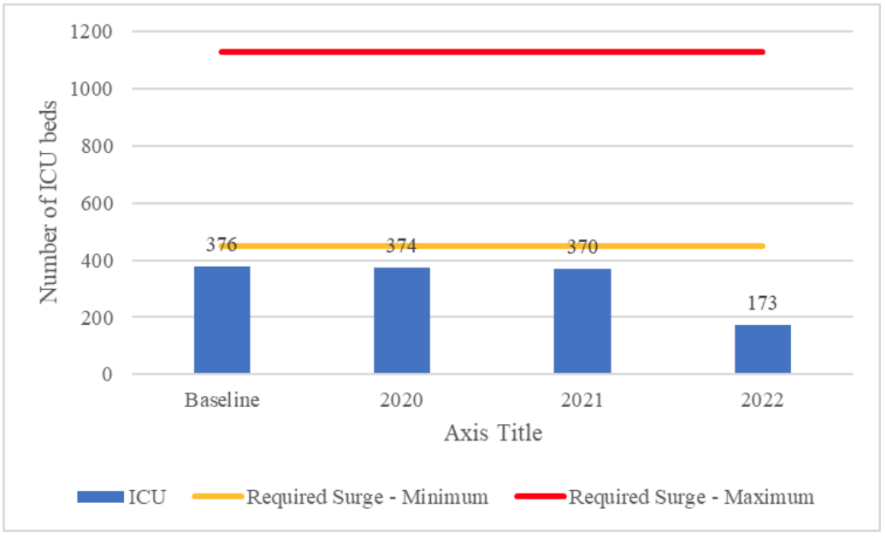
It was never clear to the public the total number of acute care or ICU hospital beds that were in use at any given time at a system level during this first year. In 2020, there were differing reports of ICU beds, as noted above, but the number of patients in hospital with non-COVID-related maladies and injuries was not reported, and therefore, true capacity was never disclosed in these early days.[77]

c) 2021 and 2022: Official Reports

The number of ICU beds as of April 1, 2021 in Alberta, including surge beds, decreased again – from 374 to 370 (a **net loss** of four beds, or 1.1% from the year prior, see Figure 1.13).[78]

[76] Jason Herring, "As ICU beds fill up with COVID-19 patients, Alberta scrambles to free up space," *Calgary Herald,* November 26, 2020.
[77] Data later became publicly available from January 2021 through May 2022 which details the ICU and non-ICU bed use, daily, by COVID and non-COVID patients. City of Edmonton, "Historical: COVID-19 in Alberta: Intensive Care Unit (ICU) bed and non-ICU bed capacity and utilization," consulted September 29, 2023.
[78] Canadian Institute for Health Information, Hospital Beds Staffed and In Operation, 2021–2022, 2023.

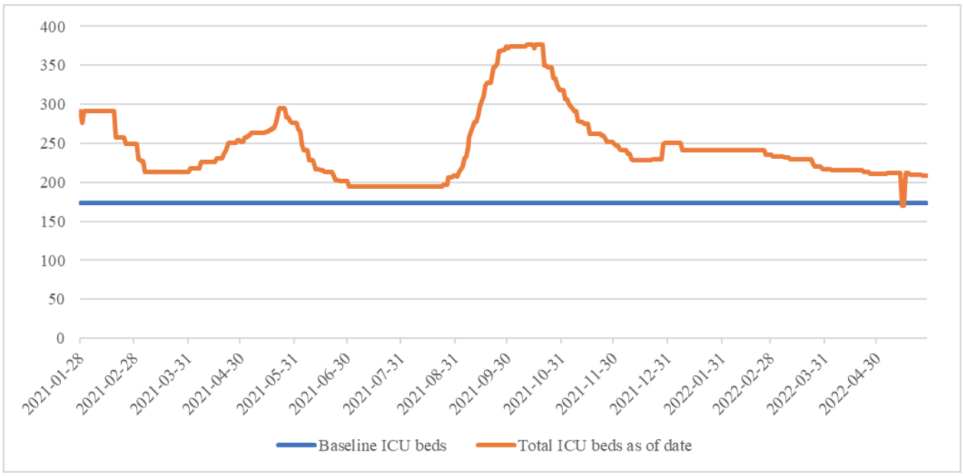
Figure 1.13. Number of ICU beds in Alberta 2019, 2020, 2021, 2022 and required surge capacity as defined by CAEP.



Note: 2022 data is collected from a different source due to data availability. Comparability between 2022 and other years is therefore not recommended until data availability allows for an appropriate comparison.
Source: Canadian Institute for Health Information. Hospital Beds Staffed and In Operation, 2019–2020, 2021; Canadian Institute for Health Information. Hospital Beds Staffed and In Operation, 2020–2021, 2022; Canadian Institute for Health Information. Hospital Beds Staffed and In Operation, 2021–2022, 2023; Alberta Health Services, "2021-22 Report to the Community: Who We Are," consulted September 3, 2023.

Daily data from AHS, however, indicates a total of 218 beds on April 1, 2021 (see Figure 1.14).[79]

Figure 1.14. Number of ICU beds vs. baseline beds, January 28, 2021 - May 28, 2021.



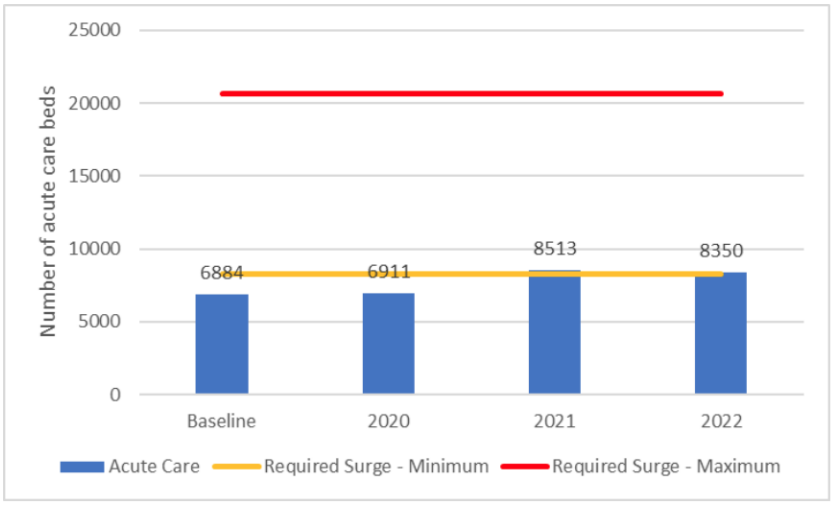
Source: City of Edmonton, "Historical: COVID-19 in Alberta: Intensive Care Unit (ICU) bed and non-ICU bed capacity and utilization," consulted September 29, 2023.

When applying the CAEP definition to CIHI data, the minimum surge capacity expansion (451 beds) was not met. Compared to a baseline of 173, as indicated by AHS, a minimum of 208 ICU beds would be required (a 20% increase) for adequate surge capacity provision. Under the daily scenario, sufficient surge capacity for this period was met.[80] However, the prevailing narrative continued to portray a system on the brink of collapse, and it bears repeating that the calculation of the number of hospital beds, acute and ICU, can be a complicated task. In 2021, the number of acute care beds, on the other hand, increased dramatically: up 23.2% year-over-year to 8,513.[81]

[79] This data is available January 28, 2021 – May 28, 2021. City of Edmonton, *op. cit.,* note 59.
[80] This period refers to January 28, 2021 through to May 28, 2022.

Unfortunately, at the time of writing, CIHI numbers were not yet available for the number of ICU beds for 2022. But according to AHS,[82] as of March 31, 2022, there were 173 ICU beds province-wide (see Figure 1.13).[83] This value, 173, is the baseline value that had been provided by AHS on its daily data starting January 28, 2021 (see Figure 1.14). This would appear, then, that no surge capacity in terms of ICU beds had materialized according to AHS by March 31, 2022. In terms of acute care beds, by 2022, the number decreased slightly to 8,350 (see Figure 1.15).[84] 2023 values had not been released at the time of writing of this report.

Figure 1.15. Number of acute care beds in Alberta 2019, 2020, 2021, 2022 and required surge capacity as defined by CAEP.



Source: Alberta Health Services, "Alberta Health Services: Annual Report 2018-19," May 31, 2019, pg. 145; Alberta Health Services, "Annual Report 2019-20," June 24, 2020, pg. 122; Alberta Health Services, "2020-21 Report to the Community: Who We Are," consulted September 3, 2023; Alberta Health Services, "2021-22 Report to the Community: Who We Are," consulted September 3, 2023.

d) Workforce and Staffing

For the purposes of this report, the surge capacity of hospital staff and the province's response will focus primarily on frontline nursing professionals.

During the crisis, the province announced or implemented plans to:

- Fast-track the education of healthcare aides to assist with long-term care staffing;
- Accelerate training for ICU nurses;
- Introduce new models of care to expand the reach of existing ICU nurses;
- Support the faculties of nursing to enable nurses to complete the senior practicums and enter the workforce;

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[81] Alberta Health Services, "2020-21 Report to the Community: Who We Are," consulted September 3, 2023.
[82] Previously AHS had failed to report the number of ICU beds separate from other special care beds annually.
[83] Alberta Health Services, "2021-22 Report to the Community: Who We Are," consulted September 3, 2023.
[84] *Idem.*

- Contact former registered nurses with ICU experience and retired staff to re-enter the workforce; and
- Redeploy anesthesiologists, physicians, nurses and allied health professionals to critical care units. [85]

Content analysis of media reports indicated a narrative of an overwhelmed workforce and a lack of capacity – surge or otherwise. In addition to high levels of burnout and absenteeism, media reports over the first year were punctuated with wage disputes, union grievances, and reports of a health care workforce in crisis. However, there was a minimal to moderate impact on overall staffing levels based on available data.[86]

In fact, the number of nursing professionals remained consistent with pre-pandemic levels for the most part. According to the College of Registered Nurses (CRNA) in Alberta, there were 39,198 practising registrants in 2019-2020,[87] 39,528 in 2020-2021,[88] and 40,014 in 2021-2022.[89] Therefore, between October 1, 2019 and September 30, 2022, there was a 2.1% increase in the number of practising nurses.

For licensed practical nurses (LPNs), the growth was more notable. In 2019-2020 there were 17,264 total LPN registrations,[90] 17,656 in 2020-2021,[91] 18,750 in 2021-2022.,[92] and in 19,969 2022-2023.[93] Therefore between 2019 and 2023, the number of LPNs in the province grew by 15.7%.

The lack of workforce surge capacity is not unique to Alberta, and was seen across Canada. The Canadian Institutes of Health Research (CIHR) conducted an in-depth engagement process with researchers, policymakers, practitioners, members of community organizations, and other key stakeholders in a series of dialogues to elicit insights, ideas, and actionable solutions on a range of issues facing public health.[94] They found that one of the key challenges facing Canada's public

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[85] KPMG LLP, *op. cit.,* note 56, p. 32; Darshina Dhunnoo, "The Alberta COVID-19 Response: Critical Considerations for Health Care Worker Single-Site Exclusion Policies and Wage Supplements," *Political Science Undergraduate Review,* Vol. 6, No. 1, 2021, pp. 2-3; Data provided by the province, August 22, 2023.
[86] In the first wave. KPMG LLP, *op. cit.,* note 56, p. 32.
[87] This includes 38,305 RNs and 675 nurse practitioners (NPs), 168 graduate nurses, 40 graduate NPs, and 10 certified graduate nurses, between October 1, 2019 and September 30, 2020. College & Association of Registered Nurses in Alberta, "2019-2020 Annual Report," 2020, p. 5.
[88] This includes 38,400 RNs and 793 nurse practitioners (NPs), 301 graduate nurses, 26 graduate NPs, and 8 certified graduate nurses, between October 1, 2020 and September 30, 2021. College & Association of Registered Nurses in Alberta, "Annual Report 2020 to 2021," 2021, p.5.
[89] This includes 38,775 RNs and 812 nurse practitioners (NPs), 389 graduate nurses, 32 graduate NPs, and 6 certified graduate nurses, between October 1, 2021 and September 30, 2022. College & Association of Registered Nurses in Alberta, "Annual Report 2021 to 2022," 2021, p. 5.
[90] A noted 3.5% increase in registration from the previous year. College of Licensed Practical Nurses of Alberta, "2019 Annual Report," 2020, p. 4.
[91] A noted 2.3% increase in registration from the previous year. College of Licensed Practical Nurses of Alberta, "2020 Annual Report," 2021, p. 4.
[92] A noted 6.2% increase in registration from the previous year. College of Licensed Practical Nurses of Alberta, "2021 Annual Report," 2022, p. 6.
[93] A noted 6.1% increase in registration from the previous year. College of Licensed Practical Nurses of Alberta, "2022 Annual Report," 2023, p. 10.

health systems was the lack of surge capacity, which impedes the ability to meet expanded human resource needs during crises, among other thing. They note:

> During the COVID-19 pandemic, inadequate surge capacity was compounded by the lack of effective processes to rapidly connect public health trainees with system needs. It was also complicated by the lack of sufficient and comparable data about the distribution and skills of public health professionals in different parts of the system, including personnel who could perform functions such as testing and contact tracing. [95]

e) Conclusion

From our analysis of several components of surge capacity – equipment and supplies (ICU beds and acute care beds) and physical resources (workforce and staffing) – it is evident that the province of Alberta struggled with its expansion of surge capacity in the early days of the COVID-19 pandemic, when the prevailing narrative and COVID-19 forecasts called for it. The deployment of surge capacity was strained in subsequent years as well, as indicated by failing to meet the threshold of an adequate surge response as suggested by the CAEP (see Figure 1.13 and Figure 1.15).[96]

This is not to say that there was an outright failure, but more, a significant struggle. This can be attributed to a lack in overall system capacity and resilience. According to a recent Preprints manuscript, "It is not clear whether ICU capacity was increased in Alberta during the pandemic; it appears more likely that current ICU resources were simply reallocated in unclear ways."[97]

As mentioned previously, there is no standardized definition of surge capacity, which makes the establishment of clear criteria for its study and measurement challenging.[98] There are multiple components, each of which can vary in different ways at different times. The unit of analysis in our assessment was the system, however, a recent study detailing a method for determining optimal surge capacity states that the precise capacity of the *individual hospital* needs testing to determine capacity-limiting factors.[99] Therefore, a more intensive and granular study into the surge capacity of Alberta's health care system during the COVID-19 pandemic is recommended.

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[94] CIHR Institute of Population and Public Health, *Moving Forward from the COVID-19 Pandemic: 10 Opportunities for Strengthening Canada's Public Health Systems,* March 2022, p. 8.
[95] *Ibid,* p. 15.
[96] Also see Allan S. Detsky and Isaac I. Bogoch, "COVID-19 in Canada – The Fourth Through Seventh Waves," *JAMA Health Forum,* Vol. 3, No. 11, November 18, 2022.
[97] Ari Joffe and Chris Milburn, "Avoidable Intensive Care Resource Use of Unvaccinated COVID-19 Patients: Interpretation and Policy Implications," *Preprints.org,* April 18, 2023, p. 2.
[98] Md. Khalid Hassan *et al*., *op. cit.,* note 50, p. 2.
[99] Since "hospitals show a wide variation with regard to size, specialisation, economy, staffing, geographic localization and potential scenarios." Kristina Lennquist Montán *et al*., "A method for detailed determination of hospital surge capacity: a prerequisite for optimal preparedness for mass-casualty incidents," *European Journal of Trauma and Emergency Surgery*, Vol. 49, 2023, p. 620.

f) Comparative Snapshot

While a complete forensic comparative analysis and multi-jurisdictional evaluation is outside the scope of this report, an assessment of indicators related to surge capacity is useful in benchmarking Alberta's response against that of other universal health care systems. In this case, the UK (England), Sweden, and the Netherlands are scrutinized. These countries are all high-income countries with universal health care systems that were better able to mobilize surge capacity as illustrated by increased ICU capacity during COVID-19. These countries also regularly outperform Canada in terms of overall system capacity, as previously discussed.

During the first wave of COVID-19 (up to July 31, 2020) Sweden and the Netherlands were able to more than double their ICU capacities[100] while England increased its capacity by 53%.[101] The increased surge capacity of these three counties meets and exceeds the threshold for the minimum adequate surge capacity as defined by CAEP. In addition, their workforce was more adaptive,[102] which lent itself to higher quality health system functioning.

Some tactics that facilitated this include:

- Focusing on increasing the health care workforce through the recruitment of new staff,[103] enrolling volunteers for simple tasks, relocating staff as needed, and increasing working hours.[104]
- Using private hospitals. A recent study found that European countries with private hospitals saw them play a role in creating additional capacity, and in England the governments block-booked private hospital beds, equipment, and staff to have flexible availability throughout the crisis.[105] Private hospitals are also present in the Netherlands and Sweden.
- Utilizing cross-border and regional collaborations to alleviate pressures on the hospital system. For instance, in the Netherlands ICU and non-ICU patients were transferred to hospitals in Germany with spare capacity.[106]
- Modifying existing work practices such as suspending legislation (i.e., on night shifts, overtime, on-call activities, minimum nurse staffing levels, emergency legislation to restrict leave, etc.).[107]

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[100] Elke Berger *et al*., "A country-level analysis comparing hospital capacity and utilisation during the first COVID-19 wave across Europe," *Health Policy,* Vol. 126, Iss. 5, May 2022, p. 375.
[101] Bilal Akhter Mateen *et al*., "Hospital bed capacity and usage across secondary healthcare providers in England during the first wave of the COVID-19 pandemic: a descriptive analysis," *BMJ Open,* Vol. 11, 2021, p. 3.
[102] Juliane Winkelmann *et al*., "European countries' responses in ensuring sufficient physical infrastructure and workforce capacity during the first COVID-19 wave," *Health Policy,* Vol. 126, Iss. 5, May 2022, p. 368.
[103] Such as physicians and nursing students, recent graduates, specialized retirees, inactive healthcare workers, military physicians, staff from private healthcare providers, staff from less affected regions, and foreign workers.
[104] Ritva Rosenbäck, Björn Lantz, and Peter Rosén, *op. cit.,* note 59, pp. 4-7.
[105] The review found that Cyprus, Denmark, France, Georgia, Greece, Hungary, Ireland, Italy, Malta, North Macedonia, Portugal, Russian Federation, San Marino, Serbia, Sprain, Switzerland, and the UK all used private hospitals. Juliane Winkelmann *et al*., *op. cit.,* note 102, p. 364.
[106] *Idem.*
[107] *Ibid,* p. 368.

- England and the Netherlands simplified the registration or hiring process of health professionals. For example, professionals who left the service in the previous years or with expiring licenses were automatically reregistered.[108]
- The Netherlands and England redeployed staff to other specialties.[109]
- Mobilizing health workers to other geographic areas or health facilities with greater need.[110]
- England sped up recognition procedures or extended visas for frontline workers from abroad so that they were allowed to continue working.[111]
- England redeployed private sector staff into the public sector.[112]

Sweden and the UK were included in a recent comparative analysis of the national responses to COVID-19 which determined there were four elements common to highly effective country responses that draw on the concept of resilient health systems mentioned earlier. These elements are presented in Box 1.3, below.

Box 1.3. Elements common to highly effective country responses to COVID-19.

- Activate comprehensive responses, which are responses that consider and address health and well-being as intertwined with social and economic considerations;
- Adapt capacity within and beyond the health system to meet the needs of communities;
- Preserve functions and resources within and beyond the health system to maintain pandemic-related and non-related routine and acute care; and
- Reduce vulnerability to catastrophic losses in communities, both in terms of health and well-being, as well as individual or household finances;

All while continually learning, monitoring and adjusting in light of emerging evidence or the evolving epidemiological situation.

Source: Victoria Haldane et al, "Health systems resilience in managing the COVID-19 pandemic: lessons from 28 countries," *Nature Medicine*, Vol. 27, 2021, p. 978

Notably, regarding surge capacity, the researchers found that countries that performed well had a number of factors in common.[113] These factors include:

[108] *Ibid,* p. 367.
[109] *Ibid,* p. 368.
[110] *Idem.*
[111] *Ibid,* p. 367.
[112] *Ibid,* p. 368.
[113] See Victoria Haldane *et al*, "Health systems resilience in managing the COVID-19 pandemic: lessons from 28 countries," *Nature Medicine,* Vol. 27, 2021, p. 978.

- Activated comprehensive responses to ensure adequate translation of evidence into policy and practices that preserve health system capacity.
    - Specific measures taken included the training of health workers, among others.
- Learned from emerging evidence and adapted the capacity of their health system in response to the evolving epidemiological situation.
    - This was achieved by:
        - Increasing capacity in hospitals, through construction of makeshift hospitals or repurposing of existing health facilities or civic spaces.
        - Expanding the health workforce through reallocation and recruitment and supported through financial and social supports.
- Took action to preserve health system functions and resources.
- Protected health and well-being more broadly by ensuring health system functioning for non-COVID-19-related health services.
    - High-performing countries supported primary care and community health workers to conduct COVID-19 screening, assessment and/or referral, while providing ongoing routine and acute care in communities.

Chapter Two: Incremental Changes to Alberta's Health Care System to Improve System Performance

The Alberta health care system struggled to deploy surge capacity due to its lack of existing system capacity and resilience, as discussed in Chapter One. In order for the province to be better prepared to respond to future public health emergencies and other crises, the capacity of the province's health care system ***must*** be improved.

Yet this is not just a question of increasing funding – per capita health care spending has been steadily increasing for years, outpacing that of most other provinces and of many comparable peer countries, as also discussed in Chapter One. Rather, the development of robust surge capacity will require incremental changes to certain features of the health system to embed flexibility and competition, and foster patient choice.

The Alberta Quality Matrix for Health indicates six dimensions of quality: acceptability, accessibility, appropriateness, effectiveness, efficiency, and safety (see Figure 2.1).[114] In order for health care services to be appropriate, effective, and safe, they need to be accessible in an efficient manner. As such, the recommendations made in this chapter will focus on the dimensions of accessibility and efficiency.

Figure 2.1. Six dimensions of quality per the Health Quality Council of Alberta.

Acceptability	Health services are respectful and responsive to user needs, preferences and expectations.
Accessibility	Health services are obtained in the most suitable setting in a reasonable time and distance.
Appropriateness	Health services are relevant to user needs and are based on accepted or evidence-based practice.
Effectiveness	Health services are provided based on scientific knowledge to achieve desired outcomes.
Efficiency	Resources are optimally used in achieving desired outcomes.
Safety	Mitigate risks to avoid unintended or harmful results.

Source: Health Quality Council of Alberta, "ALBERTA QUALITY MATRIX FOR HEALTH USER GUIDE," consulted September 12, 2023.

Incremental reform, by definition, is not big or bold. Yet, these reforms have the potential for enormous impact and generate big results. Alberta does not need to reinvent the wheel when it comes to health care, and instead should look to other, better-performing universal systems that have much better accessibility and efficiency (and a plethora of other measures, as well; see Chapter One for comparators).

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[114] Health Quality Council of Alberta, *op. cit.,* note 4.

The incremental recommendations contained in this chapter include:

1. Implement activity-based funding for hospitals,
2. Expand the use of nurse practitioners (NPs),
3. Expand the use of licensed practical nurses (LPNs),
4. Reduce the health care administration burden,
5. Reduce or eliminate barriers to labour mobility for health care workers,
6. Utilize pharmacists to their full scope of practise,
7. Expand the use of telemedicine,
8. Gradually increase medical school admissions and residency positions,
9. Incentivize medical school graduates to practice family medicine, and
10. Expand and improve the organization of home care services.

These incremental changes can be made to increase efficiency, foster flexibility and adaptability, and utilize health care resources to their fullest extent. These recommendations are in addition to the range of actions already underway or committed to in one form or another in the province of Alberta to increase the capacity of the health care system (see Appendix B). Importantly, these recommended patient-centred incremental changes can be made to Alberta's health system without diminishing universal access or violating the CHA (see Appendix C).

How to Improve the Performance of the Alberta Health Care System

1. Implement Activity-Based Funding for Hospitals.

Inefficient hospital systems drain resources, breed inefficiency, and restrain innovation. Currently, the most common hospital funding mechanism used across Canada is that of global (or historical) budgets, whereby a hospital receives a set amount of money, typically a yearly budget, based on the number of services it is expected to provide. The anticipated number of patients and services is forecast from previous years, and so is divorced from the number of patients the hospital treats in the current year.

In Alberta, budget allocations are based on the *expected* services and activity that are planned for each program area.[115] The justification for this is that using planned activity, performance metrics, and costs per activity allows AHS to have a consistent approach to budgeting.

Essentially, this form of financing views the patient as a cost for the facility, since the budget is established independently of the number of patients the hospital actually treats in the current year.[116] This has the effect of reducing the incentive to improve access to services, as each additional patient consumes more of the hospital's budget, at least in theory. In addition, while

[115] Including for wage and inflationary pressures. Data provided by the province, August 22, 2023.
[116] Maria Lily Shaw and Emmanuelle B. Faubert, "The Winning Conditions for Quebec's Mini-Hospitals," MEI, Research Paper, June 2023, p. 13.

the province says that performance metrics are considered, global budgets typically see performance and efficiency shortcomings, as with a fixed budget, the incentive to innovate and improve the efficiency of administration is eliminated.[117]

To make the most of current hospital funding, improve efficiency, and stimulate innovation, hospitals should be funded based on activity where appropriate. Activity-based funding (ABF) consists of reimbursement based on the current number of patients being treated at a standardized cost. In this model, the funding follows the patient, and the patient can be seen as an opportunity rather than a cost. If a hospital has an excess number of patients compared to previous years, it automatically gets the funding to go with those patients. If it has fewer, perhaps because service is poor or waiting times are too long, it has a direct repercussion in the form of a reduced budget.[118]

According to a recent MEI paper:

> Activity-based funding mechanisms thus encourage efficiency and innovation, but also cost control and accountability, since hospitals receive a fixed price per intervention, regardless of the actual amount spent to treat the patient. As a result, if a hospital can safely treat a patient at a lower cost than the set rate, the facility can generate a profit. On the other hand, the hospital will suffer a loss if it cannot provide the service at the determined rate, which will motivate it to become more efficient and encourage accountability.[119]

Many OECD countries with universal health care systems have adopted ABF in recent decades, including Sweden.[120] After its introduction, there was an increase in the quantity of services performed as well as increased productivity:

> By one estimate, productivity increased by no less than 20% in the first two years following the reform. The increased productivity was achieved through a reduction in average length of stay combined with faster patient turnover, and an increase in the number of operations, thereby reducing long wait lists. All of this was achieved without any evidence of patient selection, which is to say that physicians did not choose to treat only patients with mild medical issues.[121]

The MEI has written extensively about the system benefits of adopting ABF.[122]

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[117] *Idem.*
[118] Peter St. Onge, "For A Strong and Resilient Post-COVID Health Care System: Reforms to Expand Surge Capacity," MEI, Research Paper, December 2020, p. 35.
[119] Maria Lily Shaw and Emmanuelle B. Faubert, *op. cit.,* note 116, p. 13.
[120] Clas Rehnberg, "The experience of the DRG-reimbursement system in the Stockholm County council," *Applied Health Economics Sweden*, March 27, 2012, p. 5.
[121] Maria Lily Shaw, "Real Solutions for What Ails Canada's Health Care Systems," MEI, Research Paper, February 2022, pp. 19-21.
[122] See https://www.iedm.org/?s=activity-based for more details and references.

There are factors that must be taken into consideration when implementing a system like this. For instance, critics of this funding model will be quick to point to evidence that it can increase system costs,[123] create incentives to "game the system" by tweaking diagnoses to increase payment,[124] or that "cherry-picking" or "cream-skimming" could result in hospitals catering to patients preferentially.[125] These unintended consequences cannot be ignored, and need to be mitigated as much as possible within the context of the status quo, which, as seen in Chapter One, has created a system that is expensive and inefficient, with incentives to keep it so. There are checks and balances that can be instituted. The positive news is there are plenty of high-income OECD countries that have implemented this system that can be looked to for guidance.[126]

2. Expand the Use of Nurse Practitioners.

A better use of existing health care resources, including to their full scopes of practice, can increase access to health care for Albertans. During the pandemic, AHS explored nurse practitioner (NP) and midwife opportunities where there were physician shortages.[127] This should be expanded.

According to AHS:

> Nurse Practitioners (NPs) are registered nurses (RNs) with graduate degrees and advanced knowledge and skills. They are trained to assess, diagnose, treat, order diagnostic tests, prescribe medications, make referrals to specialists and manage overall care. Nurse practitioners often work closely with physicians and other health professions as part of a team. Some NPs work independently and manage their own clinics.[128]

NPs have capacities that overlap with GPs in many areas: they can diagnose and treat common health problems and minor injuries, order and interpret lab tests, make referrals to specialists, prescribe drugs, and can act as a primary care provider.[129]

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[123] Rodrigo Moreno-Serra and Adam Wagstaff, "System-wide impacts of hospital payment reforms: evidence from Central and Eastern Europe and Central Asia," Policy Research Working Paper 4987, *The World Bank Development Research Group, Human Development and Public Services Team*, July 2009, pp. 35-37. ♣ (nida.ac.th)

[124] Jonathon M. Ross, "Canadians should beware of Americans bearing 'activity-based funding'," *Physicians for a National Health Program,* August 1, 2013.

[125] Paolo Berta *et al.,* "The effects of upcoding, cream skimming and readmissions on the Italian hospitals efficiency: A population-based investigation," *Economic Modelling,* Vol. 27, 2010, pp. 818-821.

[126] For instance, when Sweden employed ABF, they did so using a diagnosis-related group (DRG) scheme to reimburse hospitals based on a patient classification system that standardizes the cost of treatment:

> DRG funding mechanisms thus encourage efficiency, but also cost containment, as hospitals receive a fixed price per procedure, regardless of how much it actually spends treating the patient. Therefore, if a hospital can effectively treat a patient at a lower cost than the DRG reimbursement, the institution can generate a profit. Alternatively, the hospital will incur a net loss if it is unable to provide the service at the determined rate, incentivizing it to become more efficient.

The positive outcomes were achieved without any evidence of patient selection, which is to say that physicians did not choose to treat only patients with mild medical issues. Maria Lily Shaw, *op. cit.,* note 121, p. 19.

[127] Provided by province.

[128] Alberta Health Services, Nurse Practitioner (NP), consulted September 22, 2023.

Research confirms that NPs improve access to high quality care at cost savings to the system.[130] The MacKinnon Report on Alberta's Finances (2019) states:

> The average annual salary of a Family Medicine Physician is $391,539 while the average salary of a Nurse Practitioner is $92,569. The percentage of Nurse Practitioners relative to Family Medicine Physicians in Ontario is 19% while the same ratio for Alberta is only 9%. Ontario also funds Nurse Practitioners to operate their own clinics. Significant savings can be achieved without affecting the quality of health care if Alberta follows the example of Ontario.[131]

According to the Canadian Nurses Association, in Ontario, "a rigorous evaluation of the clinical nurse specialist/neonatal practitioner role demonstrated that these nurses provide safe, effective, economically efficient care that is accepted by parents of neonates and health provider colleagues."[132] In addition to costing less than physicians, there is significant evidence that suggests that access to primary care could be improved through the expanded use of NPs in rural communities or communities with limited access to primary care.[133]

On a per capita basis the number of NPs in Alberta increased from 15.3 per 100,000 in 2020 to 17.6 per 100,000 in 2022.[134] This trajectory is positive, however, funding models in AB are lacking and there are limited opportunities for NPs to practise independently within the community.[135] This is something that should be a priority in addition to other measures to attract, train, retain, and employ more NPs in Alberta. Growing the NP supply, especially in underserved communities, offsets low physician supply and may increase primary care capacity.

There are apprehensions about structural/organizational barriers to deployment, namely that increased pay would threaten the financial security of GPs/family physicians who are required to pay higher salaries for NPs in their practice.[136] However, this can be overcome if the financial burden were borne by another party,. Therefore, considerations related to pay should not be overlooked. There are additional concerns that the increased utilization of NPs (to their full scope) threatens the job security of GPs/family physicians, or alternatively, whether NPs are "up

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[129] *Idem.*
[130] Feldman *et al.,* 1987; McGrath, 19905; Mundinger, 1994; Mundinger *et al.,* 2000; Kinnersley *et al.,* 2000; Shum *et al.,* 2000 as cited in Canadian Nurses Association, "Cost-Effectiveness of the Nurse Practitioner Role," *Fact Sheet,* March 2002, consulted September 6, 2023.
[131] Blue Ribbon Panel on Alberta's Finances, "Report and Recommendations," August 2019, p. 29.
[132] Mitchell-DiCenso *et al.,* 1996 as cited in Canadian Nurses Association, *op. cit.,* note 130.
[133] Kathleen Bykowski, Tammy O'Rourke, and Donna M. Wilson, "Insights gained from clarifying the role of NPs in rural Alberta primary care settings," *Canadian Nurse,* March 21, 2022.
[134] Author's calculations based on College of Registered Nurses of Alberta, "Annual Report 2021 to 2022," September 30, 2022, p. 5; College of Registered Nurses of Alberta, "Annual Report 2020 to 2021," September 30, 2021, p. 5; College of Registered Nurses of Alberta, "Annual Report 2019 to 2020," 2020, p. 5. In 2022 there were 812 NPs in Alberta, up from 793 in 2021 and 675 in 2020. Population numbers per Statistics Canada. Table 17-10-0009-01 Population estimates, quarterly, June 28, 2023.
[135] Nurse Practitioner Association of Alberta, NP Resources, What you should know about funding models, consulted September 6, 2023.
[136] Ali Wilson, David Pearson, and Alan Hassey, "Barriers to developing the nurse practitioner role in primary care – the GP perspective," *Family Practice,* Vol. 19, No. 6, pp. 643-644.

to the job."[137] These concerns, however, can be moderated with proper communication during implementation, such as clearly communicating the education and training (and scope of practice) of NPs.

To improve access to primary care for Albertans and lower system costs, the use of nurse practitioners should be expanded appropriately in line with their trained scope of practice. Increasing access to primary care has been a priority in Alberta for years, and this can be accomplished through the utilization of other health professionals to their full scope. This will also decrease pressure on EDs, EMS, and lower costs for acute care.

3. Expand the Use of Licensed Practical Nurses (LPNs).

According to AHS:

> Licensed practical nurses (also known as LPNs) are professional nurses who contribute to the assessment, planning, implementation and evaluation of patient care at AHS. Licensed practical nurses have the knowledge, skill, judgement and abilities to contribute to many types of patient care, including prevention, acute treatment and management, long term and palliative care.[138]

LPNs have a defined scope of practice that includes a variety of health care settings and tasks, some of which overlap with that of RNs.[139] For instance, LPNs can take and record vital signs, collect various samples, dress wounds, monitor progress and report reactions to treatment, and educate and advocate for patients and families. They work collaboratively with patients, families, and the health care team, including RNs, to provide high-quality treatment and care to Albertans.[140]

According to AHS:

> Currently, there are many roles within AHS for licensed practical nurses and as the profession continues to grow new opportunities are created. Licensed practical nurses may pursue advanced training and practice in specialty nursing areas such as operating room, advanced orthopedics, dialysis and immunization.[141]

The average salary for an RN in Alberta is $72,818 ($46.21 average hourly wage), and for an LPN, $48,364 ($30.17 hourly).[142] In the 2021-2022 fiscal year in Alberta, there were 38,775 registered nurses[143] and 18,750 LPNs,[144] and according to public salary disclosures, in 2022, 2.3%

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[137] *Ibid,* pp. 642-643.
[138] Alberta Health Services, "Licensed Practical Nurse," consulted September 21, 2023.
[139] Alberta Health Services, "Registered Nurse (RN)," consulted September 21, 2023.
[140] Alberta Health Services, *op. cit.,* note 138.
[141] *Idem.*
[142] Government of Alberta, ALIS, Occupations in Alberta, Registered Nurse, consulted September 21, 2023; Government of Alberta, ALIS, Occupations in Alberta, Licensed Practical Nurse, consulted September 21, 2023

of RNs and 0.1% of LPNs made over the threshold amount of $141,183 in compensation as outlined in the *Public Sector Compensation Transparency Act.*[145]

Therefore, some of the tasks being undertaken by RNs can be taken up by LPNs at a lower cost to the system, freeing up that RN to take on more complex and critical care for which they have been specifically and specially trained.

According to the MacKinnon Report on Alberta's Finances (2019):

> Ontario, whose health care system is low cost, with good outcomes and short wait times, has reduced the cost of delivering services by fully utilizing the scope of practice of health professionals (scope of practice means the responsibilities that a professional's training equips them to undertake).[146]

To reduce the burden on registered nurses and lower system costs, the use of licensed practical nurses should be expanded appropriately in line with their trained scope of practice. Research shows there are barriers to the full practice of nursing personnel, including LPNs.[147] This is something that should be considered in implementation, alongside proper differentiation between nursing scopes of practice (expectations of practice based on education). For instance, research shows that common barriers affecting the ability of nursing staff to work to full scope of practice are heavy workloads, high acuity, a lack of time, not working as a team, and unclear role definitions.[148] While not all barriers are easily surmounted, many can be overcome during implementation, provided tactics are evidence-based.

4. Reduce the Health Care Administration Burden.

In 2021-2022, administration ate up 4.3% of Canada's health budget, and in Alberta, 2.7%.[149] In terms of per capita administration costs, other OECD countries manage to do better. For instance, the average per capita administration cost in Canada is 2.7-fold higher than in Japan and Sweden, 1.9-fold higher than the UK, and 1.3-fold higher than Australia.[150] These countries also have

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[143] This includes 38,775 RNs and 812 nurse practitioners (NPs), 389 graduate nurses, 32 graduate NPs, and 6 certified graduate nurses, between October 1, 2021 and September 30, 2022. College & Association of Registered Nurses in Alberta, "Annual Report 2021 to 2022," 2021, p. 5.
[144] A noted 6.2% increase in registration from the previous year. In addition, between 2019 and 2023 the number of LPNs in the province grew by 15.7%. College of Licensed Practical Nurses of Alberta, "2021 Annual Report," 2022, p. 6.
[145] There were 885 RNs and 22 LPNs who made over the threshold amount. Alberta Health Services, Compensation Disclosure, All compensation disclosure data, consulted September 21, 2023.
[146] Blue Ribbon Panel on Alberta's Finances, *op. cit.,* note 131, p. 28.
[147] As discussed in Rena Shimoni and Gail Barrington, "Understanding Licensed Practical Nurses' Full Scope of Practice Research Study," *Bow Valley College,* September 28, 2012, pp. 25-27.
[148] Nelly D. Oelke *et al.,* "Nursing Workforce Utilization: An Examination of Facilitators and Barriers on Scope of Practice," *Nursing Research,* Vol. 21, No. 1, 2008, pp. 63-65.
[149] Canadian Institute for Health Information, Your Health System, Corporate Service Expense Ratio details for Alberta, consulted September 21, 2023.

health care systems that outperform Canada's (see Chapter One). Therefore, the heightened spending on administration isn't somehow leading to better outcomes. Rather, it is the bloat that is directing resources away from frontline healthcare service provision.

To reduce system costs, the administrative burden of the health care system should be reduced. Various studies have pronounced Germany's health care system as one of the top ranked, and as described in Chapter One, it is certainly superior to Canada's in many ways (see Table 1.1). It manages to outperform with a fraction of the administrators. In fact, Canada has 10 times as many health-care administrators as Germany, with one health care administrator for every 1,415 citizens, Germany, one for every 15,545.[151]

Considering health care spending per capita is relatively close between the two countries (see Table 1.1), it follows that with ten times the administrators, more of that per capita spending is directed at administration, rather than direct patient care.

5. Reduce or Eliminate Barriers to Labour Mobility for Health Care Workers.

European countries with more resilient health systems fared better during the COVID-19 pandemic in terms of deploying surge capacity as they were able to repurpose and redeploy the existing health workforce.[152] A flexible and adaptable workforce is better able to withstand system shocks and respond to emergencies such as COVID-19.

People move between provinces or countries for a wide range of reasons, but in deciding whether to do so, the associated costs—including processing times and administrative and regulatory hurdles to exercising one's profession—are carefully considered. These barriers are an added cost to migration. Easing the bureaucratic load in the accreditation process and the recognition of credentials is one way to increase the supply of medical professionals in the province.

In Canada (and Alberta), there are significant trade barriers to labour mobility. In February of this year, it was reported that there are hundreds of immigrants in Calgary alone with medical training and experience as physicians in their home countries who "aren't currently making use of those skills, often working menial jobs as they contend with what they describe as barriers in Canada's medical credentialing and licensing systems."[153] This is wasted potential, especially in a system with a physician shortage as palpable as Alberta's.

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[150] Canada spends an average per capita of $192 on administration. Japan and Sweden spend $70, the UK $100, and Australia $148. OECD, OECD Health Statistics 2023, July 2023 as cited in Peter G. Peterson Foundation, "How does the US healthcare system compare to other countries?" July 12, 2023.
[151] Susan D. Martinuk, "Patients at Risk: Exposing Canada's Health-care Crisis," as quoted in Licia Corbella, "Corbella: Canada's health care system overrun by administrators and lacks doctors," *Calgary Herald,* January 22, 2022.
[152] Juliane Winkelmann *et al*., *op. cit.,* note 102, p. 368.
[153] Jason Herring, "Foreign doctors in Calgary frustrated by barriers to work in Canada," *Calgary Herald,* February 14, 2023.

There is currently a pilot project in place (beginning in January of this year) to fast track some international medical graduates.[154] This process should be evaluated and expanded to jurisdictions outside the four it includes (Australia, Ireland, the United States, and the United Kingdom).[155] Speeding up licensure by jurisdiction should also be sure to take into account the country mix of where medical practitioners are coming from. There is a large proportion of newcomers who graduated from internationally accredited medical schools in Latin America, the Caribbean, Africa, and Asia but because the accredited medical schools they attended fall outside of the Canadian medical authorities approved jurisdictions, they face barriers that render licensure incredibly difficult.[156]

Interprovincial trade barriers to labour mobility in Canada prevent the simple mobilization of health workers to other geographic areas, too. For instance, the Canadian Free Trade Agreement (CFTA) has a chapter dedicated to labour mobility to allow workers to move freely between provinces.[157] This applies broadly to all professions, except for a small number of exceptions as noted by the Labour Mobility Working Group (LMWG).[158]

In Alberta there are numerous regulated occupations that have barriers to labour mobility, many of which are important contributors to the health care system. For instance, Alberta holds exceptions to licensed practical nurses (LPNs), medical radiation technologists, nurse practitioners (NPs), and advanced care paramedics.[159] This means that health workers from these professions from other provinces may be required to undergo additional testing, certification, or assessment before they are able to practice in Alberta. The government of Alberta has recently passed the *Labour Mobility Act*, with the objective of streamlining the mobility of skilled Canadians across more than a hundred regulated occupations,[160] however, more can be done.

To bolster the health care workforce, the examination and removal of barriers to labour mobility – internationally and internally – must be undertaken. To deploy surge capacity in response to the COVID-19 pandemic, the Netherlands and Sweden mobilized health workers to other geographic areas or health facilities with greater need.[161] There was also the utilization of cross-border and regional collaborations to alleviate pressures on the hospital system, whereby patients in the Netherlands ICU and non-ICU were transferred to hospitals in Germany with spare capacity.[162]

There are potential unintended consequences, such as the production of negative effects in the jurisdictions experiencing out-flow,[163] or the initial increase in administrative cost to reconcile

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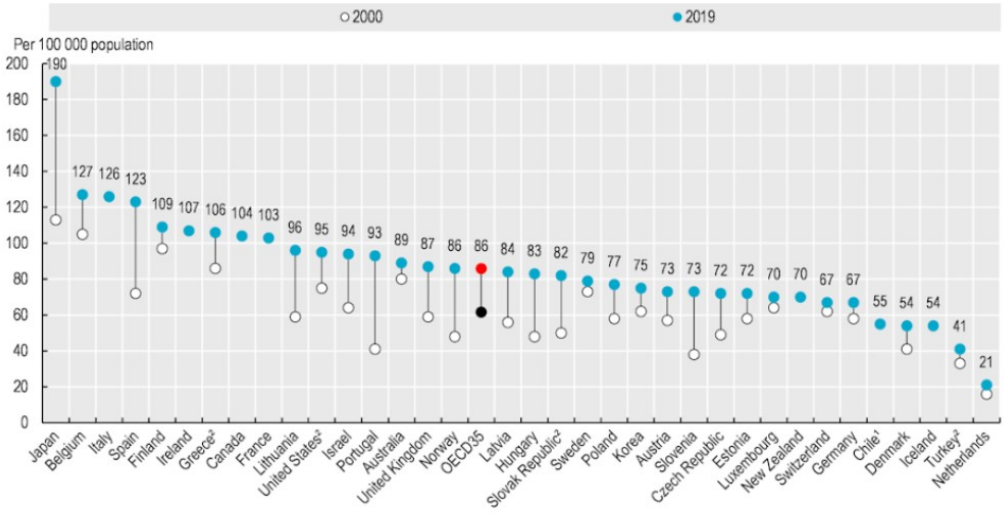
[154] Katarina Szulc, "Alberta now offering accelerated licensing for internationally trained doctors, specialists," *CBC News,* January 18, 2023.
[155] College of Physicians and Surgeons of Alberta, "Additional route to registration for IMGs: approved jurisdictions & requirements," January 16, 2023, p. 1.
[156] Evelyn Encalada Grez, Paola Ardiles Gamboa, and Simran Purewal, "The Myth of Canada: The Exclusion of Internationally Trained Physicians," *Radius,* January 24, 2023, p. 9.
[157] Canadian Free Trade Agreement, Consolidated Version, January 30, 2023. p. 83.
[158] Labour Mobility, Exceptions to Labour Mobility, consulted on August 15, 2023; Labour Mobility, Exceptions by Jurisdiction, consulted on August 15, 2023.
[159] Labour Mobility Working Group, Exceptions by Jurisdiction, 2021.
[160] Province of Alberta, *Labour Mobility Act*, April 6, 2023, consulted on August 15, 2023.
[161] Juliane Winkelmann *et al*., *op. cit.,* note 102, p. 368.
[162] *Ibid,* p. 365.

these barriers, among others. However, this is a low-hanging fruit. The 2022 mandate letter instructed the Minister of Health to work with the Minister of Advanced Education to develop streamlined automated credentialing for frontline health care workers, doctors, nurses, and paramedics. There is also the mandate to work with the Minister of Immigration and Multiculturalism to streamline immigration and certification processes.[164] Addressing and eliminating the actual barriers takes it a step further.

6. Utilize Pharmacists to Their Full Scope of Practice.

As previously discussed, the delegation of certain procedures to NPs will free up doctors to treat more complex cases and take on new patients, although this is more difficult when there is simultaneously a nursing shortage. Luckily, there is an ample supply of pharmacists whose scope of practice includes prescribing certain medications, ordering and interpreting lab tests, and administering vaccinations.[165] This is especially helpful considering that Canada has more licensed pharmacists per capita than most OECD countries (see Figure 2.2).

Figure 2.2. Practising pharmacists, 2000 and 2019 (or nearest years).



1. Data refer to all pharmacists licensed to practise. 2. Data include not only pharmacists providing direct services to patients but also those working in the health sector as researchers, for pharmaceutical companies, etc.

Source: OECD Health Statistics 2021.

The number of pharmacies in the province has increased, and currently, there are more pharmacists per capita in Alberta than ever before.[166] According to the province, a workforce strategy during the pandemic was to optimize deployment of a full spectrum of healthcare

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[163] Michele Alessandrini *et al.,* "Labour mobility and Local and Regional Authorities: benefits, challenges and solutions," *European Union Committee of the Regions,* 2016, pp. 1, 111.
[164] Premier of Alberta, 2023 Mandate Letter: Minister of Health, July 18, 2023.
[165] Canadian Pharmacists Association, "Pharmacists Scope of Practice in Canada," January 2020.
[166] Brendan Coulter, "In small Alberta communities, the struggle to recruit pharmacists is real," *CBC News,* March 5, 2023.

professionals and ensuring they are working to their full scope of practice.[167] To increase access to health care services, the use of pharmacists should be expanded.

Pharmacists and physicians have different priorities when it comes to patients, and the best use of existing resources is to focus on areas of expertise. For example, prescription-related issues or concerns can easily be dealt with by a pharmacist, whereas a physician's attention should be sought for conditions requiring a clinical diagnosis.[168] As prescription-related problems account for more than 10% of ER visits across the country, effective collaboration between physicians and pharmacists can reduce a substantial number of hospital visits.[169] This not only has the potential to free up doctors' time to take on the more complex medical cases and increase access to care overall, but it also provides patients with the best possible care.

There is the concern of conflict of interest when it comes to pharmacists: since some pharmacists run their own pharmacies, there appears to be a financial conflict of interest in issuing a prescription that the patient will then be billed for in order to have filled.[170] However, in Alberta, pharmacists are not paid for writing or authorizing prescriptions.[171] This is something that should be communicated with implementation. There are also concerns of patient privacy, given not all pharmacies have the space available for proper private consultations prior to prescribing,[172] among others. While these issues must be considered with implementation, the advantages of expanding the use of pharmacists cannot be overlooked.

7. Expand the Use of Telemedicine.

Telemedicine "facilitates delivery of clinical care between two distinct geographic locations."[173] Telemedicine has proven benefits, including increasing access to care, especially for rural and remote populations, and decreasing costs both for the patient and for the system.[174] In addition, telemedicine "may facilitate safe delivery of care outside the emergency department for certain conditions or may be used as part of a pre-emergency department triage strategy."[175]

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[167] Data provided by the province, August 22, 2023.
[168] Eugene Y. H. Yeung, "Pharmacists Becoming Physicians: For Better or Worse?" *Pharmacy*, Vol. 6, No. 3, 2018, p. 3.
[169] Cara Tannebaum and Ross T. Tsuyuki, "The expanding scope of pharmacists' practice: Implications for physicians," *Canadian Medical Association Journal*, Vol. 185, No. 14, October 2013, p. 1229.
[170] Matt Gurney, "What are the risks and benefits of pharmacists prescribing?" *TVO Today,* July 17, 2023.
[171] Alberta College of Pharmacy, "Are pharmacists paid for prescribing," consulted September 21, 2023.
[172] Matt Gurney, *op. cit.,* note 170.
[173] Ali M. Omari *et al.,* "Patient Satisfaction with Orthopedic Telemedicine Health Visits During the COVID-19 Pandemic," *Telemedicine and E-Health,* Vol. 28, No. 6, 2022.
[174] Astrid Buvik *et al.,* "Cost-effectiveness of telemedicine in remote orthopedic consultations: Randomized controlled trial," *Journal of Medical Internet Research,* Vol. 21, No. 2, 2019; Juan C. Duchesne *et al.,* "Impact of Telemedicine Upon Rural Trauma Care," *Journal of Trauma and Acute Care Surgery,* Vol. 64, No. 1, 2008.
[175] David Gomez *et al.,* "A population-based analysis of the impact of the COVI-19 pandemic on common abdominal and gynecological emergency department visits," *Canadian Medical Association Journal,* Vol. 913, No. 21, 2021.

During the COVID-19 pandemic, its use increased and expanded. For example, there was a shift to virtual visits, and in some cases home monitoring technology was used to provide care for patients who might have otherwise required hospitalization.[176] In addition, usage in surgeries has seen an increase, such as in orthopedic surgery.

To increase access to health care, uptake of telemedicine and telehealth capabilities should be encouraged and supported by permanent regulatory solutions. Ensuring that telemedicine and integrated technological solutions are in place to allow ICU physicians to advise non-ICU physicians in community hospitals, or hospitals lacking the adequate ICU workforce, would help support surge capacity. This should also be expanded to include the use of NPs and pharmacists, where additional support may be required for full scope operation or to perform certain acts or services.

Telemedicine usage is predicted to increase even further with the rise of interconnected health devices and high-speed connectivity, though this will depend on permanent regulatory solutions.[177]

Hand in hand with large scale telemedicine deployment, and for telemedicine that crosses provincial borders, interoperable digital health records that follow the patient are necessary.[178] In the 2022 mandate letter to the Minister of Health, there was mention of assessing the interfunctionality of the 1,300 or more IT systems currently in use in health care.[179] This priority should be aligned with telemedicine.

There are some disadvantages to telemedicine or telehealth solutions. These include technical difficulties, potentially inequitable access (technical), limitations with performing comprehensive physical examinations, and increased risks to privacy/security breaches.[180] In addition, some critics "worry that telehealth may adversely affect continuity of care, arguing that online interactions are impersonal and dangerous in that the virtual provider does not have the benefit of a complete history and physical examination to aid with diagnosis and treatment."[181]

There is also a need to ensure proper infrastructure when implementing telemedicine in hospitals, as well as proper training and time for the workforce to adapt.[182] So, despite its incredible potential, there are still shortcomings that have deterred its large-scale clinical deployment. Safeguards need to be instituted. According to a recent review:

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[176] Data provided by the province, August 22, 2023.
[177] Carlo M. Contreras *et al.,* "Telemedicine: Patient-Provider Clinical Engagement During the COVID-19 Pandemic and Beyond," *Journal of Gastrointestinal Surgery*, Vol. 24, 2020.
[178] Maria Lily Shaw and Krystle Wittevrongel, "Improving Access to Health Data in Quebec," MEI, Economic Note, June 9, 2022.
[179] Premier of Alberta, 2022 Mandate Letter: Minister of Health, November 14, 2022.
[180] Shilpa N. Gajarawala and Jessica N. Pelkowsi, "Telehealth Benefits and Barriers," *The Journal for Nurse Practitioners,* Vol. 17, 2021, pp. 218-219.
[181] *Idem.*
[182] Lie Rebecca Yem Hwei and Gilbert Sterling Octavius, "Potential advantages and disadvantages of telemedicine: A literature review from the perspectives of patients, medical personnel, and hospitals," *Journal of Community Empowerment for Health,* Vol. 4, No. 2, 2021, p .184.

Therefore, it is imperative for all sectors to work together to implement, execute, and develop telemedicine to better serve the patients' needs. Governments need to tackle the legal aspects of telemedicine while hospitals and medical personnel need to work hand in hand to maximize the clinical use of telemedicine.[183]

8. Gradually Increase Medical School Admissions and Residency Positions.

Provinces control both the number of spots in medical schools and the number of residency positions, or in-hospital training positions, which are needed for postgraduate medical training prior to becoming a fully licensed physician. Gradually increasing medical school admissions is a surefire way to increase the number of doctors in the province. Currently, there are two medical schools in the province: the Cumming School of Medicine at the University of Calgary and the University of Alberta Faculty of Medicine and Dentistry. Combined, the two schools had 347 available seats for the 2023 academic year.[184] As only 8%-12% of those who apply are accepted,[185] there is certainly a consistent pool to draw from, as long as they meet admission requirements.

The 2022 mandate letter instructs the Minister of Health to increase the number of training seats for health professionals in Alberta,[186] but along with this, a similar increase in residency spots is needed in order to increase the number of practising doctors.

Across Canada, medical school graduates are matched to residency positions by the Canadian Residency Matching Service (CaRMS). For 2023, in its first round, it matched 93.5% of those graduating from Canadian medical schools, 86.7% of those educated in the US, and 72.3% of those educated internationally.[187] However, some people do not get residency positions, even after having completed the required schooling.[188]

To increase the number of physicians in Alberta, the number of places available in medical schools should be increased at a pace that is compatible with the availability of residency positions. Canada has well below the number of practicing physicians in other OECD countries (see Table 1.1) and wait times to see both GPs and specialists are lengthy and increasing (see Table 1.4). Growing the pool of health professionals will improve access. However, increasing the number of physicians without introducing measures to curb demand on the patient side or implementing tactics to recoup costs will certainly lead to increased health spending.

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[183] *Ibid,* p .185.
[184] The University of Alberta has 182 seats available in the MD program for the 2023-2024 year, and the Cumming School of Medicine had 165 seats in 2023. University of Alberta Faculty of Medicine and Dentistry, Selection and Admission, consulted September 13, 2023; University of Calgary Cumming School of Medicine, Undergraduate Medical Education, consulted September 13, 2023.
[185] Master Student, "UofA Medical School Requirements and Acceptance Rate," *Master Student,* May 31, 2022..
[186] Premier of Alberta, *op. cit.,* note 179, p. 2.
[187] Canadian Resident Matching Service, "2023 CaRMS FORUM," May 4, 2023, p. 7
[188] In 2023, 54 Canadian medical school graduates, one American medical school graduate, and 25 foreign-educated graduates did not get residency positions after the second round. *Idem.*

In addition, public education is expensive, and medical school is costly for taxpayers. In 2021, it was estimated that the cost to taxpayers in Nova Scotia to educate and train physicians over the entire course of their education and training, including their undergraduate degree, exceeded $500,000 per physician.[189] Despite regional differences in tuition and costs, that figure is assumed to be similar in Alberta. Therefore, while graduating more medical professionals is part of the answer, measures to retain them are also needed.

For international medical graduates who undertake residency matches/positions in Canada, a return-of-service (ROS) agreement obliges them to serve rural or under-served geographic areas once residency training is completed.[190] An ROS-like agreement for additional medical school admissions and/or residency positions in the province of Alberta should be considered.

9. Incentivize Medical Graduates to Practise Family Medicine.

The impact of primary care in reducing health disparities, facilitating better outcomes, decreasing health care utilization, and lowering costs is well established in the literature. In the province of Alberta, family physicians provide the overwhelming majority of care[191] while also playing an important role in managing common diseases and avoiding hospitalization or hospital re-admission. Family physicians/GPs also gatekeep the system before referral to a specialist, and research shows that increasing the number of family physicians has a positive impact on health outcomes.[192]

While increases to medical school admissions and residency placements are needed, there are often unfilled residency positions after the second round, many of which are in family medicine. In fact, since 2019, that number has been growing, while the number of unfilled internal medicine, non-surgical disciplines, and surgical specialties have remained stable or decreased.[193] In addition, there is a decreasing proportion of medical graduates who rank family medicine as their first choice for residency.[194]

To increase access to primary care, medical graduates should be incentivized to practise family medicine. There are, however, going to be increased costs with increased numbers of physicians, unless demand declines or costs are otherwise driven down, as a key factor driving physician

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[189] Anthony Davis, "Nova Scotia taxpayers should get more bang for med school, nursing bucks," *SaltWire,* October 28, 2021.
[190] Other than Alberta and Quebec. Maria Matthews *et al.,* "'At the mercy of some of the regulations': the impact of the residency match and return of service requirement on the early-career decisions of international medical graduates in Canada," *Human Resources for Health,* Vol. 20, No. 15, 2022, p.2.
[191] Moira Stewart and Bridget Ryan, "Ecology of health care in Canada," *Canadian Family Physician,* Vol. 61, May 2015, p. 452.
[192] Per 100,000 Medicare beneficiaries. Chiang-Hua Chang, A. James O'Malley, and David C. Goodman, "Association between Temporal Changes in Primary Care Workforce and Patient Outcomes," *Health Services Research,* Vol. 52, No. 2, April 2017, p.642.
[193] Canadian Resident Matching Service, *op. cit.,* note 187, p. 23.
[194] Canadian Resident Matching Service, Quota and applications by discipline, National data on CMG applicants and quota in the R-1 match by disciplines (first iteration only), consulted September 22, 2023.

costs is how they are remunerated. In Alberta, the majority of physicians are paid on a fee-for-service basis.[195] This type of model works well clinically (ED or surgery, for example), but not in an aging population with high levels of chronic conditions or in primary care.

According to the MacKinnon Report (2019):

> It is also a very expensive way to pay doctors. In 2016/17 the average fee-for-service earning for all Alberta physicians was $413,000. That is $107,000 or 35% higher than the average in comparator provinces. Alternative Payment Plans (APP) in Canada have been on the rise since 2001/02, but adoption in Alberta has been the slowest. Alberta has the lowest percentage of doctors being paid through APPs in Canada. Alberta's total APP payments as a percentage of total clinical payments grew by a modest 1.6% between 2006/07 and 2016/17. APPs as a percentage of all clinical payments is a modest 13.2% in Alberta while in Ontario, 35.7% of doctors are on APPs. It should also be noted that 92% of Ontarians have a regular family doctor, compared with 84% of Albertans who have a regular family doctor.[196]

Essentially:

> There aren't effective incentives in place to encourage more physicians to choose Alternative Payment Plans which would not only reduce costs but also improve care for many types of patients. There also aren't effective ways of encouraging physicians to locate in places outside of the major urban centres.[197]

In July of this year, the Alberta Medical Association called the family doctor shortage in Alberta an "urgent crisis."[198] Therefore, an evaluation of alternative incentives (i.e., not remuneration) to increase the proportion of medical graduates practising family medicine in the province of Alberta is needed. At the same time, it will also be important to consider incentives to encourage alternative funding models.

10. Expand and Improve the Organization of Home Care Services.

Home care in Alberta is a publicly funded service for patients living in a private residence or other setting, such as suites in a retirement residence, to promote independence and supplement care and supports provided by families and community services.[199] In 2021, the province increased home care funding to open hospital beds for COVID-19 patients.[200] In fact, the

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[195] Blue Ribbon Panel on Alberta's Finances, *op. cit.,* note 131, p. 31.
[196] *Idem.*
[197] *Idem.*
[198] Global News, *op. cit.,* note 26.
[199] Alberta Health Services, "Home Care: Continuing Care," consulted September 21, 2023.
[200] Diego Romero, "Alberta increasing home care funding to open hospital beds for COVID-19 patients," *CTV News,* September 9, 2021.

provision of hospital-level care in patients' homes has been a surge management strategy for many years in many countries.[201]

The demand for alternative care models that are capable of supplying inpatient-level care outside traditional brick-and-mortar hospitals has increased following COVID-19.[202] Acute care delivery at home can also be a long-term strategy to allow patients more flexibility in the provision of equivalent or superior care, while also reducing the cost, an acute care bed ranging anywhere from $800 - $2,000 per day, compared to about $200 for a home care bed, according to an 2015 estimate in BC.[203] Studies show that hospital-level care provided as a substitute for traditional acute inpatient care generates better or similar clinical outcomes[204] as well as greater patient and caregiver satisfaction,[205] cost savings,[206] and reduced health care utilization.[207]

The continuing care review indicates that along with more than 33,000 supportive living spaces and 15,000 long-term care (LTC) spaces, there are 127,000 Albertans receiving home care each year.[208] The most recent provincial budget dedicates funding for the transformation of the continuing care system to "increase the number of home care hours provided and the number of unique/individual clients served."[209] Through this transformation and the recent *Continuing Care Act,* which "enables a person-centred, flexible, innovative system of care,"[210] home care services should be further expanded.

Conclusion

The health care system in Alberta was struggling with a lack of capacity pre-COVID, which translated into a lack of resilience and adaptive capacity when developing and deploying surge

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[201] ASPR TRACIE, "Acute Care Delivery at Home," *Healthcare Emergency Preparedness Information Gateway,* April 2021, p. 1.
[202] Pamela M. Saenger *et al.,* "Cost of Home Hospitalization vs. Inpatient Hospitalization Inclusive of a 30-Day Post-Acute Period," *Journal of the American Geriatrics Society,* Vol. 70, No. 5, 2022, p. 2.
[203] CBC News, "Free up acute care beds with seniors-specific funding say care providers," *CBC News,* September 30, 2015.
[204] B. Leff *et al.,* 2009; N. Aimonino Ricauda *et al.,* 2008; W. T. Summerfelt *et al.,* 2015; J. Conley *et al.,* 2016; L. Cryer *et al.,* 2012; P. Corwin *et al.,* 2005; R. Harris *et al.,* 2005; N. A. Ricauda, 2004; A. Wilson *et al.,* 1999; A. Vianello *et al.,* 2013, as cited in Pamela M. Saenger *et al.,* "Cost of Home Hospitalization vs. Inpatient Hospitalization Inclusive of a 30-Day Post-Acute Period," *Journal of the American Geriatrics Society,* Vol. 70, No. 5, 2022, p. 2.
[205] Summerfelt *et al.,* 2015; J. Conley *et al.,* 2016; L. Cryer *et al.,* 2012; P. Corwin *et al.,* 2005; R. Harris *et al.,* 2005, as cited in Pamela M. Saenger *et al., idem*.
[206] N. Aimonino Ricauda *et al.,* 2008; Cryer *et al.,* 2012; B. Leff *et al.,* 2005; K. D. Frick *et al.,* 2009; S. Shepperd *et al.,* 2009; E. Skwarska *et al.,* N. Board, N. Brennan, and G. A. Caplan, 2000; C. Hernandez *et al.,* 2003; D. M. Levine *et al.,* 2020; V. Tibaldi *et al.,* 2009; S. Cai *et al.,* 2018; K. Mooney *et al.,* 2021; S. Cai *et al.,* 2021, as cited in Pamela M. Saenger *et al., idem.*
[207] L. Cryer *et al.,* 2012; D. M. Levine *et al.,* 2020, as cited in Pamela M. Saenger *et al., idem.*
[208] Government of Alberta, Reviewing Alberta's continuing care system, consulted September 22, 2023.
[209] Government of Alberta, "Securing Alberta's Future 2023-2026," *Budget 2023,* 2023, p. 80.
[210] Expected to come into force in Spring 2024. Government of Alberta, Transforming Continuing care, consulted September 22, 2023.

capacity and ultimately responding to the COVID-19 pandemic. The Canadian Federation of Nurses Unions and other stakeholders have reported that "surge capacity is difficult to create when there are shortfalls in resources for usual public health and personal health service needs."[211]

In order for the Alberta health care system to prepare for and respond to future crises or public health emergencies, the capacity and performance of the system must be improved. As per capita health care funding has steadily increased and has outpaced many peer countries, increased funding is simply not the answer.

Rather, the development of robust surge capacity will stem from increasing overall system capacity, which requires incremental changes to certain features of the health system to embed flexibility and competition, and foster patient choice. The recommendations discussed in Chapter Two have the potential for enormous impact through increased efficiency, added flexibility and adaptability, and utilization of health care resources to their fullest extent. These reforms can be made within the confines of the CHA, which is further discussed in Appendix C.

Alberta does not need to reinvent the wheel when it comes to health care, and in addition to the recommendations noted, should look to what can be learned from better-performing, universal systems that have superior accessibility and efficiency. Countries with flexible health systems that are supported by adaptive capacity proved superior in their ability to mobilize surge capacity in the first year of COVID-19, when it was most urgent. There is much that can be learned from these universal health care systems in terms of system-level adjustments that can be made to better equip the province of Alberta to improve its health system performance.

[211] Government of Canada, *op. cit.,* note 3, p. 102.

Appendix A

Table A.1. OECD metrics for Australia, Canada, Germany, Japan, Korea, the Netherlands, Sweden, and the UK.
Data are from 2019 or the latest available year (in parentheses).

	Cost		Physicians				
	Expenditure on health - all financing schemes - per capita ($USD)	Percent difference from Canada	Practicing physicians (per 1,000)	Professionally active physicians (per 1,000 population)	Physicians licensed to practice (per 1,000)	Generalist medical practitioners (per 1,000)	Specialist medical practitioners (per 1,000)
Australia	$ 5,126.65	1.9% less	3.83	4.02	4.67	1.7	1.85
Canada	$ 5,222.64	0%	2.74	2.78	2.92	1.32	1.46
Germany	$ 6,418.32	22.9% more	4.4	4.82	6.31	1	3.4
Japan	$ 4,610.79	11.7% less	2.49 (2018)	2.57 (2018)	n/a	n/a	n/a
Korea	$ 3,290.83	37.0% less	2.46	n/a	2.94	0.67	1.79
Netherlands	$ 5,643.59	8.1% more	3.75	n/a	3.97	1.74	2.02
Sweden	$ 5,387.73	3.2% more	4.29	4.49	6.91	0.62	2.22
UK	$ 4,389.04	16.0% less	2.95	n/a	3.9	0.76	2.18

*worst performing in red
*best performing in green
Note: there are potential differences in data collection methdology and, in some cases, estimated values vs. final reports. Please contact research team with any questions.

	Nurses			Other workers		Graduates	
	Practicing nurses (per 1,000)	Professionally active nurses (per 1,000)	Nurses licensed to practice (per 1,000)	Practicing care workers (per 1,000)	Practicing pharmacists (per 1,000)	Medical graduates (per 1,000 practicing physicians)	Nursing graduates (per 100,000 population)
Australia	12.23	13.43	15.76	n/a	0.89	41.45	109
Canada	9.98	10.93	11.7	6.18	1.04	27.77	52.71 (2017)
Germany	11.79	13.76	n/a	7.57	0.67	28.01	43.92
Japan	11.76 (2018)	12.46 (2018)	n/a	1.53 (2017)	1.9 (2018)	27.75 (2018)	52.25
Korea	7.93	n/a	22.56	n/a	0.75	30.07	100.16
Netherlands	10.77	n/a	11.15	13.49	0.21	40.23	58.58
Sweden	10.86	11.48	20.11	n/a	0.8	31.43	43.22
UK	8.2	n/a	9.88	17.41	0.87	44.36	44.77

	Hospitals and Hospital Beds							Equipment	
	Number of hospitals (per 1,000,000 population)	General hospitals (per 1,000,000 population)	Total hospital beds (per 1,000)	Total acute care beds (per 1,000)	Long-term care beds (per 1,000 population aged 65 years and older)	Total ICU beds (average, per 100,000)	Total adult ICU occupancy rate (average, %)	CT Scanners (per 1,000,000)	MRI units (per 1,000,000)
Australia	52.76	n/a	n/a	n/a	n/a	n/a	71.8	69.81	14.8
Canada	18.86	14.65	2.52	1.97	2.43	16.99	76.61	14.6	10.05
Germany	36.42	18.97	7.91	5.95	n/a	31.67	77	35.26	34.71
Japan	65.79	57.43	12.84	n/a	n/a	18.71	n/a	111.49 (2017	55.21 (2017)
Korea	77.66	35.6	12.43	7.08	35.51	19.97	64.5	39.58	31.99
Netherlands	32.75	4.32	3.02	2.56	1.87	n/a	71 (2018)	14.87	13.84
Sweden	n/a	n/a	2.07	n/a	n/a	n/a	n/a	26.17	16.64
UK	29.61	11.44	2.45	n/a	n/a	n/a	n/a	n/a	n/a

Source: OECD Data, Topic, Health, Healthcare Resources, Health expenditures and financing, consulted August 29, 2023.
Extracted August 29, 2023
Note: Beware of differences in methdology and estimated values vs. final reports in some cases.

Appendix B

We agree that these priorities are important ones for the province. As these tactics are being undertaken and implemented (or have been committed to), they will be listed, but not elaborated upon.

- Maximizing the use of all surgical facilities across the province while using chartered facilities to deliver more needed surgeries in a timelier fashion.[212]
- Improving EMS response times by shortening patient transfer times at EDs, using specialized non-emergency vehicles for inter-facility transfers, and empowering paramedics to provide on-site evaluation and treatment where medically appropriate.[213]
- Improving health care for pregnant women through the use of midwives, which will reduce the pressure on obstetrics.[214]
- Expanding mental health supports with focus on early intervention, diagnosis, and treatment to reduce longer-term system costs and improve outcomes.[215]
    - Ensuring Albertans have access to recovery by building more therapeutic recovery communities with integrated care where they are needed (including with First Nations partnerships).[216]
- Restoring decision making authority to the local level, incentivizing regional innovation and competition to provide increased medical services and surgeries, and attracting health care professionals domestically and internationally.[217]
- Decentralizing decision-making and resources is a common theme.[218]
- Leveraging all health care workers and utilizing alternative models of care.[219]
- Supporting seniors to stay in their homes for longer, with additional supports.[220]
- Establishing Health Spending Accounts,[221] which is a non-taxable benefit that can be used to pay for eligible health and dental expenses.[222]
- Improving continuing care for Albertans by passing Bill 11: Continuing Care Act to replace multiple acts with one piece of modern, streamlining legislation for continuing

[212] Government of Alberta, *op. cit.,* note 32.
[213] *Idem;* Premier of Alberta, *op. cit.,* note 179, p. 2.
[214] Premier of Alberta, *op. cit.,* note 164, pp. 1 – 2.
[215] *Idem.*
[216] Government of Alberta, Opening doors to recovery in southern Alberta, September 21, 2023; Government of Alberta, Breaking ground on Blood Tribe Recovery Community, July 19, 2023; Government of Alberta, Building a recovery community with Siksika Nation, July 6, 2023; Government of Alberta, Building a recovery community with Tsuut'ina Nation, July 5, 2023; Government of Alberta, Building a recovery community with Enoch Cree Nation, April 24, 2023.
[217] Premier of Alberta, *op. cit.,* note 164, p. 2; Premier of Alberta, *op. cit.,* note 179, p. 2.
[218] *Idem.*
[219] *Idem.*
[220] *Idem.*
[221] *Idem.*
[222] Government of Alberta, Health Spending Account (HAS) Guide, January 2018.

care, and improve transparency and accountability to Albertans regarding how the continuing care system is governed.[223]

- Ensuring Albertans are attached to a primary care provider and improving the primary care system by implementing the recommendations set out in Modernizing Alberta's Primary Health Care System (MAPS).[224]
- Streamlining mental health and addiction care.[225]
- Recruiting more registered nurses and adding to Alberta's heath care workforce. As of July 2023, CRNA has issued more than double the number of permits compared to last year.[226]

There have undoubtedly been many additional priorities that have been announced or are being undertaken that are not included in the above list.

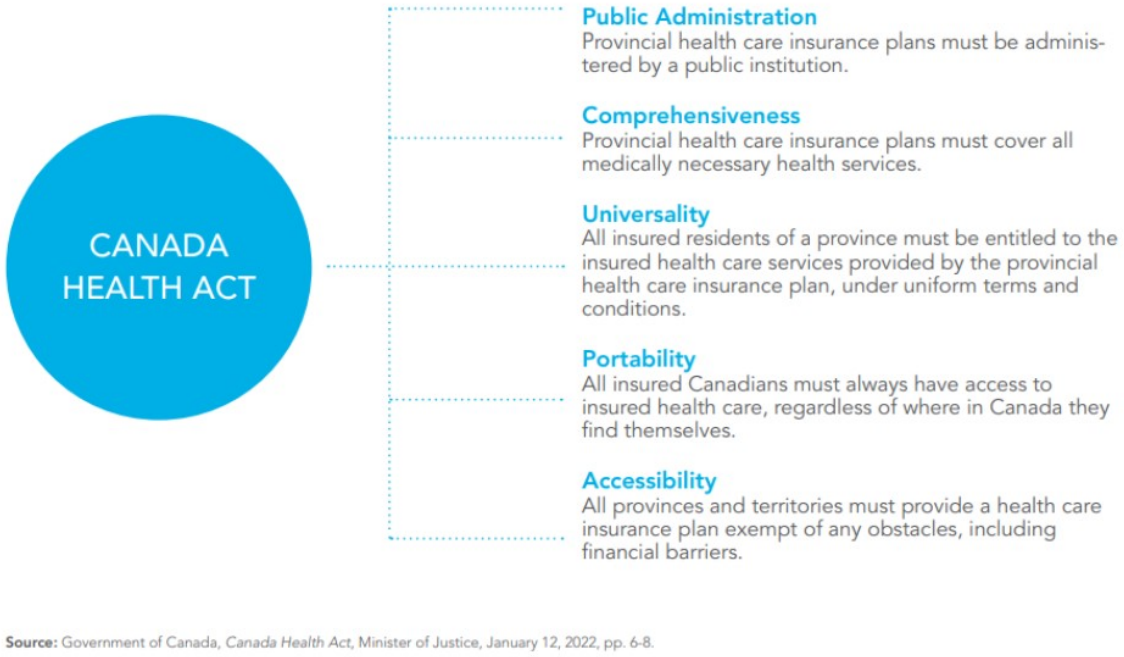
[223] Expected to come into force in Spring 2024. Government of Alberta, Transforming Continuing care, consulted September 22, 2023.
[224] Government of Alberta, MAPS final reports: Statement from Minister Copping, April 28, 2023.
[225] Government of Alberta, Streamlining mental health and addiction care, August 3, 2023.
[226] 4,519 out of 5,501 applications in the past nine months have received permits, which is more than double the permits issued last permit year and adds over 2,300 additional registered nurses to the Alberta workforce. College of Registered Nurses of Alberta, Record Numbers of Registered Nurse Permits Issued in Alberta, July 12, 2023.

Appendix C

Under the *Constitution Act*, 1867, provincial and territorial governments have most of the responsibility for delivering health and other social services. The federal government is responsible for setting and administering national principles for the system under the *Canada Health Act (CHA) in addition to* providing financial support to the provinces and territories.[227]

The CHA establishes criteria and conditions for health insurance plans that must be met by provinces and territories for them to qualify for Canada Health Transfer (CHT) funds.[228] To qualify fully, the provinces must satisfy five criteria: public administration, comprehensiveness, universality, portability and accessibility[229] (see Figure 2.6).

Figure 2.6. Pillars of the *Canada Health Act* (CHA).



Source: Government of Canada, *Canada Health Act*, Minister of Justice, January 12, 2022, pp. 6-8.

Essentially, under the CHA, provinces and territories are required to provide reasonable access to medically necessary hospital and doctors' services (although "medically necessary services" is **not** defined, leaving the responsibility for that up to provinces and territories).[230] The Act also discourages extra-billing and user charges.[231]

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[227] The federal government's role also includes several other functions, including shared responsibility for public health as well as funding and/or delivery of primary and supplementary services to certain groups of people. These groups include: First Nations people living on reserves; Inuit; serving members of the Canadian Armed Forces; eligible veterans; inmates in federal penitentiaries; and some groups of refugee claimants. Government of Canada, Canada's Health System, consulted September 5, 2023.
[228] *Canada Health Act*, 1984, s4, consulted September 7, 2023.
[229] *Ibid,* s.7-12.
[230] Government of Canada, Canada's Health System, consulted September 5, 2023.

The public insurance program itself must be publicly administered, but the CHA does not set parameters around how health services are provided or by whom. In addition, there are no distinctions among public, not-for-profit, or for-profit delivery of services made in the CHA, nor are there any references to the status of physicians or other medical practitioners or how they operate.

According to a paper in the Library of Parliament:

> Using its spending power, Parliament may set conditions for receipt of the money. The *Canada Health Act,* therefore, is constitutionally about the *financing* of health care, not health care directly. The national standards it establishes are the conditions to which the provinces must adhere if they wish to continue to receive federal money.[232]

Provinces can legally adopt legislation contrary to the five principles outlined in the CHA, but the determination of provincial non-compliance with a criterion is entirely at the discretion of the federal government.

As the CHA is not binding, a provincial law that disregards it is **not** illegal.[233]

Non-compliance or failure to comply with any of the principles of the CHA subjects a province or territory to a discretionary penalty from the federal government and a dollar-for-dollar penalty is levied, depending on the magnitude of non-compliance.[234] For instance, if a province allows extra-billing, the federal government can "claw back," dollar for dollar, the amounts charged by publicly-employed physicians through this practice, and may withhold further sums.[235] This has occurred on several occasions in Alberta (and other provinces) in the past.[236]

Thus, "the only sanction on a province for breach of any of the Act's criteria or conditions is for the federal government to reduce or withhold payments to the province."[237]

Consequently, it is the provinces and territories that have the jurisdictional responsibility to make the appropriate changes to improve the performance of their respective health care systems. This includes the freedom to incorporate the entrepreneurial sector in their health care innovations,

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[231] Extra billing is defined as "the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist in an amount in addition to any amount paid or to be paid for that service by the health care insurance plan of a province." A user charge is "any charge for an insured health service that is authorized or permitted by a provincial health care insurance plan that is not payable, directly or indirectly, by a provincial health care insurance plan, but does not include any charge imposed by extra-billing." *Idem.*

[232] Martha Butler and Marlisa Tiedemann, "The Federal Role in Health and Health Care," *Publication No. 2019E*, Library of Parliament, September 20, 2013, p. 3. "Health care reforms: Just how far can we go?"

[233] Philippe H. Trudel, Bruce W. Johnson, and Michel Bedard, "Health care reforms: Just how far can we go?" Montreal Economic Institute, April 2003, p. 1.

[234] Health Canada, *Canada Health Act* Annual Report 2021-2022, February 2023, pp. 11, 13.

[235] Colleen M. Flood and Tom Archibald, "The illegality of private health care in Canada," *CMAJ,* Vol. 164, No. 6, 2001, p. 827.

[236] Colleen M. Flood, "The structure and dynamics of Canada's health care system," in Jocelyn Downie and Timothy Caulfield (eds.), *Canadian Health Law and Policy*, Toronto, Butterworths, 1999, pp. 5-50, as cited in Colleen M. Flood and Tom Archibald, *idem.*

[237] Martha Butler and Marlisa Tiedemann, *op. cit.,* note 232, p. 3.

whether through private delivery of publicly funded medically necessary hospital services, private insurance to finance health care services, or permitting dual practice for physicians.

Appendix D

This report is produced in accordance with EXC24-007 Schedule A:

> (a) Provision of definitions of the “capacity” and “surge capacity” of a healthcare system and review of evidence indicating the need to improve the surge capacity of the Alberta healthcare system in order to handle surges in demand for health care services created by a province-wide public health emergency.
>
> (b) Development and presentation of a list of “incremental changes” to the to the Alberta healthcare system which could be made without violating the *Canada Health Act* and by simple policy changes and/or amendments to the *Public Health Act* or other provincial statutes of Alberta relevant to the functioning and performance of its healthcare system.

APPENDIX 11

Samples of Relevant Orders in Council, Ministerial Orders and Orders of the Chief Medical Officer of Health

Research Memorandum

RRI CANADA

October 18, 2023

TO: Preston Manning
Chair, Public Health Emergencies Governance Review Panel

FROM: Gerard A. Lucyshyn, President/Executive Director

RE: Examples of Orders in Council, Ministerial Orders, and Orders by the Chief Medical Officer of Health used to Cope With the COVID Crisis

Further to your email request on October 17, 2023, *to provide examples of Orders in Council, Ministerial Orders, and Orders by the Chief Medical Officer of Health that were used to cope with the COVID Crisis."* I am pleased to submit the following research memo:

An Example of Order in Council (OIC)

Date:	OIC No.	Recommended by:	Signed by and Purpose
Mar 17, 2020 (Attachment #1)	080/2020	Minister of Health	Lois Mitchell, Lieutenant Governor of Alberta - Declares a State of Public Health Emergency Due to Pandemic

Examples of Ministerial Order (MO)

Date:	MO No.	Signed by:	Brief Description
May 12, 2020 (Attachment #2)	MO 2020-27	Minister of Labour and Immigration	an order In respect of the Employment Standards Code (Act) because such an order will: (a) allow employers to adjust their workforce. In order to Implement measures as recommended or directed by the Chief Medical Officer to protect their employees and to limit and control the spread of the pandemic COVID-19; and (b) provide employers with flexibility to respond to workforce changes required as a result of the pandemic COVID-19; [Layoff Notice]

Mar 25, 2020 (Attachment #3)	MO 612/2020	Minister of Health	extends the definition of "person infected with a communicable disease" to "a person returning to Alberta after having travelled internationally", "a close contact of a person who is confirmed as having COVID-19", and "any person exhibiting any of the symptoms listed below which are not related to a pre-existing illness or health condition: (i) cough, (ii) fever, (iii) shortness of breath, (iv) runny nose), or (v) sore throat," the person shall be isolated or quarantined in a hospital or other place approved for the purpose by a medical officer of health.

Examples of Chief Medical Officer Orders (CMOH)

*see the attachment for a copy of the order.

Date:	CMOH Order	Recommended by:	Brief Description
Mar 16, 2020 (Attachment #4)	CMOH Order 01-2020	Chief Medical Officer	orders all persons who are eligible to or are attending a school location (students) in the Province of Alberta are prohibited from doing so. For certain exemptions such as home schooling, First Nation reserves, etc.)
Mar 17, 2020 (Attachment #5)	CMOH Order 02/2020	Chief Medical Officer	Dr. Deena Hinshaw, CMOH - orders that all persons in the Province of Alberta are prohibited from attending mass gatherings of more than 50 attendees (including places of worship, family events, children play centres, bars and nightclubs etc.) unless stated capacity is limited to 50% up to maximum of 50 people with exemptions for take-out and delivery and not-for-profit community kitchens.

(see attachments for copies of the orders)

ATTACHMENT #1
O.C. 080/2020
244

MAR 17 2020

Province of Alberta
Order in Council

ORDER IN COUNCIL

Approved and ordered:

Lois Mitchell
Lieutenant Governor
or
Administrator

WHEREAS the Chief Medical Officer of Health has provided advice to the Lieutenant Governor in Council under section 52.1 of the Public Health Act that a public health emergency exists due to the presence of pandemic COVID-19 in Alberta;

WHEREAS the Chief Medical Officer of Health has provided advice to the Lieutenant Governor in Council that there is a significant likelihood of pandemic influenza due to the presence of pandemic COVID-19 in Alberta;

WHEREAS under section 52.8(1)(a) of the Public Health Act an order made in respect of pandemic influenza has effect for 90 days; and

WHEREAS the Lieutenant Governor in Council is satisfied that as a result a public health emergency exists and prompt co-ordination of action or special regulation of persons or property is required in order to protect the public health;

CHAIR

THEREFORE the Lieutenant Governor in Council declares a state of public health emergency in Alberta due to pandemic COVID-19 and the significant likelihood of pandemic influenza.

For Information only

Recommended by: Minister of Health

Authority: Public Health Act
(sections 52.1 and 52.8)

ATTACHMENT #2

MINISTERIAL ORDER No. 2020-27

ALBERTA

LABOUR AND IMMIGRATION
Office of the Minister

WHEREAS the Lieutenant Governor in Council made Order in Council 080/2020 under section 52.1(1) of the *Public Health Act* (PHA) on March 17, 2020 declaring a state of public health emergency in Alberta due to pandemic COVID-19 and the significant likelihood of pandemic influenza;

WHEREAS Order in Council 080/2020 has effect for 90 days following March 17, 2020 under section 52.8(1)(a) of the PHA;

WHEREAS section 52.1(3) of the PHA authorizes the Minister responsible for an enactment (Minister), to make an order without consultation, to:

(a) suspend or modify the application or operation of all or part of an enactment, subject to the terms and conditions the Minister prescribes, or
(b) specify or set out provisions that apply in addition to, or instead of, any provision of an enactment

if the Minister is satisfied that doing so is in the public interest; and

WHEREAS I am satisfied that it is in the public interest to make such an order in respect of the *Employment Standards Code* (Act) because such an order will:

(a) allow employers to adjust their workforce, in order to implement measures as recommended or directed by the Chief Medical Officer to protect their employees and to limit and control the spread of the pandemic COVID-19; and

(b) provide employers with flexibility to respond to workforce changes required as a result of the pandemic COVID-19;

THEREFORE, I, Jason Copping, Minister of Labour and Immigration responsible for the *Employment Standards Code*, pursuant to section 52.1(2) of the *Public Health Act*, do hereby order that:

1. Clause 10 of Labour and Immigration Ministerial Order 18.2020 is repealed and the following is substituted:

    10. Clause 9 of this Order applies to:
        (a) a layoff where the layoff notice is given to the employee on or after March 17, 2020, and

(b) a layoff as a result of COVID-19 that is underway as of March 17, 2020.

This Order comes into effect on April 6, 2020.

This Order lapses, unless it is sooner continued by an order of the Lieutenant Governor in Council under section 52.811(3) of the PHA, at the earliest of the following:

(a) August 14, 2020;

(b) 60 days after Order in Council 080/2020 is terminated by the Lieutenant Governor in Council, if Order in Council 080/2020 is terminated before June 15, 2020;

(c) when this Order is terminated by the Minister under section 52.811(2) of the PHA because the Minister is satisfied that this Order is no longer in the public interest; or

(d) when this Order is terminated by the Lieutenant Governor in Council under section 52.811(1)(c) of the PHA.

DATED at Edmonton, Alberta this 12th day of May, 2020.

Jason Copping
Minister of ~~Labour~~ and Immigration

ALBERTA
HEALTH

Office of the Minister
MLA, Calgary - Acadia

ATTACHMENT #3

M.O. 612/2020

WHEREAS the Lieutenant Governor in Council made Order in Council 080/2020 under section 52.1(1) of the *Public Health Act* (PHA) on March 17, 2020 declaring a state of public health emergency in Alberta due to pandemic COVID-19 and the significant likelihood of pandemic influenza;

WHEREAS Order in Council 080/2020 has effect for 90 days following March 17, 2020 under section 52.8(1)(a) of the PHA;

WHEREAS section 52.1(3) of the PHA authorizes the Minister of Health to make an order without consultation, to suspend or modify the application or operation of all or part of an enactment, subject to the terms and conditions the Minister prescribes, if the Minister is satisfied that the application or operation of all or part of the enactment is not in the public interest;

WHEREAS I am satisfied that the application or operation of all or part of the *Public Health Act* is not in the public interest because more stringent requirements are required to ensure persons are isolated or quarantined in accordance with the Record of Decision - CMOH Order 05-2020 to address the significant public health risks posed by COVID-19;

THEREFORE, I, TYLER SHANDRO, Minister of Health, pursuant to section 52.1(2) of the *Public Health Act*, do hereby order that:

1. the application of section 33 of the PHA is modified so that references to "person infected with a communicable disease" and "person who is suffering from a communicable disease" are read to include the following persons:

    a. a person returning to Alberta after having travelled internationally;

    b. a close contact of a person who is confirmed as having COVID-19 and

    c. any person exhibiting any of the symptoms listed below which are not related to a pre-existing illness or health condition:
        i. cough;

ii. fever;
iii. shortness of breath;
iv. runny nose; or
v. sore throat.

2. the application of section 1 of the PHA is modified to add the definition of the term "close contact" to section 1 of the PHA:

   "close contact" means
   a. a person who provides care, lives with, or has close physical contact, without consistent and appropriate use of personal protective equipment, with a person who is confirmed as having COVID-19; or

   b. a person who comes into direct contact with the infectious body fluids of a person who is confirmed as having COVID-19.

3. This Ministerial Order is effective upon signing.

Unless continued by an order of the Lieutenant Governor in Council under section 52.811(3) of the PHA, this Order lapses at the earliest of the following:

(a) August 14, 2020;

(b) 60 days after Order in Council 080/2020 is terminated by the Lieutenant Governor in Council, if Order in Council 080/2020 is terminated before June 15, 2020;

(c) when this Order is terminated by the Minister under section 52.811(2) of the PHA because the Minister is satisfied that this Order is no longer in the public interest; or

(d) when this Order is terminated by the Lieutenant Governor in Council under section 52.811(1)(c) of the PHA.

DATED at Edmonton, Alberta this 25 day of March, 2020.

TYLER SHANDRO
MINISTER

Alberta Health

Office of the Chief Medical Officer of Health
10025 Jasper Avenue NW
PO Box 1360, Stn. Main
Edmonton, Alberta T5J 2N3
Canada

RECORD OF DECISION–CMOH Order 01-2020

Re: 2020 COVID-19 Response

I, Dr. Deena Hinshaw, Chief Medical Officer of Health (CMOH) have initiated an investigation into the existence of COVID-19 within the Province of Alberta.

This investigation has confirmed that COVID-19 is present in Alberta and constitutes a public health emergency as a novel or highly infectious agent that poses a significant risk to public health.

Under section 29(2.1) of the *Public Health Act* (the Act), I have the authority by order to prohibit a person from attending a school location for any period and subject to any conditions that I consider appropriate, where I have determined that the person's engaging in that activity could transmit an infectious agent. I also have the authority to take whatever other steps that are, in my opinion, necessary in order to lessen the impact of the public health emergency.

Therefore, having determined that certain activities could transmit COVID-19 as an infectious agent and that certain other steps are necessary to lessen the impact of the public health emergency, I hereby make the following Order:

1. Effective immediately, all persons who are eligible to or are currently attending a school location (students) in the Province of Alberta are prohibited from doing so.

2. All students are prohibited from attending any classes or programs offered at any school location with the exception of education programs offered in a home environment by a parent or guardian to immediate family members only.

3. Students may attend a school location on the following conditions:

   (a) the student, or parent or guardian of the student, makes prior arrangements with school officials in advance of attending the school location for any purpose;

   (b) the school undertakes to ensure that proper public safety precautions and all applicable special measures are in place as may be specified by the medical officer of health;

   (c) the student, parent or guardian will comply with all directions from school officials and the medical officer of health.

4. For the purposes of this order, "school" is as defined in the Act and a school located on a First Nations reserve in Alberta. For greater certainty, this includes:

   (a) a school operating under the *Education Act*, and includes the physical location or place where the school provides a structured learning environment through which an education program is offered or provided;

(b) a school located on a First Nations reserve in Alberta;

(c) a place where an early childhood services program is offered or provided, and

(d) the premises where a child care program that is licensed under the *Child Care Licensing Act* is offered or provided.

5. All persons are prohibited from attending a place where an early childhood services program is offered or provided. All persons are also prohibited from attending a place where day care, out of school care or preschool programs licensed under the *Child Care Licensing Act* are provided or offered. For greater certainty, group family child care and approved family day homes are excluded from this Order.

6. All persons who are eligible to attend or are currently attending the following in the province of Alberta:

(a) a public post-secondary institution or private post-secondary institution as defined in the *Post-secondary Learning Act*;

(b) an institution that provides vocational training under the *Private Vocational Training Act*;

(c) an institution accredited by the following entities:

i. the Association of Biblical Higher Education or the Association of Theological Schools (undergraduate and graduate programs at private, faith-based institutions);

ii. Transport Canada - Canadian Aviation Regulations (flight schools);

iii. Cecchetti Society of Canada (ballet programs and institutions);

iv. Languages Canada (English language programs at public and private institutions),

(d) any Community Adult Learning Programs (part-time, non-formal adult literacy, and foundational learning opportunities) grant funded by Alberta Advanced Education;

(e) any approved training provider under the *Training Provider Regulation*;

(f) any First Nations College entity including:

i. Maskwacis Cutlatural College;

ii. Old Sun Community College;

iii. Red Crow Community College;

iv. University nuhelot'ine thaiyots'i nistameyimâkanak Blue Quills;

v. Yellowhead Tribal College,

(g) any Indigenous adult learning provider entity including:

i. Bullhead;

ii. Chiniki Community College;

iii. Kayas Cultural College;

iv. Nechi Institute: Center of Indigenous Learning;

v. Riel Institute;

vi. Rupertsland Institute, and

(h) the Alberta Pipe Trades College (apprenticeship program provider)

are prohibited from attending in-person classes at the institution, provider or training provider.

7. This Order remains in effect until rescinded by the Chief Medical Officer of Health.

Signed on this 16 day of March, 2020.

Deena Hinshaw, MD
Chief Medical Officer of Health

Alberta Health

Office of the Chief Medical Officer of Health
10025 Jasper Avenue NW
PO Box 1360, Stn. Main
Edmonton, Alberta T5J 2N3

RECORD OF DECISION–CMOH Order 02-2020

Re: 2020 COVID-19 Response

I, Dr. Deena Hinshaw, Chief Medical Officer of Health (CMOH) have initiated an investigation into the existence of COVID-19 within the Province of Alberta.

This investigation has confirmed that COVID-19 is present in Alberta and constitutes a public health emergency as a novel or highly infectious agent that poses a significant risk to public health.

Under section 29(2.1) of the *Public Health Act* (the Act), I have the authority by order to prohibit a person from attending a location for any period and subject to any conditions that I consider appropriate, where I have determined that the person's engaging in that activity could transmit an infectious agent. I also have the authority to take whatever other steps that are, in my opinion, necessary in order to lessen the impact of the public health emergency.

Therefore, having determined that certain activities could transmit COVID-19 as an infectious agent and that certain other steps are necessary to lessen the impact of the public health emergency, I hereby make the following Order:

Effective immediately, all persons in the Province of Alberta are prohibited from attending the following locations or places where the activities listed are taking place:

1. Mass gatherings of more than 50 attendees. This includes places of worship, gatherings and family events such as weddings. Grocery stores, shopping centres, health care facilities, airports, the legislature and other essential services are not included.

2. Public recreational facilities and private entertainment facilities, including but not limited to, gyms, swimming pools, arenas, science centres, museums, art galleries, community centres, children's play centres, casinos, racing entertainment centres, and bingo halls.

3. Bars and nightclubs where minors are prohibited by law.

The above prohibitions do not apply, or apply with modifications set out below, to the following locations or places where the activities listed are taking place:

4. Albertans can attend restaurants, cafes, coffee shops, food courts and other food-serving facilities, including those with a minors-allowed liquor license. Such locations are limited to 50 per cent of their stated capacity, up to a maximum limit of 50 persons within a given location or place.

5. Take-out, delivery or drive-through food services are permitted. Licensed facilities are also be permitted to deliver liquor.

6. Not-for-profit community kitchens, soup kitchens and religious kitchens are exempt, but sanitization practices must be utilized and followed.

This Order remains in effect until rescinded by the Chief Medical Officer of Health.

Signed on this 17 day of March, 2020.

Deena Hinshaw, MD
Chief Medical Officer of Health

Alberta