4 | COVID-19 in the Toronto Context EX17.1

4.1 Key Facts about the City of Toronto

Fastest growing city, and part of the fastest growing region, in North America[2].

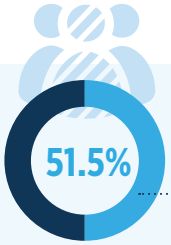
Between July 2018 and July 2019:

Toronto's population grew by **45,742**

Toronto Region's population grew by **127,575**

Toronto had an operating budget of **$13.5 billion** in 2020.

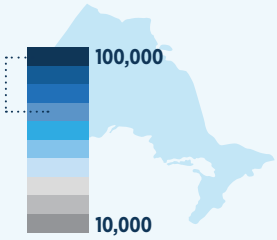
Generates **$180 billion GDP** (2018), and part of a region that **generates $358 billion in GDP**. This is equivalent to Alberta and Quebec[3].



One of the most multicultural and multiracial cities in the world.

of Toronto residents belong to a visible minority group.[4]

Largest Indigenous population in Ontario and the **4th largest in Canada** with between **70,000** and **100,000** First Nations, Inuit and Métis.[5]



One in five adults and one in four children live in poverty in Toronto

The City of Toronto's poverty rate is:

1.5 times higher than the greater Census Metropolitan Area

1.7 times higher than the provincial rate

1.8 times higher than the national rate

Operates Canada's most heavily used transit system, and the third busiest in North America.

of all transit ridership of the province.

Pre-COVID-19, the TTC had over:

3 million trips per day[6]

Poverty is disproportionately experienced by Indigenous People, Black Torontonians, and other equity-seeking communities such as:

- **Racialized youth**
- **Socially isolated individual**
- **Vulnerable seniors**
- **People with disabilities**[7]

Economic Impact of COVID-19

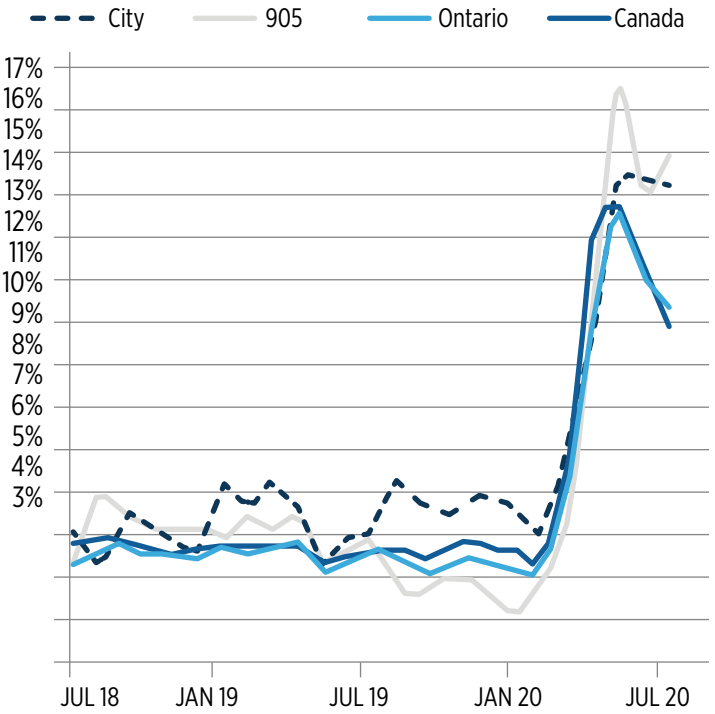
COVID-19 has produced the worst economic downturn since the Great Depression.

The Canadian economy is estimated to contract by 6.9 per cent in 2020[8] – a recession that is two to three times as deep as the Great Recession of 2008/09. Toronto's unemployment rate rose from 5.9 per cent in February 2020 to 14.2 per cent in July[9]. However, the unemployment rate does not account for unemployed workers that are not looking for work, for example due to health concerns or child care responsibilities.

The Toronto CMA lost nearly 630,000 jobs in March, April and May, and many workers are working reduced hours[10]. The labour market is gradually recovering as COVID-19 restrictions ease. Total employment across the Toronto CMA increased by 199,100 in June, and by 68,400 in July. The rebound in hiring recoups about 40 per cent of the jobs lost from February through May[11].

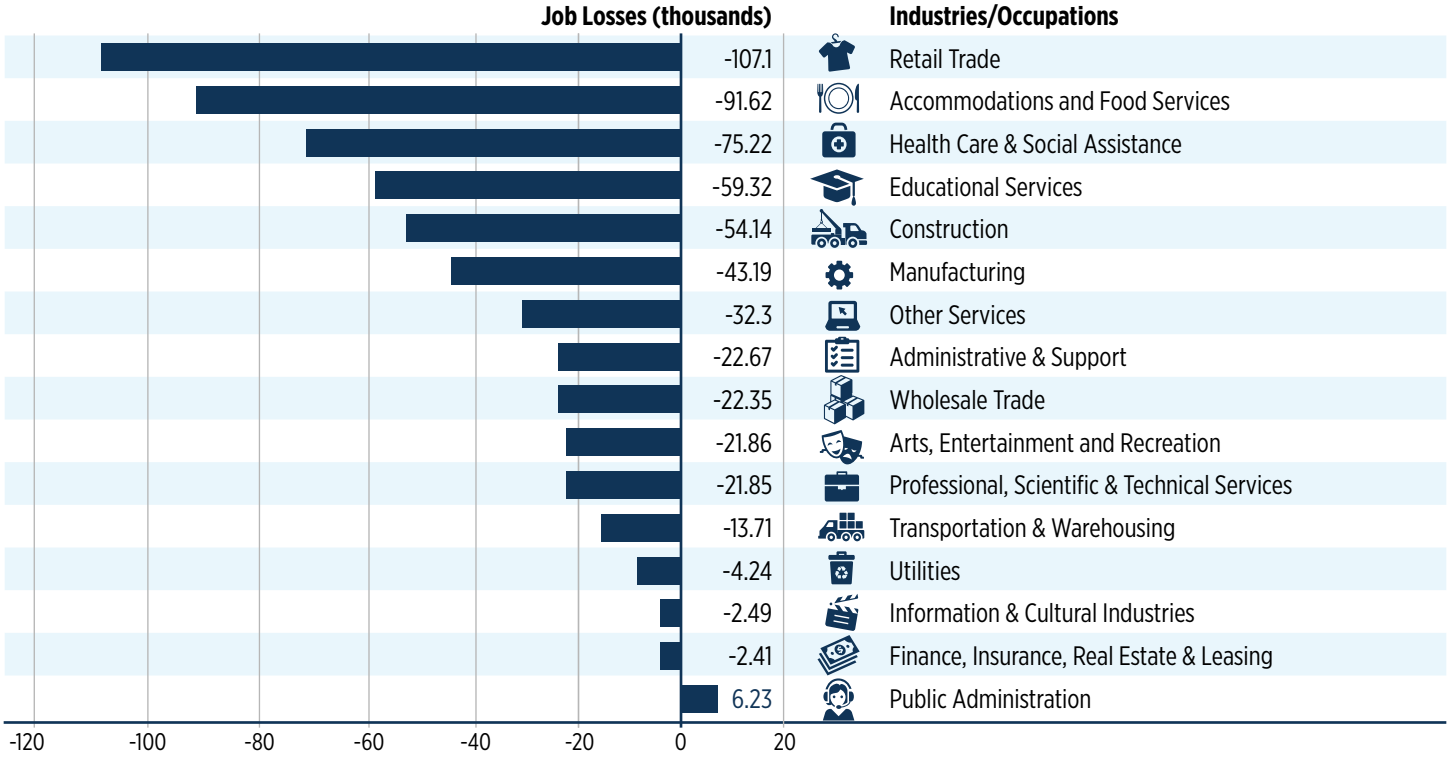
Jobs across industries and occupations have not been impacted equally. The largest employment changes are in industries affected by social distancing rules, including retail, accommodation, and food services[12].

Figure 1 – Unemployment Rate, July 2020



Source: Statistics Canada Labour Force Survey, Seasonally Adjusted Monthly.

Figure 2 - Toronto CMA Employment Change (Feb to May, 2020)



Social impact of COVID-19

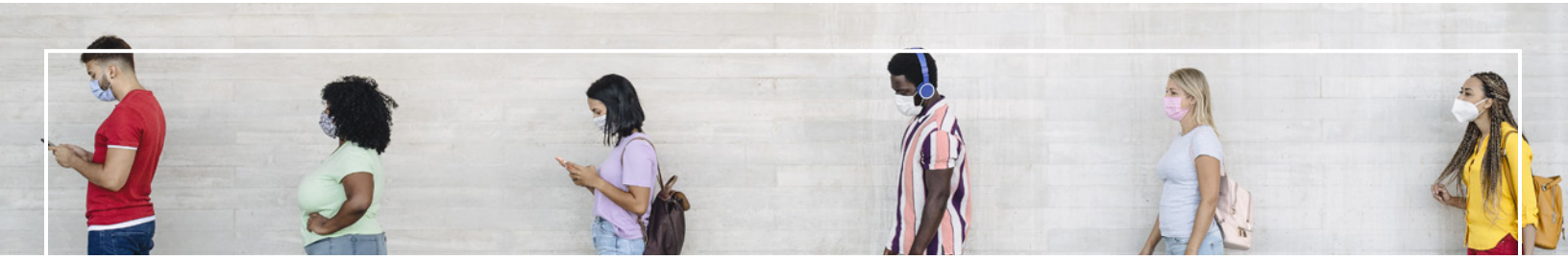
- COVID-19 has predominantly affected urban Canada. Toronto accounts for 8 per cent of Canada's population and 13 per cent of Canada's cases of COVID-19. Provincially, Toronto accounts for 20 per cent of Ontario's population and 39 per cent of Ontario's cases of COVID-19[13].
- Racialized groups are over-represented in reported COVID-19 cases. The majority (83 per cent) of reported COVID-19 cases in the City of Toronto identified with a racialized group[14]. This is compared to 52 per cent of Toronto's population who identify as belonging to racialized groups. In addition, 71 per cent of people who were hospitalized identified as coming from racialized groups.
- Recovery is likely to be hardest for communities that already face significant challenges and is likely to exacerbate income inequality. The risk of experiencing work interruptions during the pandemic has fallen disproportionately on financially vulnerable workers in industries most impacted by the need to socially distance, as demonstrated in job loss numbers. Approximately 60 per cent of Canadians are in jobs that cannot be done from home and the likelihood of holding such a job is not the same for all Canadians. Households with lower levels of education and earnings are the least likely to hold jobs that can be done from home[15].
- Vulnerable communities, for example, immigrants, particularly women, account for a disproportionate share of nurse aides, orderlies, and patient service associates, putting them at higher risk of contracting COVID-19. In 2016, immigrants accounted for 78.7 per cent of nurse aides, orderlies and patient service associates in the Toronto CMA compared with 50.2 per cent of workers in all other occupations[16].
- The COVID-19 pandemic has pushed women's participation in the labour force down to its lowest level in three decades. Women are overrepresented in industries — hospitality and food services, retail trade, educational services, health care and social assistance — most affected by closures, earnings losses and layoffs, such as hospitality and food services, retail trade, educational services, health care and social assistance[17].

Key facts about City services

Cities play a central role in preparing for, mitigating and adapting to pandemics. Globally, cities with a high concentration of urban poor and deep inequalities have been more vulnerable than those that are better resourced, less crowded, and more inclusive. Cities that are open, transparent, collaborative and adopt comprehensive responses are better equipped to manage pandemics than those that are not. Likewise, cities with robust governance and health infrastructure are in a better position to manage pandemics than those that do not.[18]

The City of Toronto responded to the pandemic by working with other levels of government, agencies, corporations, businesses and community organizations and its residents to stop the spread of COVID-19, provide support to those who need it most, and prepare to recover from the pandemic.

Public health and City services are critical to community health, safety and economy. Neighbourhoods have been impacted when community centres, libraries and child care centres are closed. During the pandemic, emergency services – including police, fire and paramedic services – continued to operate normally. Toronto Water ensured safe, reliable drinking water and Toronto Hydro continued to provide energy to homes and businesses. Where services could not be delivered in the same ways, new approaches were put in place including shifting library resources to provide food security programs, delivering recreation programs online and web-streaming City Council meetings. The City established dedicated operational taskforces to respond to the emergency, secured supplies of personal protective equipment for frontline workers, and continued to respond to environmental risks such as heatwaves. City workers enforced provincial orders and the orders issued by the Medical Officer of Health to keep residents and businesses safe.



4.2 **Emergency Management and Public Health Context**

Separate frameworks establish the federal, provincial and municipal emergency management and public health roles and the management of public health orders. Associated authorities, such as those related to occupational health and safety, ensure further guidance and compliance. Those relevant roles, responsibilities and legislation are noted below and throughout this report.

The Government of Canada:

- Liaises with other governments and international entities such as the World Health Organization.
- Has the Emergency Management Act, which sets out the role and responsibility of federal cabinet ministers, coordination of activities within government and cooperation with the provinces.
- Works with provinces on the Emergency Management Framework and Emergency Management Strategy for Canada.
- Has the Public Health Agency of Canada, whose mandate includes responding to public health emergencies.
- Under the Quarantine Act, can enact measures to prevent the introduction and spread of communicable diseases, including controlling the movement of potentially infected persons across international borders and issuing emergency quarantine orders.
- Can issue orders under various pieces of legislation including those related to travel (e.g. orders issued by the Minister of Transport).

The Province of Ontario:

- Has the Emergency Management and Civil Protection Act (EMCPA) and associated regulations, which "establish the province's legal basis and framework for managing emergencies." This includes defining the authority of provincial ministries and municipalities.
- Under the EMCPA and its associated regulations, the province can:
  - declare a state of emergency throughout Ontario or in any part of Ontario under section 7.0.1(1).
  - issue orders (via provincial cabinet) to, for example, modify existing legislation, and regulations, suspend certain appeal mechanisms and bargaining rights and require the closure of businesses, limit the size of gatherings and require physical distancing.
- The Chief Medical Officer of Health (CMOH) may provide additional guidance, after orders are issued under the EMPCA.
- Sets minimum standards for municipalities under the EMCPA and Ontario Regulation 380/04, including the requirement to conduct of emergency planning and training, exercises and public outreach.
- Can, under the Occupational Health and Safety Act, issue many guidance documents for workplaces.
- Has the Health Protection and Promotion Act (HPPA) governing all aspects of boards of health/ public health units in Ontario. It provides authority for the local Medical Officer of Health to issue orders.
- Public Health Ontario is a Crown corporation that provides scientific and technical advice and support to clients working in government, public health, health care, and related sectors.

The City of Toronto:

- May make bylaws with respect to the health, safety and well-being of persons (as empowered under the City of Toronto Act).
- Fulfils requirements as outlined in the EMCPA and Ontario Regulation 380/04.
- Can declare an emergency in the municipality (or any part of the municipality) under section 4 of the EMCPA and section 59-5.1 of City of Toronto Municipal Code Chapter 59, Emergency Management.
- Mayor may take necessary actions to protect property and the health, safety and welfare of residents in a state of emergency, per the Toronto Municipal Code Chapter 59, Emergency Management. City Council delegates its statutory authority under the City of Toronto Act, 2006 to the Mayor.
- Public Health Unit (Toronto Public Health) may:
  - Use the existing public health powers in the HPPA such as issuing class orders.
  - Develop guidance to support residents and businesses prepare.
- Enforces the provincial EMCPA and the orders issued by the Medical Officer of Health under the HPPA.

Governmental Roles and Responses to COVID-19

The fight against COVID-19 has by necessity required strong collaboration and coordination among all governments. At this critical time all orders of government responded quickly, effectively and responsively to save lives and livelihoods. At a high level, roles and responsibilities as related to the pandemic are as follows (as outlined in the Toronto Office of Recovery and Rebuild Discussion Guide):

Municipal - Toronto	Provincial - Ontario	Federal - Canada
Utilities (water, wastewater, garbage)	Schools	Income Tax
Transit (TTC)	Hospitals/Healthcare	Mortgages
Roads	Supports for employers/employees	Borders
Emergency (Police, Fire, Paramedics)	COVID-19 Testing	RCMP/Military
Municipal Enforcement	Justice	Student Loans
City Hall	Highways	Airports
Property Taxes	School Taxes	International Travel
Culture & Recreation	Safety Orders/Enforcement	Safety Orders/Enforcement
Family & Community Supports	Economic Stimulus	Income Supports (Employment Insurance, Canada Emergency Response Benefit, Canada Child Benefit)
Affordable/Social Housing	Transit (Metrolinx, GO Transit)	Economic Stimulus
COVID-19 Case & Contact Management	Post-Secondary Institutions	Environmental Protection
Long-Term Care	Long-Term Care	
	Environmental Protection	

Federal Actions

The federal government's efforts have focused on limiting the spread of COVID-19 into Canada, mobilizing and coordinating public health across the country (including ramping up procurement and manufacturing of personal protective equipment), providing significant supports to individuals and businesses who are impacted by the resulting economic slowdown, and providing supports to Indigenous communities and vulnerable populations.

The federal government has used orders under legislation (including the Quarantine Act) to stop the spread of COVID-19 in areas of federal jurisdiction. That includes prohibiting entry into Canada, mandating quarantine and isolation, reducing risks in marine, rail and aviation, expanding income supports and expediting approval of health products.

As of the end of July 2020, according to the Government of Canada the federal COVID-19 Economic Response Plan anticipates at least $241 billion in direct spending. Significant measures include:

- $83.6 billion Canada Emergency Wage Subsidy (CEWS) program designed to support employers retain their employees.
- $80.5 billion Canada Emergency Response Benefit (CERB) providing direct income supports to individuals (plus $5.25 billion in income supports for students).
- $19 billion under the Safe Restart Agreement for provinces and territories, which includes federal contributions of up to $2 billion for municipalities and $1.8 billion for public transit (both to be cost matched by provinces/territories), and federal funding for other re-start priorities such as $625 million for child care.
- $13.75 billion to forgive a portion (25 per cent) of the interest free loans to be provided to businesses through the Canada Emergency Business Account (CEBA).

When combined with deferrals and liquidity measures (such as credit for small- and medium-sized businesses available through Business Development Canada (BDC) and Export Development Canada (EDC)) this rises to more than $400 billion in federal supports.

Of the total support announced by the Government of Canada, the City of Toronto has, as of early August 2020, received approximately $25 million through the expansion of the Reaching Home program to support people experiencing homelessness. The City also has been allocated funding under the $19 billion in federal contributions from the Safe Restart Agreement. Details are noted below. The City anticipates receiving its fair share in recognition of the unprecedented fiscal impact of COVID-19 due to unrecoverable revenue losses (including in transit fare revenues) and increased expenditures.

More details on the federal response are available at www.canada.ca/en/public-health/services/diseases/coronavirus-disease-covid-19.html.

Provincial Actions

Provincial governments exercise control over the healthcare system (including in Ontario, Public Health Ontario and Ontario Health), schools and school boards, post-secondary institutions and workplaces. Provinces have led the health and emergency response (including in long-term care homes), established processes for reopening their province's economy and critical services such as schools and child care, and provided supports to individuals, businesses and vulnerable communities throughout the pandemic. In total, across the country, the Federal Economic and Fiscal Snapshot quantifies provincial/territorial direct spending at $24.1 billion. When combined with tax deferrals to individuals and businesses and liquidity measures, the figure grows to $65.6 billion in supports.

Through emergency orders, the Province of Ontario has taken significant action to protect the health of Ontarians. It has included a full range of measures to shut down services and the economy (such as recreational amenities, restaurants, child care centres, schools, public events/gatherings, etc.), provide stronger measures and increase flexibility to respond to the pandemic (such as in long-term care homes, etc.), support consumers and businesses during the shutdown (such as enabling delivery of alcohol/cannabis, reducing electricity rates, addressing price gouging, etc.), and outline rules that would apply as the economy is reopened in stages on a regional basis.

The Province of Ontario, as of its fiscal update on August 12, 2020 has specifically committed to spend more than $30 billion in response to COVID-19 , including but not limited to:

- $11 billion to support people and jobs through electricity cost relief, funding for social services, pandemic pay, support for seniors and Indigenous communities and the provision of other emergency assistance. This also includes $4 billion under the Safe Restart Agreement as noted below.
- $7.7 billion in health measures, including hospital capacity, testing, medical equipment (including personal protective equipment) and in long-term care.
- $10 billion in support through tax and other deferrals.

Of the total support announced by the Province of Ontario, the City of Toronto has, as of early August 2020, received approximately $90 million through the first allocation under the Social Services Relief Fund (for homelessness and for an emergency benefit for those on social assistance), the Transit Cleaning Program, Pandemic Pay measures and additional funding for long-term care.

Federal/Provincial Safe Restart Agreement

In addition, the Federal/Provincial Safe Restart Agreement requires matching spending by provinces to support municipalities and transit systems. The Province of Ontario has noted it is contributing up to $2.22 billion to meet that requirement.

Combined with federal contributions noted earlier, the allocation provides Ontario municipalities with up to $4 billion in total - up to $2 billion in emergency funding for municipalities, up to $2 billion for public transit.

Note that the Province will be rolling out funding for the Municipal and Public Transit Streams in two phases, with the first phase totalling $1.66 billion in emergency support for municipalities and $660 million for public transit. An additional $212 million is also provided through an additional allocation of the Province of Ontario's Social Services Relief Fund. Further, the Province of Ontario has announced $175.8 million in federal contributions to service managers for the Child Care Reopening Plan.

The Province has announced the City's initial allocations under the Safe Restart Agreement, as follows. Further contributions are anticipated by the City through Phase 2 contributions under the Municipal and Public Transit streams.

MUNICIPAL STREAM
allocated on a per household basis

$145,683,100
Toronto's Allocation Phase 1

PUBLIC TRANSIT STREAM
allocated based on ridership

$404,088,232
Toronto's Allocation Phase 1

Total $549,771,332

PROVINCIAL SOCIAL SERVICES RELIEF FUND

$118,770,782
Toronto's Allocation Phase 1

$47,545,885
Federal Safe Restart Funding
September Child Care Reopening

Total $716,087,999

More details on the Province of Ontario's response can be found at https://covid-19.ontario.ca/.

Impact of Government Actions

Through formal emergency protocols, interventions to support economic sectors and individuals and public health measures, federal, provincial and municipal governments have largely planked the curve and headed off a larger economic downturn. Findings from engagement noted that while the response and certain initiatives and economic programs have been received poorly (for example the Ontario-Canada Emergency Commercial Rent Assistance Program (OCECRA)) the response to the collective efforts of governments in Canada have largely been positive.

Despite differences in local contexts, local public health units worked together to influence provincial public health decisions throughout the pandemic. This cohesiveness was demonstrated in their advocacy for a phased approach to reopening based on local public health data. This regional reopening approach was adopted by the provincial MOH informed by local data.

Actions by each government has largely been guided by areas of responsibility. The pandemic has exposed vulnerabilities in areas such as long-term care, public health preparedness and response and the trend toward precarious jobs in the modern economy. Governments have had to take unprecedented interventions. They have included expanded roles such as a broad-based income support program led by the federal government, rapid scale up in provincial testing and health care capacity (including wage top-ups for front-line workers) and new forms of collaboration. Examples of collaboration are shared federal/provincial action in procurement and manufacturing of personal protective equipment, contact tracing, long-term care operations, commercial rents and eviction prevention and labour standards to expand sick days.

Vulnerabilities have also been exposed in the municipal fiscal framework. Municipalities, including Toronto, have been on the front lines, providing essential supports to those in need and ensuring that critical services such as transit continues throughout the pandemic. The Federation of Canadian Municipalities has quantified that, in 2020, the fiscal pressures on municipalities will amount to between $10 and $15 billion for unrecoverable revenue losses and added expenditures related to COVID-19. Requests were also made by the Large Urban Mayor's Caucus of Ontario as well as the Greater Toronto and Hamilton Area Mayors and Chairs which have been strongly advocating for funding from the federal and provincial governments, given unprecedented financial impacts.

While the Federal-Provincial/Territorial Safe Restart Agreement will provide some mitigation against these operating losses, there remains an immediate pressure and an uncertain future for Canada's municipal governments. The post-pandemic recovery is expected to be uneven, impacting revenues and expenditures for services such as child care, housing and homelessness and transit. Even as economic growth occurs, the City of Toronto will not be able to catch up fiscally, as there are limited revenue tools that are directly linked to the economy, making the losses to date and into 2021 and 2022 likely unrecoverable. To this point, federal and provincial funding committed to municipal governments, including through the Safe Restart Agreement, is unlikely to fully address these pressures. Finally, the accelerated transition to a digital economy, combined with uncertainty in the commercial property market, may even undermine the very nature of revenue sources such as the property tax.

Government Collaboration

City Approaches and Action

During the pandemic, governments were able to rapidly coordinate their responses by leveraging existing mechanisms for collaboration (including agreements, networks and structures) such as the *Toronto-Ontario Cooperation and Consultation Agreement.* For example, City of Toronto staff co-chaired with the Province of Ontario and the Association of Municipalities of Ontario, a Municipal Technical Working Group on Emergent Municipal Needs in Response to COVID-19. The group continues to meet regularly with the goal of providing insight into the local impacts and responses to COVID-19 to help inform the provincial response and ensure coordination and alignment.

Active partnerships support alignment, create synergy, inform decisions and ultimately result in mutually beneficial outcomes across governments. For example, at the onset of the pandemic, all governments identified that the viability of small and medium enterprises would be essential for the long-term success of the economy. Municipalities acted by first providing property tax relief in the form of deferrals, and then ramped up strategies to promote local economic development including the City's partnership with the private sector to expand ShopHERE and Digital Main Street. Federal and provincial governments acted to provide commercial rent relief and prevent commercial evictions, and together funded the expansion of the Digital Main Street program across the province.

Municipal Partnerships

Municipal governments also increased their collaboration during the pandemic. Political leadership at FCM and the GTHA Mayors and Chairs focused on the fiscal impacts of the pandemic while coordinating advocacy and public awareness on issues such as recovery and reopening strategies and policies. The relative geographic proximity of municipalities highlighted the need for a regional approach to reopening and the need to consider differing public health circumstances while ensuring some regional consistency.

Similar networks were leveraged federally, such as with staff at the Federation of Canadian Municipalities, and Toronto worked with other large Canadian cities including Vancouver, Edmonton, Calgary, Ottawa and Montreal. Senior management in these large cities increased their collaboration to discuss the impacts of COVID-19, emergency response and recovery, and potential areas of federal-municipal collaboration.

The Recovery

Response to the pandemic by governments highlights opportunities to explore further, proactive, collaborative intergovernmental partnerships during the recovery and beyond.

City plans and strategies provide directions for consideration as part of recovery, including:

- Long-Term Financial Plan, considered by Executive Committee in 2018, sets out the need for a new and positive framework with the potential to serve provincial and national goals as well as achieve Toronto priorities. Potential actions identified then included: continuing to pursue shared policy outcomes with the Governments of Ontario and Canada on housing, transit, public good pricing and community services, developing a strategic intergovernmental approach based on Council's priorities and augmenting provincial and federal investments in Toronto in a fair and equitable manner.
- Corporate Strategic Plan highlights the importance of intergovernmental relationships and partnerships in delivering the six key priorities for the Toronto Public Service.
- The Value Based Outcomes Review, considered by City Council in late 2019, notes structural challenges related to the unique role of the City of Toronto and the need for partnerships with other governments, including approaches to fairly fund city services and infrastructure that provide regional benefits.

Achieving desired long-term outcomes and opportunities through new relationships and agreements with other governments will require new or augmented internal approaches, with a focus on populations, in addition to by service area, in order to successfully achieve City Council's desired goals. Taking a systems approach with other governments, matched with appropriate resources and a co-developed intergovernmental strategy that reflects lessons from the pandemic emergency to date, will allow the City and its partners to identify the full range of possible policy and program interventions needed to achieve shared outcomes and appropriate government actions.

Roles and Responsibilities of Governments

It is important that municipalities play a critical role in shaping the national conversation about Canada in a COVID-19 and post-COVID-19 world. Part of this role will include reflecting on the structural conditions that undermined a collective response. It will also include work to examine and clarify how governments can best serve Canadians by matching each level of government with the appropriate roles, responsibilities and resources. The pandemic highlighted that public policy at the national and provincial levels should be informed by first-hand experiences in municipalities.

Additionally, there is an opportunity for all governments to boost local economies and create jobs through a stimulus infrastructure package. That kind of stimulus funding would not only spur economic growth but would also help build infrastructure that mitigates, and is more resilient to, climate change.

Important conversations have already begun and will continue as cities recover. For example, intergovernmental actions through the 2017 National Housing Strategy are now more urgent than ever as demonstrated by the impact of the pandemic, which reinforced the need to provide affordable and supportive housing for those in need. Municipalities remain central to this conversation and its Collaboration and flexibility will be essential to meet the challenges governments face to recover from the impacts of the pandemic, and to address challenges that existed prior to COVID-19 including the continued effects of climate change.

4.3 **Highlights of Phases and City Actions**

Overview

In January 2020, a new coronavirus was identified as the cause of an outbreak originating in Wuhan, China. The disease caused by the Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2). COVID-19 is spread through direct contact with the respiratory droplets of someone who is infected with the virus through their cough or sneeze. Symptoms of COVID-19 include new or worsening cough, shortness of breath or difficulty breathing, fever, fatigue, muscle aches and headaches. In severe cases, infection has led to death.

On January 25, 2020 Canada confirmed its first case of COVID-19, in Toronto.

On March 11, the global case count of COVID-19 reached 126,000 and the World Health Organization (WHO) declared a pandemic. On the same day, Toronto's Emergency Operations Centre (EOC) was activated and the EOC began coordinating emergency response efforts to protect the health and safety of Toronto residents; to ensure business continuity so that residents could continue to access the services they rely on; and to protect the health and safety of City staff who provide these services.

In March 2020, Mayor Tory convened an Economic Support and Recovery Task Force, which engaged a number of City Councillors to host discussions with stakeholders. The Task Force included roundtables on Business and Community, Children and Youth, Cultural and Arts Communities, Recovery and Restart, Small Businesses BIAs, Social Services and Housing, Upper Education and Industry. Input collected through the Mayor's Task Force was considered by TORR.

As shown in the **timeline on the next page**, cases of COVID-19 continued to increase. On March 17, 2020, the Province of Ontario declared a State of Emergency under section 7.0.1(1) of the *Emergency Management and Civil Protection Act*. Shortly after, on March 23, 2020, on the advice of the Medical Officer of Health and the Office of Emergency Management, the City of Toronto declared an emergency under section 4 of the *Emergency Management and Civil Protection Act*, and section 59-5.1 of *City of Toronto Municipal Code Chapter 59, Emergency Management*. All non-essential businesses were closed and various services and amenities shut down.

Toronto's Medical Officer of Health and Toronto Public Health actively monitored the situation, identified potential cases of COVID-19 and their contacts, implemented public health measures to contain and reduce the spread of the virus, and provided daily updates to inform media and the public and emphasize/explain the public health measures put in place. The measures included actions to maintain physical distancing, such as recommendations to stay at home, and hygiene measures such as frequent handwashing.

In addition to the ongoing response efforts that were underway, the City of Toronto established the Toronto Office of Recovery and Rebuild (TORR) to coordinate a city-wide approach to recovering and rebuilding from COVID-19 and to prepare recommendations for the City Manager, informed by public health evidence and best practices for the City's recovery strategy. Establishment of TORR and planning for recovery began at the end of April, with the recognition that response and recovery would happen concurrently.

The reopening of businesses and services followed directions from the Provincial Government according to a multi-phased approach outlined in, A Framework for Reopening our Province. Toronto entered Ontario's opening of Stage 1 on May 19 along with municipalities across Ontario. Given the differences in the impact of COVID-19 in different parts of the province, a regional approach to reopening was implemented for Stages 2 and 3. As a result, while many parts of Ontario entered Stage 2 reopening on June 12 and 19, Toronto did not enter Stage 2 until June 24. Similarly, for Stage 3, some municipalities opened July 17, others opened on July 24 and Toronto waited until July 31 to reopen.

There are several phases to the City's COVID-19 strategy: **response, restart, recovery and rebuild**. There is no distinct point at which activities transition from one phase to the next, as the City's strategy timelines are guided by the course and nature of the pandemic. The response phase will continue for as long as required and EOC activation levels will remain in step with the virus spread and associated impacts. The restart phase was dictated by the lifting of provincial orders, aligned with Ontario's *A Framework for Reopening our Province*, and advice from the City's Medical Officer of Health. Recovery and rebuild phases will continue until all systems return to better than normal and a re-imagine phase will allow the City to continue to innovate and deliver its services within a COVID-19 environment and beyond.

This section of the report provides a brief summary of each of the phases related to the City's action taken during the unprecedented COVID-19 pandemic.

COVID-19 Key Events | January 2020 to September 2020

This timeline identifies important global, federal and provincial events during the COVID-19 pandemic, as well as the City of Toronto's response and actions in greater detail.

JANUARY

January 9, 2020
A novel coronavirus is identified as the cause of a cluster of respiratory illness in Wuhan, China

January 15
Public Health Agency of Canada activates Emergency Operation Centre (EOC)

January 25
Canada's first confirmed case of COVID-19 (in Toronto)

January 30
World Health Organization (WHO) declares COVID-19 a public health emergency of international concern

MARCH

March 11
WHO declares a pandemic;
Toronto's Emergency Operation Centre activates at Level 1

March 12
EOC increases activation to Level 2

March 14
City of Toronto cancels all programs, closes most facilities

Mid-March
Ontario opens dedicated COVID-19 assessment centres

March 16
Mayor Tory establishes Economic Support and Recovery Task Force

March 17
Ontario declares state of emergency closing schools, libraries, child care centres, recreation facilities, bars and restaurants; EOC increases activation to Level 3; Toronto's Medical Officer of Health (MOH) recommends all bars, dine-in restaurants, nightclubs, and theatres close

March 21
Toronto's first death related to COVID-19

March 23
City of Toronto declares a state of emergency; Toronto's COVID-19 Strategic Command Team is established

Mar 25
Ontario orders closure of non-essential businesses; Federal Government requires 14-day isolation on entering Canada; Toronto closes park amenities

Mar 28
Ontario prohibits social gatherings of more than five people

Mar 30
Ontario announces closure of outdoor recreation amenities

Mar 31
Toronto opens four emergency child care centres, cancels mass events to June 30

APRIL

April 1
Toronto's MOH issues COVID-19 class order for self-isolation

April 2
One million cases confirmed globally;
Toronto enacts physical distancing bylaw

April 9
Toronto announces mental health support strategy for residents

April 14
Toronto launches Distantly.ca to support main street businesses

April 15
Toronto launches DonateTO portal; Canada surpasses 1,000 deaths related to COVID-19

April 16
Toronto expands Digital Main Street program to help local businesses;
Toronto Public Health (TPH) launches new information system for case and contact management

April 21
Toronto receives three million surgical masks for long-term care homes and shelters

April 22
Toronto launches local BusinessTO Support Centre

April 24
Toronto establishes Office of Recovery and Rebuild (TORR)

April 27
Ontario announces A Framework for Reopening our Province;
Toronto launches CurbTO

April 29
Toronto begins providing interim housing to people in encampments

April 30
Toronto City Council has first virtual meeting

MAY

May 6
Toronto and partners open a COVID-19 recovery site for people experiencing homelessness

May 9
Toronto partners with GlobalMedic and University of Toronto Scarborough to provide food to residents

May 13
Toronto adopts the Social Debenture Framework

May 14
ActiveTO program launches with weekend major road closures and 57 kilometres of "Quiet Streets"

May 15
Toronto extends period of cancellation of permits to major festivals and launches recovery program for events; Toronto cancels summer camps

May 19
Toronto enters Ontario's Stage 1 reopening

May 20
Toronto opens 850+ park amenities, recommends face coverings or non-medical masks be worn when physical distancing cannot be maintained

May 22
TPH partners with Registered Nurses Association of Ontario (RNAO) to scale up case and contact management work

May 23
Toronto expands ActiveTO

May 25
Select Toronto Public Library drop boxes open to accept returns

May 27
Toronto releases geographic information on COVID-19 cases in Toronto

May 28
City Council approves 40 km of expanded and accelerated bike routes for ActiveTO; City Council approves next phase of Housing Now sites to increase the supply of new affordable rental housing; City Council approves property tax relief to help sustain live music venues

May 29
City and other major downtown employers encourage employees to work from home until at least September; TORR launches consultation on how the City can recover, rebuild and emerge from the COVID-19 pandemic; Toronto accepts applications for Community Crisis Response Fund

JUNE

June 1
Drop boxes at all accessible Toronto Public Library branches open; Toronto reopens waste Drop-Off Depots; Toronto and United Way Greater Toronto partner to create COVID-19 Shelter Interim Recovery Strategy

June 3
Toronto street food vendors, and food and ice cream trucks resume operations

June 8
Toronto's Emergency Operations Centre launches a "restart roadmap" to guide the restarting of City operations and to support businesses in their safe reopening

June 9
Bike Share Toronto announces expansion to 20 of 25 Wards

June 10
ActiveTO implements 65 kilometres of Quiet Streets; announces SwimTO

June 11
Federal and provincial governments partner to expand City of Toronto's Digital Main Street program

June 12
TPH launches COVID-19 Monitoring Dashboard; Ontario increases limit on social gatherings from five to ten people; some regions in Ontario enter Stage 2 of reopening (excludes Toronto); Ontario reopens child care centres with strict guidelines about cohort size and public health protocols

June 15
Toronto accepts registrations for CaféTO for outdoor bar and restaurant dining

June 16
Toronto issues Canada's first public sector social bond offering of $100 million

June 18
Toronto records 1,000 deaths due to COVID-19

June 19
Additional regions in Ontario enter Stage 2 of reopening (excludes Toronto)

June 22
Toronto resumes marriage licence service; lifeguards return to beaches

June 23
Toronto announces approximately $4.97 million from TO Supports Investment Fund to community agencies supporting vulnerable populations

June 24
Toronto enters Ontario's reopening Stage 2

June 27
Limited Toronto Island Park Ferry Service resumes

June 29
City of Toronto's directly operated child care centres begin reopening

JULY

July 1
Toronto and Canada host Canada Day celebrations virtually

July 6
Toronto reopens outdoor sport and multi-use fields

July 7
Toronto's new mandatory mask bylaw comes into effect

July 8
Toronto launches online business licensing and permit application

July 19
22 new affordable housing units open at 25 Leonard Ave

July 13
CampTO begins

July 17
24 regions in Ontario enter Stage 3 of reopening (excludes Toronto and Peel Region)

July 20
Toronto opens community centres and indoor pools

July 24
Seven additional regions in Ontario enter Stage 3 of reopening (excludes Toronto and others)

July 27
Ontario with the federal government announce up to $4 billion to 444 municipalities for maintenance of critical services under the Safe Restart Agreement

July 30
Toronto Public Health releases new socio-demographic COVID-19 data

July 31
Toronto enters Ontario's reopening Stage 3; Toronto launches Family Well-Being Plan

AUGUST

Aug 5
Bylaw for common areas in apartments and condos comes into effect

SEPTEMBER

Sept 1
All child care centres permitted to resume normal operations at full capacity

Legend

The timeline reflects key events that occurred at the global, federal, provincial, and municipal levels, as identified by the symbols below.

- Government of Canada
- Province of Ontario
- City of Toronto
- Global Event

City of Toronto COVID-19 Decision-Making Governance

At the outset of Toronto's state of emergency and prior to the establishment of the Toronto Office of Recovery and Rebuild, the City's Senior Leadership Team – the City Manager, the Deputy City Managers and the Chief Financial Officer and Treasurer – implemented a governance structure to support COVID-19 response and lay the ground work for recovery efforts. Processes were established across teams to share information, escalate issues, make decisions, and implement actions. The cornerstones of this structure were:

Strategic Command Team, composed of the Mayor, City Manager, Medical Officer of Health and other senior leaders, provides oversight of key emerging issues.

Emergency Operations Centre (EOC) continues to lead all emergency responses, including urgent, short-term or operational actions. The EOC created a taskforce to manage issues such as PPE, business continuity, human resources, shelter and vulnerable supports and donations coordination.

Toronto Public Health leads the public health response, and is responsible for all public health directions, actions and coordination.

Strategic Issues Table led the non-emergency response, specifically mid to long-term impacts and strategies. The table was an extended Senior Leadership Team, which in addition to the City Manager, Deputy City Managers and Chief Financial Officer and Treasurer, also included the City Manager's Office Directors and other senior leaders. To lead and manage work across City divisions and agencies, three working groups were established: a Financial Implications Working Group, an Economic Support and Recovery Working Group and a City-Community Response Working Group.

With the establishment of TORR, the Strategic Issues Table pivoted back to meetings of the Senior Leadership Team, which continued to lead City divisions through response, restart and recovery. The Working Groups adjusted their focus to respond to corporate and public needs.

TORR was positioned to have a comprehensive line of sight into work taking place across COVID-19 response and recovery actions. Two functions served as liaisons with Toronto Public Health (TPH) and the Emergency Operations Centre (EOC). The direct connections to these two critical public health and emergency support functions ensured alignment with TPH and the EOC as operations evolved.

4.4 City's Response

At the beginning of the pandemic, the City responded to address both the immediate needs of the City's residents and businesses and to consider what would be required for the City's long-term recovery.

The objectives of the City's response are:

1. Preventing loss of life
2. Preserving the capacity of the health-care system
3. Minimizing the social and economic impacts of the pandemic

Public Health Response

COVID-19 has created an unprecedented global health emergency, requiring a comprehensive public health response. Toronto Public Health's role in protecting the health and safety of Torontonians includes monitoring, preventing and controlling the spread of infectious disease in the City.

Toronto Public Health's response included several strategies. A comprehensive overview of TPH's role and actions implemented throughout the pandemic is included in Section 5 of this report.

Coordinated Emergency Response

The Office of Emergency Management (OEM) oversees and coordinates the City's emergency management program in partnership with divisions, agencies, and corporations. Required by Ontario's Emergency Management and Civil Protection Act, the City's emergency management program includes emergency planning and conducting training, exercises, and public outreach. The OEM maintains the City's Emergency Operations Centre (EOC) in a state of readiness and during an emergency, coordinates priorities, resources and information across divisions, agencies, and corporations, operating in accordance with the Incident Management System, a standardized framework to organize personnel, facilities, equipment, procedures and communication.

On March 11, 2020, the City's Emergency Operations Centre (EOC) was activated to support coordinated emergency operations working with the Senior Leadership Team, Divisional Operations Centres, external agencies and the Provincial Emergency Operations Centre.

On March 17, 2020, the Province of Ontario declared a State of Emergency under section 7.0.1(1) of the *Emergency Management and Civil Protection Act*. On March 23, 2020, on the advice of the Medical Officer of Health and the Office of Emergency Management, the City of Toronto declared an emergency under section 4 of the *Emergency Management and Civil Protection Act*, and section 59-5.1 of *City of Toronto Municipal Code Chapter 59, Emergency Management.*

As of August 31, the City's Emergency Operations Centre (EOC) has been activated for 174 days and continues to be activated at Level 3, in response to the COVID-19 pandemic emergency.

An escalation process, implemented on March 11, allowed the EOC to escalate critical decisions to the Senior Leadership Team. On March 23, the COVID-19 Strategic Command Team was established to provide clear strategic oversight of key emerging issues. This team, convened daily, included the Mayor, the City Manager, the Medical Officer of Health, the COVID-19 Incident Commander, and other senior leaders. It provided strategic direction and oversight for all aspects of the City's COVID-19 response.

Divisions and agencies, through the EOC-led Incident Management Process, collaborated to ensure solutions met emerging needs in response to this unprecedented situation.

Under the Declaration of Emergency, the City:

- Secured supplies of personal protective equipment for frontline workers;
- Opened 30 new shelter facilities, secured 18 hotels with more than 1,900 rooms and moved 1,309 people into permanent housing (as of July 20);
- Enabled physical distancing for Ontario Works recipients when picking up their cheques;
- Implemented a Food Access Strategy;
- Opened eight emergency child-care centres prioritizing spaces for frontline healthcare and essential City workers;

- Launched a Community Coordination Plan in partnership with United Way Greater Toronto to support community organizations and vulnerable residents;
- Launched and expanded support for businesses through BusinessTO Support Centre, Digital Main Street program and Distantly.ca, a tool to donate online to small businesses;
- Maintained normal police, fire and paramedic services operations;
- Launched DonateTO for online donations of products, services and funds to support the City's pandemic relief efforts (more than $4 million as of July 31);
- Maintained organic, garbage and recycling collection, resumed yard waste collection;
- Worked with telecom and community partners to provide free Wi-Fi to apartment buildings in low income neighbourhoods, long-term care homes and City shelters;
- Established chatbot support for COVID-19 questions;
- Developed a new public health information system called Coronavirus Rapid Entry System (CORES);
- Introduced an automated burial permit application process with funeral homes;
- Redeployed almost 500 staff to critical City services such as shelters and long-term care homes; and,
- Delivered the first-ever virtual Toronto City Council meeting.

Community and Social Services Response

At the onset of the pandemic, a City-Community Response Table was immediately convened with representatives from about 75 community agencies and 11 City divisions. The objectives of the table were to identify issues affecting vulnerable Torontonians, understand the community sector's capacity to respond, and leverage their combined expertise and resources to meet the needs of-vulnerable populations during this crisis.

Throughout the COVID-19 pandemic, the City of Toronto, in partnership with the community-based sector took comprehensive action to support vulnerable residents through the T.O. Supports model. Consistent with a social determinants of health approach, the T.O. Supports model focused on:

- Community sector support
- Family support
- Food access
- Grieving and mourning
- Health care
- Housing and homelessness
- Income support
- Mental health
- Safety and well-being
- Social connections

Because many situations affecting vulnerable people require a local response, the City worked and partnered with United Way on a Local Community Response: Community Coordination Plan to coordinate service provision to vulnerable residents at the neighbourhood and community level and share resources across the community sector. The City was divided into 10 geographic areas (clusters). Dedicated coordinators engaged with local service providers to identify needs and issues and rapidly coordinate supports, services, and information sharing. There are also three city-wide clusters: one working with sector partners on city-wide issues and service responses, another with organizations to support the unique needs of African, Black and Caribbean communities, and a third partnership with Indigenous service organizations through the City's Indigenous Affairs Office and Toronto Aboriginal Support Services Council (TASSC). Information about social and community services and supports continues to be available through 211, a 24/7 phone line and web service available in more than 160 languages.

City Division and Agency Response

The City has modified and adapted its services to meet the needs of Torontonians during the pandemic. That has included staff working remotely and the provision of support to Toronto's residents, communities and businesses in new ways to keep them safe and to reduce the spread of COVID-19.

Section 7 includes information about how City and agency services were impacted by COVID-19, responses that were implemented and input from the TORR consultation on these services, programs and related issues.

- Support for Local Businesses
- Emergency Child Care
- Long-Term Care Homes (LTCHs)
- Shelter Support and Housing (SSHA)
- Toronto Community Housing Corporation (TCHC)
- Food Access Plan
- Mental Health Support Strategy (MHSS)
- Parks, Forestry and Recreation
- Toronto Paramedic Services (TPS)
- Social Assistance

PPE has been a key issue due to the unprecedented demand on the global PPE supply chain. The EOC's PPE Task Force has been able to maintain a working inventory of PPE that continues to meet the needs of City staff. That includes the creation of the PPE Inventory Management Dashboard that analyzes current consumption/inventory levels and leverages predictive analytics to enable PPE demand forecasting.

Preparing for Ongoing and Future Response

Throughout the response period, the OEM planned and prepared for a potential resurgence in cases of COVID-19 ("second wave"). That effort included a review of all internal processes that had been implemented to inform the development of an action plan in response to a potential second wave of COVID-19. Toronto Public Health played a key role in this planning to ensure the safety and well-being of Toronto's residents and visitors.

4.5 **Restart and Reopen**

As efforts to contain the virus continued and the cases started to decline, the response shifted to supporting the reopening of businesses and services as permitted through the province's re-opening plan.

This phase included the gradual resumption of City programs and services and the gradual reopening of businesses, private sector and community sector services based on:

1. Changes to or termination of the Province of Ontario emergency orders, under s.7.0.2 (4) of the Emergency Management and Civil Protection Act. Any resumption of service must conform to the prevailing provincial order.
2. Toronto's MOH advice based on four criteria (as per the province's Framework for Reopening our Province):
    a. Evidence of a significant and sustained reduction in local virus transmission
    b. Sufficient healthcare system (e.g. hospital) capacity to provide an effective response to any resurgence of cases
    c. Sufficient public health system capacity to manage a resurgence in cases; and
    d. Laboratory testing trends that indicate timely identification of cases and the ability to rapidly detect increases in COVID-19 activity.

The City established guidance to support divisions and agencies to identify mitigation strategies to slow the spread of COVID-19 as they restarted their programs and services, including Toronto Public Health's COVID-19 Recovery Planning Guide for City of Toronto Programs and Services. Sector-specific information was developed to support business owners and operators in preparing for the safe reopening of their operations.

In May, a City *COVID-19 Restart Roadmap* was used to assess the re-start of programs and services that had stopped or been reduced during the emergency. The assessment included:

- public health and risk mitigation plans
- personal protective equipment
- staffing
- technology
- Occupational Health and Safety and PPE requirements
- facilities (office and public space) and physical distancing plans
- stakeholder consultations
- communication plans

City divisions worked with subject matter experts to complete the necessary assessments for service restart and with City agencies and corporations as they completed similar assessments. More information about the City's Service Restart and Readiness process is provided in Section 7.

Public health initiatives that supported the restart of City services as well as business reopenings are discussed in Section 5.

The City and feds need to work together to generate new jobs for a new reality of climate change, ongoing vulnerability to pandemics, and social unrest. While I understand the City's constitutionally constrained ability to generate income, the City does need to look at substantial tax increases and simultaneously re-examine the police budget. This is the opportunity to do things differently - to value/ pay some jobs in essential human services better ...

Comment from Consultation

4.6 Recover and Rebuild

In April, the City of Toronto started to develop a strategy to support Toronto residents and businesses to recover from the social and economic impacts of COVID-19. The City established the Toronto Office of Recovery and Rebuild (TORR) to develop recommendations to support the recovery and rebuild of Toronto's communities, organizations, partners and businesses. Building upon existing City engagement and collaboration, TORR consulted with diverse stakeholders and communities to identify what would be needed for an effective recovery and what services or programs should be considered by the City when rebuilding local government to operate in a COVID-19 context.

Details about the Toronto Office of Recovery and Rebuild can be found in Section 6.1.

The Rebuild Phase will involve exploring opportunities for new ideas and partnerships and a renewed approach with the provincial and federal governments related to how programs and services are delivered. Input was gathered through the TORR consultation process to guide rebuild actions for each of the themes identified.

4.7 **Re-Imagine**

The City, as with other governments, has had to modify and adapt its services to meet the needs of Torontonians during the pandemic. That effort included changes to support the need for staff to work remotely and to support Toronto's communities and businesses in new ways to keep them safe and to reduce the spread of COVID-19.

Modernization was part of the City's initial response and is serving as a catalyst for further recovery and re-imagine work. As City services restart, opportunities to continue to innovate approaches introduced during the pandemic have been identified, even those services that continued through the emergency. For example, during the pandemic, the City accelerated its ModernTO (Employee Experience) and Digital Government (Customer Experience) strategies.

Prior to the COVID-19 pandemic, the City had begun service modernization, focusing on digital government and a mobile workforce.

The City's TO programs are examples of how the City took steps to act quickly and modify services to benefit both businesses and the community. Examples of these initiatives include: CampTO that enables children to attend summer camp during the pandemic safely; DriveInTO that supports the film culture and participation in arts events by the public safely; and CurbTO that supports businesses by allowing safe, dedicated, and convenient locations in the public right of way for customers to pick-up their shopping or meals without entering the facility. These are successful examples of how the City has introduced new approaches to accommodate the unique needs of businesses and residents in the midst of the pandemic.

In addition to creating new initiatives and scaling up existing programs such as CaféTO, CurbTO and expanded bike lanes, the pandemic accelerated modernization work in these four areas:

1. **Digital Customer Experience** – delivering services digitally
2. **Mobile Working** - putting in place the technology tools, network infrastructure and business culture to sustain scaled remote work moving forward
3. **Automation** - digitizing behind-the-scenes processes, operations, and organizational enablers such as digital approvals and signatures, data integration, etc.
4. **Acceleration** – pursuing strategies, new partnership models, and opportunities to support speed and scale and that will have broader economic or regional impact

Many of the new services and processes will be maintained as the City rebuilds and re-imagines its services moving forward. The City is also pursuing new models for partnerships, collaboration and better access for vulnerable populations. Re-imagined experiences will elevate the Toronto Public Service's responsiveness and resiliency, and drive equity-based outcomes.

Several City programs were modified to adapt to physical distancing requirements while still enabling provision of services to the public and other new programs were introduced. They include SwimTO, HistoricTO and CaféTO.

5 Public Health Considerations and Actions

5.1 SARS-CoV-2 and COVID-19

In January 2020, a new coronavirus called severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) was identified as the cause of an outbreak of respiratory disease originating in Wuhan, China. SARS-CoV-2 is the virus that causes the disease COVID-19. The first case of COVID-19 was reported in Toronto on January 25, 2020. In March 2020, COVID-19 was declared a global pandemic by the World Health Organization.

Coronaviruses are a large group of viruses that circulate in humans and animals. They can cause diseases that range in severity from the common cold to severe acute respiratory syndrome (SARS). While our knowledge of the novel coronavirus, SARS-CoV-2, has developed since its introduction, much is still unknown.

SARS-CoV-2 spreads primarily through close contact with the respiratory droplets of a person infected with the virus, such as when coughing and sneezing, but also when just breathing or speaking. These droplets can spread up to two metres, or six feet. The virus can also survive on surfaces and spread when a person touches a surface and then touches their mouth or nose with unwashed hands, although it is thought that the virus does not spread easily that way.

Our understanding of the symptoms of COVID-19 has evolved over the course of the pandemic. Early on, the most commonly identified symptoms included fever, dry cough and shortness of breath. However, as additional cases have been identified it became clear that there are several symptoms of COVID-19 including: fever, cough, difficulty breathing, sore throat, runny nose, loss of taste or smell, nausea, vomiting, diarrhea, and difficulty swallowing. Symptoms may appear up to 14 days following exposure to the virus, although typically appear after about five days. Some people with COVID-19 may have mild or no symptoms. That can contribute to viral transmission as an asymptomatic person may be less likely to take precautions.

Most people with COVID-19 recover following mild or moderate illness. Older adults and people with pre-existing illnesses such as respiratory or cardiovascular disease, however, are more likely to develop serious illness and require hospitalization and intensive care.

Currently there are no specific drugs or a vaccine for COVID-19, but research is underway to develop treatments, including clinical trials for a vaccine.

5.2 The Course of the Pandemic

The COVID-19 (Coronavirus disease 2019) pandemic is the biggest global crisis in a hundred years. To date, worldwide, it has caused 654,000 reported deaths (and many more in reality), disrupted schooling for about 90 per cent of students, and caused an initial shrinking of global economic activity to rival that of the Great Depression. First identified on December 8, 2019, in Wuhan, China, there is speculation that the first case may have occurred as early as November 17.

The virus identified as the cause of COVID-19 was designated SARS-CoV-2. The initial outbreak in Wuhan was reported as originating in a seafood market, but that is now in doubt, and there is general agreement that the virus originally infected an animal species and jumped species to infect humans. The probable origin was in bats, but there may have been an intermediate species.

The World Health Organization (WHO) received the first notification from China on December 31, 2019. On January 5 the WHO issued an assessment that there was no significant human-to-human transmission, but by January 30 had declared COVID-19 to be a Public Health Emergency of International Concern, and the WHO declared a Global Pandemic on March 11.

My number one priority is public health. Any programs that can be put in place to ensure the accessibility of public health information and measures in order to keep Ontarians safe is of the utmost importance.

Comment from Consultation

The first case outside China was in Thailand on January 13. Thereafter, the virus spread quickly, including by international travel, and is thought to have been in North America by January 2020. On January 22, Canada initiated screening for travellers from China. Canada's, and Ontario's first case, in Toronto, was recorded on January 25, and the first case not linked to travel occurred on February 23.

In Ontario SARS-CoV-2 was made a reportable disease by ministerial order on January 24. Non-essential foreign travel was discouraged by the Government of Canada from March 13 and a ban was put in effect. The Canada-U.S. border was closed to non-essential travel from March 21. On March 16, travellers entering Canada were advised to self-isolate for 14 days, and this became mandatory on March 25. A Provincial Emergency was declared in Ontario on March 17 and a Municipal Emergency in Toronto on March 23. Schools across Ontario were closed on March 17, and only essential visitors were allowed in long-term care homes. On March 25, Ontario closed all but essential businesses and parks were closed on March 30. People over 70 years of age were advised to stay home. A Class Order under the Health Protection and Promotion Act (HPPA) was issued by Toronto's Medical Officer of Health on April 1, requiring the self-isolation of symptomatic and test-positive persons and their contacts.

Thereafter, the number of cases increased steadily, in Toronto and across Ontario. Toronto's daily case count peaked in the middle of April. The provincial government issued "A Framework for Reopening Our Province" on April 27. Since that point there has been a gradual, staged reopening of businesses, public places, services and activities, with conditions. There is more detail in Section 5 (Public Health and the Recovery).

5.3 **Epidemiology of COVID-19 in Toronto**

Overview of COVID-19 Cases in Toronto

Throughout the course of the COVID-19 pandemic, local data have been collected and analyzed to provide a picture of the progression of the disease, and the distribution of the disease across various groups (e.g. by age, sex, socio-economic status, time, severity, etc.). Figure 1 provides a summary of the COVID-19 cases in Toronto as of August 4, 2020.

As shown in the figure, overall, the majority of people infected with COVID-19 recover from their illness (91 per cent). Approximately 12 per cent of cases have required hospitalization, and 2.6 per cent have required intensive care. The case fatality rate for COVID-19 in Toronto is about 7.5 per cent overall, however, there are notable differences between the case fatality rate for cases in the community (2.6 per cent) compared with the higher rate among outbreak-associated cases (15.6 per cent). In terms of specific congregate settings, analyses conducted in the GTA have shown

Figure 1: Summary of COVID-19 Cases in Toronto

ALL CASES	
Case Count*	15,451
Recovered Cases	14,015
City Incidence Rate per 100,000 People	504
Fatal Cases	1,161
Ever Hospitalized	1,889
Ever in ICU	408
Currently Hospitalized	77
Currently in ICU	20

As of August 4, 2020

CASES IN THE COMMUNITIY	63%
Recovered Cases	9,163
Median Age at Time of Illness	44
Per cent Female	48%
Per cent Male	51%
Fatal Cases	255
Median Age of Deaths	72

OB ASSOCIATED CASES**	37%
Recovered Cases	4,852
Median Age at Time of Illness	61
Per cent Female	61%
Per cent Male	36%
Fatal Cases	906
Median Age of Deaths	88

* Includes confirmed and probable cases.

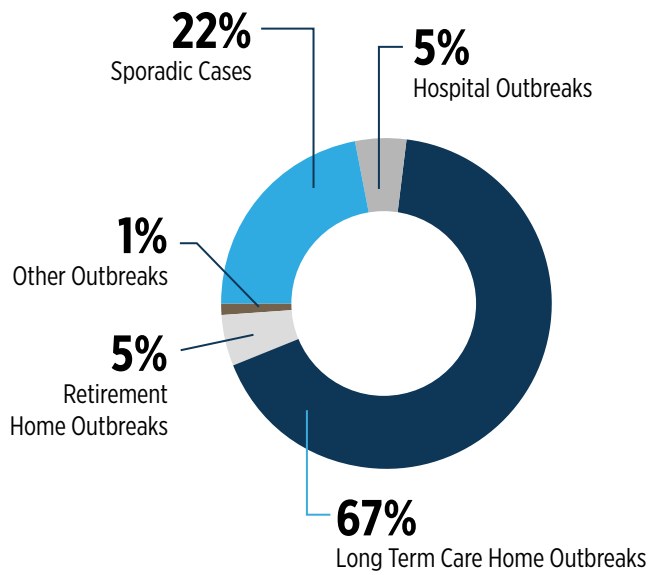
** Outbreak associated cases include persons with COVID-19 within a defined group or setting. These are generally in healthcare (e.g., long-term care homes, hospitals) and residential or congregate settings (e.g., homeless shelters, group homes) but can also be in workplaces and other settings.

Note: Gender was unknown or other for some cases

that the case fatality rate of COVID-19 is 1.4 times higher among long-term care residents compared with the rest of the population.[19] The case fatality rate among residents of long-term care homes is higher than those in other settings (Figure 2). Of all COVID-19 related deaths in Toronto, 67 per cent occurred in long-term care homes (72% if retirement homes are included) (Figure 3).

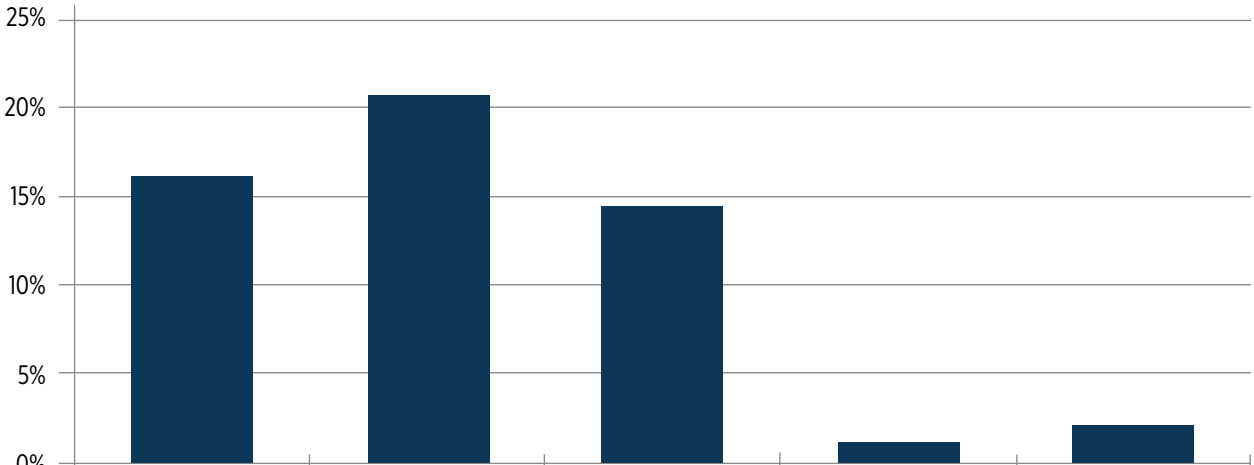
The incidence rate of COVID-19 in Toronto is estimated at 504 per 100,000 people. However, the true incidence and mortality rates are higher than the reported rates given the spectrum of severities for COVID-19, extending down to asymptomatic. As such, cases would be missed if symptoms were either absent or mild, because medical help and lab testing were not sought. Early in the epidemic, cases were underestimated because access to testing was restricted. Deaths might not be counted if COVID-19 was not given on the death certificate as a cause of death, either because there was no test result or because of the certifier's opinion as to the cause of death. There is evidence of undercounting in North America, where seroprevalence studies have shown rates of immunity higher than reported rates of incidence. A recent study by Public Health Ontario suggested that 1.5 per cent of Toronto's population tested between June 5 and June 30, 2020 were positive for COVID-19 antibodies.[20]

Figure 3: Proportion of COVID-19 Deaths by Setting, Toronto



Data Source: Ontario Ministry of Health, intergrated Public Health Information System (iPHIS), Toronto Public Health, Coronavirus Rapid Entry System (CORES), extracted August 4, 2020 (3PM).

Figure 2: Case Fatality Rate and Number of Deaths by Setting, Toronto



	Hospital Outbreaks	LTCH Outbreaks	Retirement Home Outbreaks	Other Outbreaks	Sporadic Cases
Case Fatality Rate	16.2%	20.5%	14.8%	0.7%	2.6%
Number of Deaths	58	777	62	9	255

Data Source: Ontario Ministry of Health, intergrated Public Health Information System (iPHIS), Toronto Public Health, Coronavirus Rapid Entry System (CORES), extracted August 4, 2020 (3PM).

Testing practices also have an impact on the measured incidence of COVID-19. For example, the polymerase chain reaction (PCR) test that is the most commonly used testing method in Canada for COVID-19 can result in false negative results (i.e. the test result indicates the person does not have COVID-19 when the person does have COVID-19). Emerging evidence suggests that the likelihood of a false negative result varies throughout the course of infection.[21]

Evolution of the Pandemic

It is important to note that the epidemiology of the COVID-19 pandemic has changed over time. These changes include the most common exposure settings, the age distribution of cases and changes in illness severity.

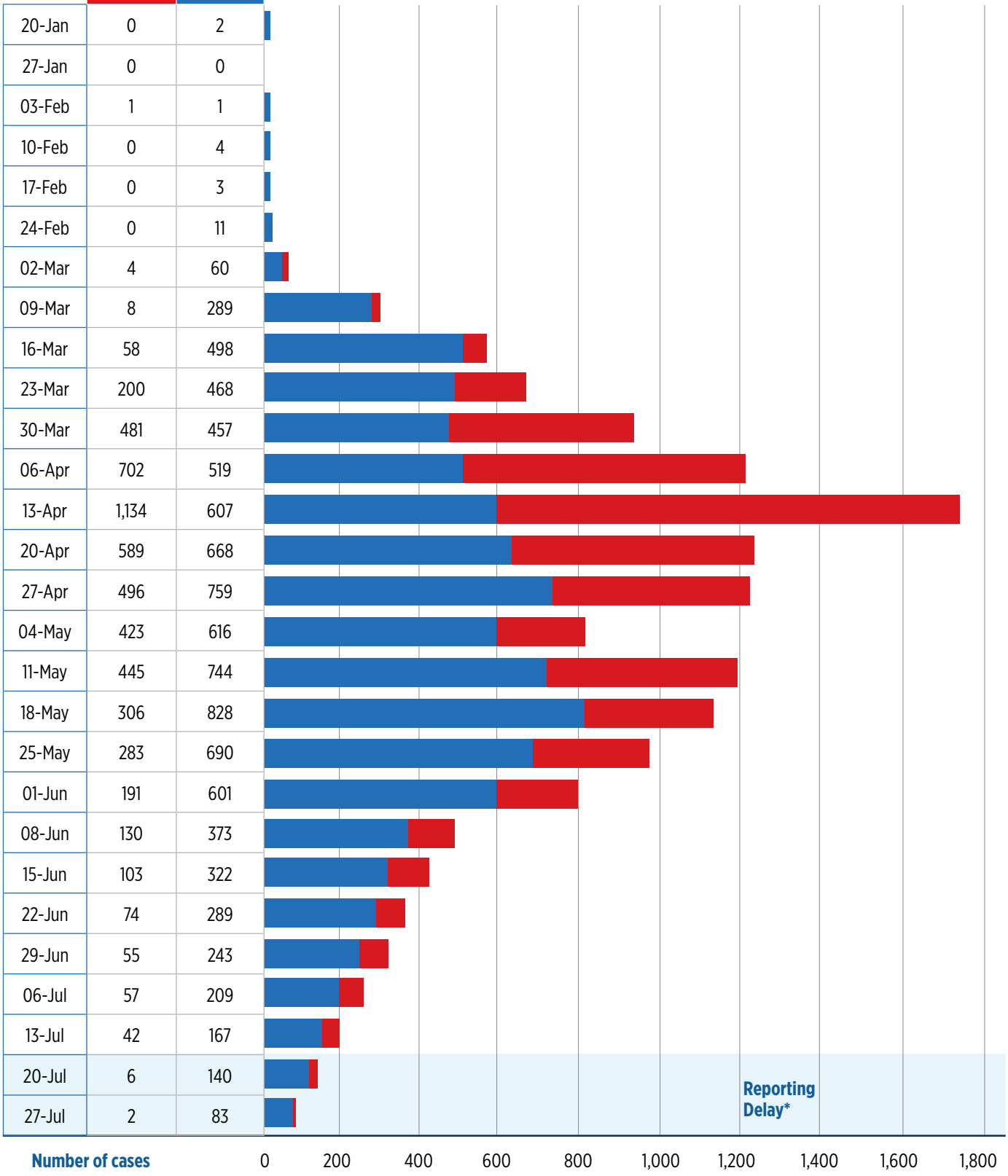
The first case of COVID-19 in Canada was reported in Toronto on January 25, 2020 in a returning traveller. In the early stages of the pandemic, in January and February 2020, the majority of COVID-19 cases in Toronto were identified as travel-related. In March 2020, the pattern shifted from primarily travel-related exposures to exposures in community settings. This shift in exposure setting was likely influenced by a number of factors, including the introduction of travel restrictions at that time. At the end of March, the Public Health Agency of Canada reported that nearly half of all COVID-19 cases were the result of community transmission. By the end of March and into April, there was also an increase in congregate outbreak settings, particularly among residents of long-term care homes. Figure 4 provides an illustration of the distribution of COVID-19 cases over time in Toronto, including by exposure setting (i.e. community or outbreak-associated).

The number of cases has also changed, as shown in Figure 4, with the peak of Toronto cases occurring in the middle of April, followed by a gradual decline. The proportion of outbreak-associated cases also decreased including a decline in institutional outbreaks.

The median age of COVID-19 cases in Toronto is 50 years, and overall, older individuals have been disproportionately impacted (Figure 5). However, there has been a shift in the age distribution of cases toward younger people, particularly those under 40 years of age (Figure 6). For cases in the most recent two weeks (July 20 – August 2), the median age was 35 years. There are several possible causes for this change. One is there may be greater social contact in the younger age group, including at settings where people are in close physical proximity to others. It has also been suggested that increased testing to include those with milder/no symptoms may

Figure 4: Community and Outbreak-associated COVID-19 Cases, by Reported Date, Toronto

Episode Week†	Outbreak Associated	Sporadic
20-Jan	0	2
27-Jan	0	0
03-Feb	1	1
10-Feb	0	4
17-Feb	0	3
24-Feb	0	11
02-Mar	4	60
09-Mar	8	289
16-Mar	58	498
23-Mar	200	468
30-Mar	481	457
06-Apr	702	519
13-Apr	1,134	607
20-Apr	589	668
27-Apr	496	759
04-May	423	616
11-May	445	744
18-May	306	828
25-May	283	690
01-Jun	191	601
08-Jun	130	373
15-Jun	103	322
22-Jun	74	289
29-Jun	55	243
06-Jul	57	209
13-Jul	42	167
20-Jul	6	140
27-Jul	2	83

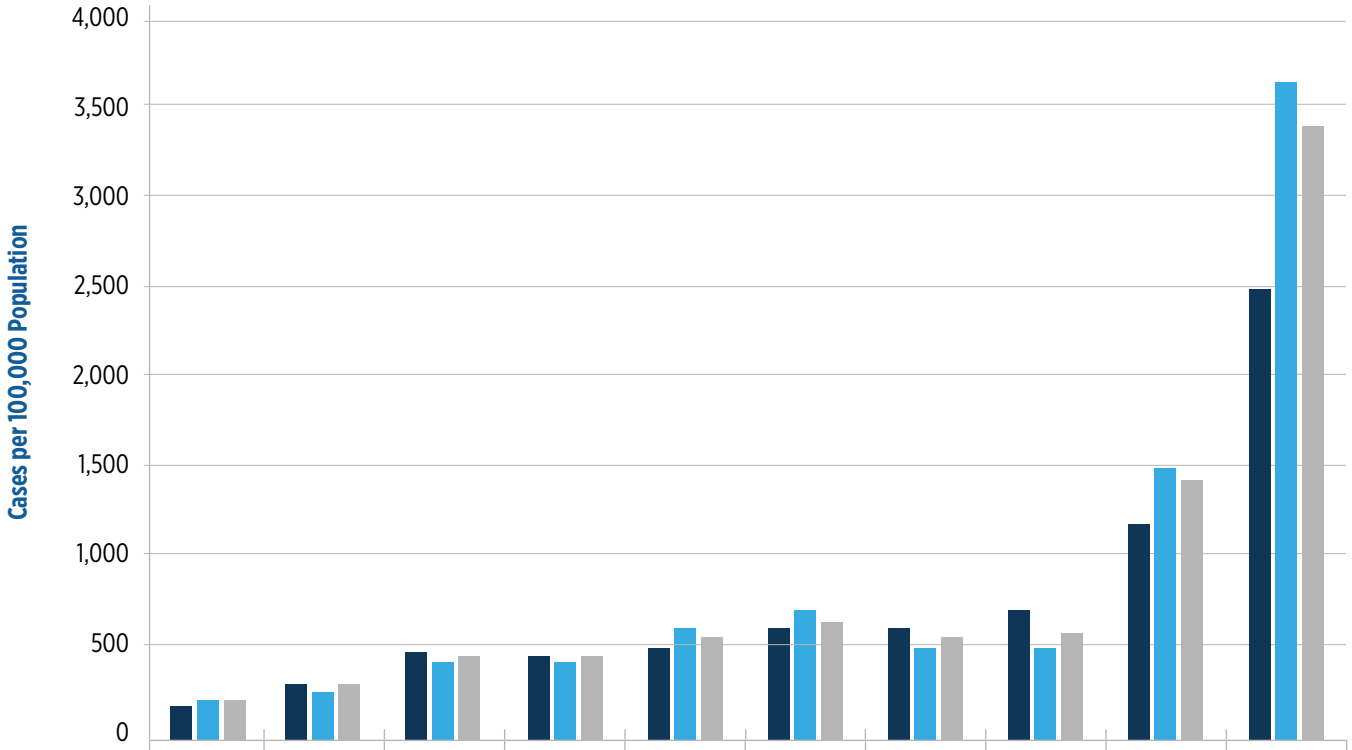


*Interpret case reports for the recent 2 weeks with caution due to reporting delays. †Refers to first day of episode week. Data Source: Ontario Ministry of Health, intergrated Public Health Information System (iPHIS), Toronto Public Health, Coronavirus Rapid Entry System (CORES), extracted August 4, 2020 (3PM).

have played a role. Further, there has likely been a drop in the number of cases in older age groups as a result of the success in mitigating the spread of COVID-19 in long-term care facilities.

The distribution of COVID-19 by gender in Toronto is nearly equal between men and women for community cases. A recent analysis of cases in Ontario found that while more women than men were tested for SARS-CoV-2, men had a higher rate of laboratory-confirmed COVID-19 infection, hospitalization, ICU admission and death.[22] A higher fatality rate in men has been reported in other jurisdictions globally, although reasons for it are unknown. Some suggestions have included behavioural and biological differences, as well as hypotheses related to the differences in smoking rates between men and women and its potential role in virus transmission.

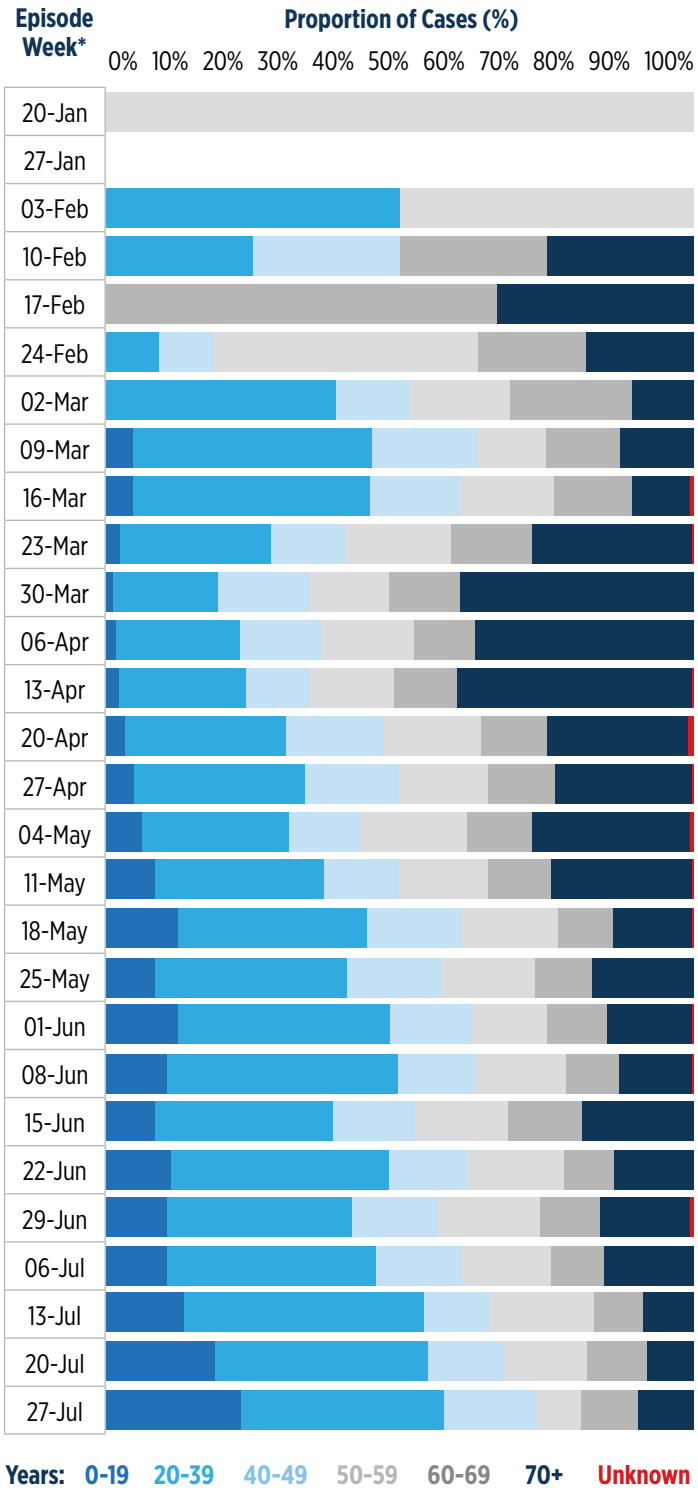
Figure 5: COVID-19 Cases and Incidence Rates by Age Category and Gender, Toronto



Age Group† (years)	0-9	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90+
Male Rates	119.8	221.6	456.3	433.9	477.4	558.3	556.4	612.3	1,184.9	2,479.4
Female Rates	125.1	200.7	419.8	408.2	550.3	663.1	480.1	485.9	1,485.6	3,596.1
Overall Rates	127.5	217.5	441.9	425.4	522.0	615.1	522.2	551.5	1,408.7	3,374.2
Male Cases	179	326	1,177	1,094	974	1,090	837	530	532	262
Female Cases	177	278	1,049	1,081	1,162	1,329	802	523	957	803

*241 cases reported unknown or missing gender, 6 reported transgender, and 6 reported their gender as other. †Age was missing for 26 cases. Data Source: Ontario Ministry of Health, intergrated Public Health Information System (iPHIS), Toronto Public Health, Coronavirus Rapid Entry System (CORES), extracted August 4, 2020 (3PM).

Figure 6: Proportion of COVID-19 Cases by Age Group and Episode Week, Toronto

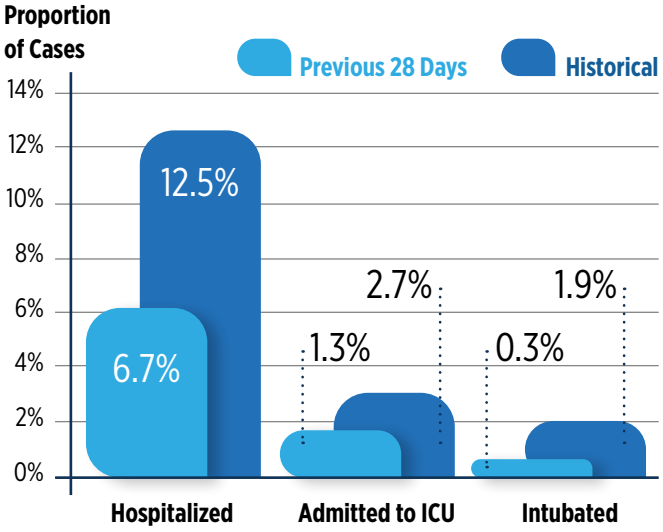


*Refers to first day of episode week. Data Source: Ontario Ministry of Health, intergrated Public Health Information System (iPHIS), Toronto Public Health, Coronavirus Rapid Entry System (CORES), extracted August 4, 2020 (3PM).

Over time, the proportions of COVID-19 cases requiring hospital admission, ICU admission and intubation have all decreased (Figure 7). There are several possible causes for this change, including a rising proportion of younger cases, most of whom experience a milder course of disease; increased experience of, and new evidence about treatment, resulting in more success and avoidance of some intensive care; and mutation of the virus toward a less virulent form.

While it is challenging to predict how the epidemiology of COVID-19 may change in the future, it is reasonable to conclude that shifts will occur as businesses, schools and workplaces reopen and as public health measures are modified. Ongoing surveillance and collection of local epidemiological data will inform future management of ongoing response and potential resurgences of COVID-19 cases.

Figure 7: Proportion of COVID-19 Cases Hospitalized, Admitted to ICU and/or Intubated. Previous 28 days (July 6 to August 2, 2020) and historical (January 20 to July 5, 2020)



Data Source: Ontario Ministry of Health, intergrated Public Health Information System (iPHIS), Toronto Public Health, Coronavirus Rapid Entry System (CORES), extracted August 4, 2020 (3PM).

Socio-demographic Characteristics of COVID-19 Infection in Toronto

Given the diversity of Toronto's population and reports from other jurisdictions that COVID-19 infection was disproportionately affecting some ethno-racial groups and people living in lower-income areas, Toronto Public Health began collecting individual-level data on Indigenous identity, ethno-racial identity, household income and household size from reported COVID-19 cases on May 20, 2020.

These data show that racialized groups are over-represented in reported COVID-19 cases. The majority (83 per cent) of reported COVID-19 cases in the City of Toronto with valid ethno-racial data up until July 16, 2020 identified with a racialized group (Figure 8). This is compared to 52 per cent of Toronto's population who identify as belonging to racialized groups, based on the 2016 Census. In addition, 71 per cent of people who were hospitalized identified as coming from racialized groups.

Specific racialized groups over-represented in COVID-19 cases include:

- Arab, Middle Eastern or West Asian people
- Black people
- Latin American people
- South Asian or Indo-Caribbean people
- Southeast Asian people

Ethno-racial groups under-represented in reported COVID-19 cases include:

- East Asian people
- White people

Data on Indigenous identity have not yet been released, as consultation and engagement with the Indigenous community is ongoing.

People living in lower-income households are also over-represented in COVID-19 cases as shown in Figure 9. Approximately half (51 per cent) of reported COVID-19 cases with valid income data up to July 16, 2020 were living in households that could be considered low income, compared to 30 per cent of the population of Toronto in 2016 that met that same definition. Sixty per cent of people who were hospitalized met this definition of lower income, although it should be noted that those hospitalized represented a very small portion of cases with valid income data (5 per cent).

Figure 8: Share of COVID-19 cases among ethno-racial groups compared to the share of people living in Toronto, with valid data up to July 16, 2020, Toronto Public Health

Ethno-Racial Group	Share of COVID-19 Cases	Share of Toronto Population	Comparison
Arab, Middle Eastern or West Asian	11%	4%	
Black	21%	9%	
East Asian	4%	13%	
Latin American	10%	3%	
South Asian or Indo-Caribbean	20%	13%	
Southeast Asian	17%	7%	
White	17%	48%	

Figure 9: Share of COVID-19 cases by household income compared to the share of people living in Toronto by income group, with valid data up to July 16, 2020, Toronto Public Health

Household Income	Share of COVID-19 Cases	Share of Toronto Population	Comparison
$0-$29,999	27%	14%	
$30,000-$49,999	26%	15%	
$50,000-$69,999	16%	14%	
$70,000-$99,999	15%	17%	
$100,000-$149,999	11%	18%	
$150,000 or more	6%	21%	

Early in the pandemic, individual-level data were not available for many socio-demographic characteristics for COVID-19 cases. In order to gain a preliminary understanding of any socio-demographic health disparities in COVID-19 infection across the city, TPH conducted an area-based analysis using data from the 2016 Canadian Census. While that kind of analysis has several limitations, it contributes to our understanding of trends and associations between socio-demographic characteristics and COVID-19 infection.

These analyses produced similar findings to the individual-level data, showing that areas with a higher percentage of people with lower income levels and people from racialized groups had higher rates of COVID-19 infection and COVID-19 hospitalization.

In addition, areas with a higher percentage of people with the following characteristics also had higher rates of COVID-19 infection and COVID-19 hospitalization:

- Newcomers to Canada (immigrants arriving in Canada in the past 5 years, as of 2016);
- People with lower education levels (no certificate, degree, or diploma);
- Unemployed people
- People living in 'unsuitable' (crowded) housing.

Figure 10 shows the rate of COVID-19 cases by area-based group based on the per cent of newcomers to Canada. For this analysis, census tracts were ranked from highest to lowest based on the per cent of newcomers to Canada using 2016 Canadian Census data. The City was divided into five equally sized groups called quintiles where quintile 1 has the highest per cent of newcomers and quintile 5 has the lowest per cent of newcomers. As shown in Figure 10, the group with the highest per cent of newcomers had the highest rate of COVID-19 cases, compared to the other groups.

Similar trends were found for the other socio-demographic characteristics that were assessed. Higher COVID-19 case and hospitalization rates were identified for the quintiles with the highest percentage of people with lower education levels, people living in crowded households, and unemployed people compared to the quintiles with the lowest per cent for each, as shown in Figures 11-13.

An analysis was also conducted to understand the association between different categories of occupations and the rate of COVID-19 infection. Areas with a high COVID-19 case rate had a higher per cent of people in the labour force in occupations in the following categories compared with areas with a low COVID-19 case rate: sales and service occupations; trades, transport and equipment operators and related occupations; and occupations in manufacturing and utilities.

Figure 10: COVID-19 Cases, Quintiles of per cent of Newcomers in Census Tracts (Sporadic Cases up to June 18, 2020)

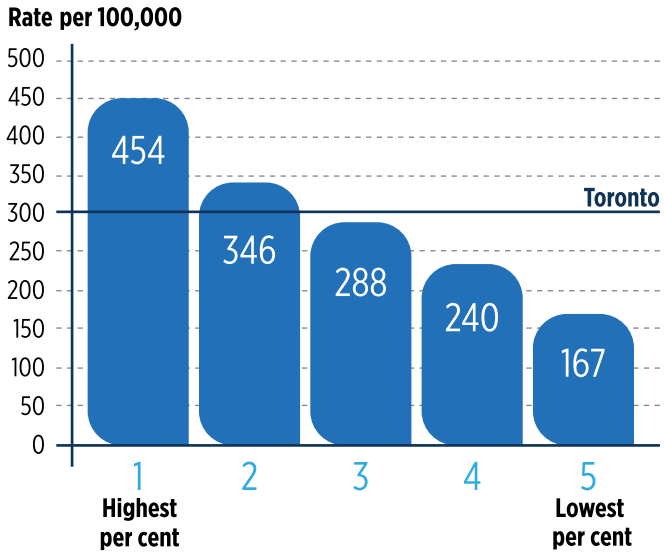


Figure 11: COVID-19 Cases, Quintiles of per cent of People with no Degree, Certificate or Diploma in Census Tracts (Sporadic Cases up to June 18, 2020)

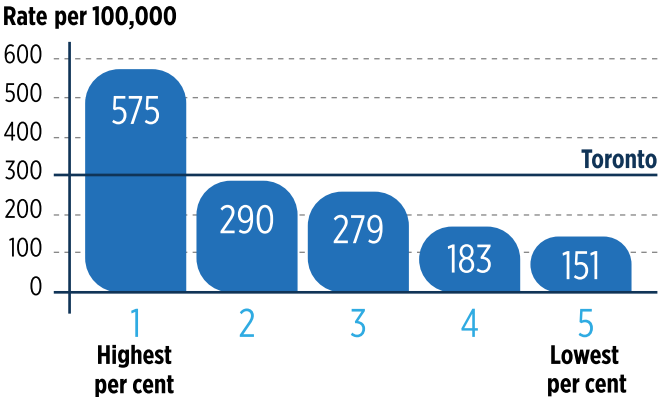


Figure 12: COVID-19 Cases, Quintiles of per cent of Household Crowding in Census Tracts (Sporadic Cases up to June 18, 2020)

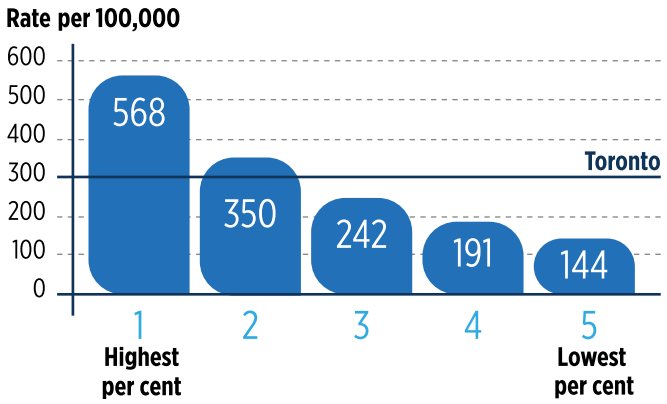
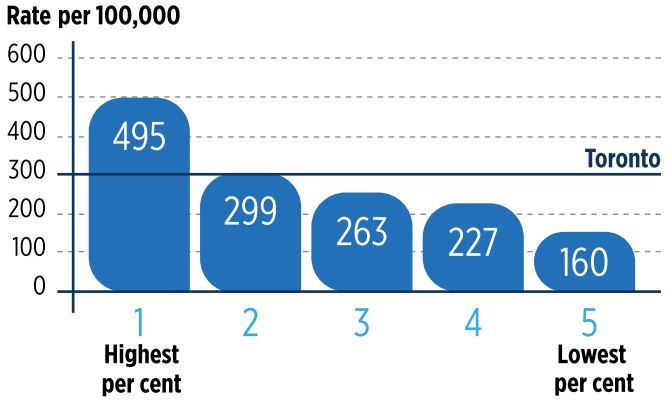


Figure 13: COVID-19 Cases, Quintiles of per cent of Unemployed People in Census Tracts (Sporadic Cases up to June 18, 2020)



Experiences in Other Jurisdictions

Findings from other jurisdictions also illustrate similar trends. For example, higher infection and death rates from COVID-19 have been reported in racialized groups in the United States and the United Kingdom.[23,24] Lower income and more deprived areas have also been shown to have higher COVID-19 case rates.[25]

Data Needs to Support Further Understanding

Individual-level data on additional socio-demographic characteristics among reported COVID-19 cases can also support focussed intervention to reduce COVID-19 infection. This includes collecting information about characteristics that potentially confound the association between a risk factor of interest and COVID-19 (i.e. to enable multivariate analysis and adjust for these factors). Toronto Public Health is exploring additional data collection and linkage strategies that could help to fill this current data gap.

5.4 **Science and Decision-Making**

Under normal conditions, a decision-maker in public health will collect data to understand the presenting public health problem, then find generalizable relevant knowledge (from scientific studies) that will provide guidance on, for example, the natural history of a disease, its distribution within the population by person, place and time, and the effectiveness of interventions that may prevent the disease or mitigate its effects.

In the case of COVID-19 – a new disease – there is little existing science to provide public health guidance. The evidence is also of low quality at present, being based by necessity on observational studies, with small numbers and short-term outcomes, but it is improving rapidly in quantity and quality. Also, COVID-19 has resulted in a reliance upon studies which have not yet undergone peer review, but which are published as "preprints", rather than waiting to publish in journals after a lengthy peer-review process. One such website – medRxiv – contains many thousands of articles, with more being added each day. While there are benefits in terms of making information available relatively quickly, there are also limitations in the absence of a comprehensive peer-review process and in many cases the findings should be considered preliminary.

The evidence may consist of a large number of studies, of varying quality and showing conflicting results. In order to generate an overall impression of the evidence for use in decision-making a process of evidence synthesis is necessary. Individual studies are located, assessed for quality and the strength and direction of effects examined. For COVID-19 this process is challenging: there are many small, contradictory and low-quality studies, with weak designs and multiple end-points. It has proved necessary to default to the "best available" evidence, including ecological (those comparing two populations, which may differ in many ways other than those of interest), and other observational studies. Several

universities across Canada, and some government research bodies, have come together to form the Evidence Synthesis Network, which provides simple, free and rapid access to evidence reviews. Toronto has requested and received reviews on three topics – the risks associated with singing; sudden loss of the senses of smell and taste as indicators of early COVID-19 infection and its inclusion in screening questionnaires; and technologies used in contact tracing. Public Health Ontario has continued its production of evidence reviews and the Technical Advisory Committee (TAC) of the Public Health Agency of Canada and the National Collaborating Centres for Public Health have also produced some. As evidence accumulates, it is often worthwhile to update previous reviews to incorporate new evidence.

New findings and the changes in recommendations that follow may be interpreted as a failure or a disagreement among experts. As evidence changes over time, policies must also change accordingly. The previous decision was not necessarily "wrong" – we must endeavour to make the best possible decision with the evidence available at the time.

Explaining how new decisions are based on new evidence should be part of the communications strategy. One must also understand what is knowable and what is not. It is not possible to predict how the pandemic might evolve with certainty, and the effects of policy measures will not be apparent until they have been in effect for some time.

In the absence of knowledge of how COVID-19 will evolve and the effectiveness of preventive measures, we must rely on inferences from experience with other infective organisms, and observations of the experience to date here and elsewhere in the world. Both approaches have limitations. SARS-CoV-2 – the virus that causes COVID-19 – is a coronavirus, and thus related to four coronaviruses that are a cause of the common cold, as well as to Severe Acute Respiratory Syndrome (SARS) and Middle Eastern Respiratory Syndrome (MERS). The resemblance of COVID-19 to any of these is remote: a cold is a very mild illness, SARS spreads mainly through aerosol-generating procedures in healthcare and MERS is not easily transmissible. There has been considerable debate concerning the mechanisms of transmission in COVID-19, although it is clear that spread by droplets is the predominant method, with transmission by direct contact with contaminated surfaces and airborne transmission playing a minor role. Knowledge about transmission is accumulated through observational studies, laboratory studies (e.g. of synthetic droplet/aerosol generation), simulation studies and cautious extrapolation from experience of other respiratory pathogens.

As physical distancing is one of our best defenses against the virus, and key to keeping people safe, affordable housing and shelters as well as safe transit (where people can abide by physical distancing measures) is very important. This would also help our essential workers maintain their safety and health.

Comment from Consultation

The collection of local epidemiologic data serves to generate a picture of the progression of the epidemic and the distribution of infection by age, sex, socio-economic status, place and time, severity, outcome, etc. Data are collected from service providers such as hospitals and laboratories, but richer data may be collected from infected persons through the case and contact management process. Other sources of data include testing sewage for the virus. Data on behaviours may also be useful – examples include mobility data from Google and data on the use of modes of transportation, retail sales, etc.

Epidemiological data may also be interpreted in light of similar data in other jurisdictions in Ontario, Canada and elsewhere. This is a challenge in that many factors other than the one of interest may also vary among the jurisdictions, so assuming a causal relationship is misleading.

Perhaps the most significant challenge in using evidence is arriving at decisions under conditions of uncertainty. We need to understand relationships between risk factors and the probability of infection, or the distribution of specific risks, or the effectiveness of preventive measures. However, we may have only one small observational study, a few studies with inconsistent results, studies with obvious confounding effects unaccounted for, or solely ecological studies.

The “precautionary principle” states that when there is some evidence of a significant threat to health, even though it is not conclusive, then action should be taken to protect against it. There is no consensus, however, on what constitutes conclusive evidence, or regarding other terms used in this context, such as "substantial" or "credible". Nevertheless, through debate and discussion among scientists, clinicians and public health practitioners, a rough consensus on most issues evolves, and it tends to favour the protection of health over other outcomes. These positions should, and do, evolve as more evidence becomes available. For example, the consensus position on the use of non-medical masks for source control by the general public has evolved from "don't use" to "recommended indoors when distancing is not possible" to "recommend in all indoor public places", to, eventually, "mandate in all indoor public places".

Gaining the evidence necessary to make rational decisions is particularly challenging for a novel communicable disease that is both highly infectious and severe – such as COVID-19. Early in the pandemic there is little evidence, for obvious reasons. At this point, it may be necessary to take action, and, in the absence of enough high-quality evidence, there is no choice but to invoke the precautionary principle and implement a wide range of restrictions and preventive measures. Unfortunately, it then becomes impossible to measure the transmission of the infection because relevant activities become prohibited. For example, the risk of playing or singing music is unknown because it has, until very recently, been prohibited everywhere. Decision-makers may also be influenced by reports in the news media and those which occur early tend to be repeated often and may exert a disproportionate influence. Such is the case with the outbreak in a choir in Washington State in April, resulting in 32 confirmed and 20 probable cases and two deaths among 61 members;[26] those outcomes may well have been confounded by prolonged social contact among the members. Progress in the understanding of transmission will depend on laboratory studies and the evaluation of the outcomes when one jurisdiction makes the first move to change their preventive measures: for example, Germany is leading the way in allowing concerts involving singing and wind instruments.

All policy making involves the balancing of risks and benefits, and of different interests. It is apparent in the current pandemic that avoidance of risks to health is highly valued, and that public opinion and the statements of political leaders alike demonstrate a willingness to rely strongly on the advice of public health officials. Nevertheless, attention must also be paid to balancing the benefits of public health measures against their adverse effects upon economic activity and the quality of life. Adding a consideration of a community's values to the scientific evidence to achieve this balance is the responsibility of elected officials rather than public health experts. The public health advice achieves its goals of maximum effectiveness and minimum adverse side effects if it is solidly founded on the best available scientific evidence. This involves a conscious effort to find, critically appraise, synthesize and apply the evidence.

5.5 **Public Health Strategy**

Throughout the course of the pandemic Toronto's Medical Officer of Health has been guided by three goals:

1. **To minimize loss of life**
2. **To conserve the capacity of the healthcare system**
3. **To minimize adverse effects on economic activity and the quality of life**

Originally conceived during the first days of the outbreak of COVID-19, these goals continue to guide public health activities during the recovery phase, although the balance among the three goals changes over time.

During the initial phase, "flattening the curve" was imperative. Drastically reducing contact between people by shutting down most activities outside the home reduced transmission. The message was to stay home and to limit time outside the home to only essential activities. Globally, at that time (spring 2020), severe outbreaks, particularly in Italy and Spain, were overwhelming the capacity of the healthcare system, with the result that many people in those countries were unable to receive treatment and the case fatality rate was high. There was a shortage of PPE and it was believed that a very large increase in the availability of intensive care beds and of ventilators would be required. The efforts to protect the healthcare capacity were successful in that healthcare facilities were not overwhelmed, although at times PPE supplies were marginal and staff endured long hours and stressful working conditions. All other activity by the health professions was suspended, except for emergencies.

After the peak of the epidemic, the transition to the recovery phase has been challenging. The intent is to slowly return life toward a sense of normalcy and to contribute to a return of economic activity while ensuring that infection rates remain low and manageable. After the shutdown in the early part of the epidemic, there has been a stepwise progress through the three provincial stages of reopening, with several weeks in between each stage, and careful monitoring of progress, so that progression to the next stage might be slowed or halted. As each business or activity was allowed to reopen, it was allowed do so only if protective measures were put into effect. That changed the approach from attempting to keep every person (or household) apart from every other person, to attempting to keep only vulnerable people sheltered away from others and allowing most of the population to start to move about more.

> **Public health programs need to be at the centre of reopening to curb spread of COVID-19.**
>
> Comment from Consultation

The second strategic element in Phase 3 is to maintain a capacity to follow up notifications of confirmed and probable cases and to interview them in order to identify all contacts, starting from two days before the onset of symptoms. Those contacts are then traced and required to enter quarantine for 14 days from the day of contact. Checks are made to verify observance of quarantine and to identify symptoms. By this means, it is possible to vigorously investigate both sporadic cases and outbreaks in order to control further rapid spread and manage numbers until they have been reduced to the level that can be effectively handled by the case and contact management system.

The third component of the strategy is to reduce serious outcomes, in particular by protecting vulnerable persons as much as possible. That includes those who might suffer serious disease were they to be infected – the elderly and those with chronic conditions, as well as those who are at high risk for infection because they live in crowded circumstances in congregate settings such as homeless shelters or prisons. Some are at risk in both of those categories, e.g. residents of long-term care institutions.

The final strategic component of recovery is the surveillance, monitoring and analysis provided by Toronto Public Health in order to provide data for making decisions about the public health management of the pandemic. This is particularly important in the context of a new disease such as COVID-19, as well as to inform the response to any resurgence in cases if and as it arises. As has been discussed previously, the epidemiology of COVID-19 has changed throughout the course of the pandemic. Understanding these changes in terms of progression of the epidemic and the distribution of infection by age, sex, socio-economic status, place, time, etc., supports decision-making to manage the pandemic.

5.6 **Reducing Transmission**

The basis of public health methods of preventing COVID-19 is to understand as much as possible of the biology and epidemiology of SARS-CoV-2, particularly how the disease spreads between persons. The virus infects the respiratory system, although we now know that it can also affect many other body systems. It is transmitted through breathing, speech, coughing and sneezing. All of these generate droplets of varying sizes, each containing particles of virus. Those with a size of greater than five microns are classified (by WHO and CDC) as droplets and smaller particles are called aerosols (or droplet nuclei). The droplets fall to the ground with a distance of about two metres (but farther in some cases or in some studies), but the aerosols, with each droplet containing 10 to 100 virus particles, remain suspended in the air, some for up to an hour or more, and are usually dispersed by air movement. Particle speed, evaporation, air flow, humidity and temperature all play a role in the distance virus-laden respiratory particles can travel after release by an infectious individual. SARS-CoV-2 is thought to be predominately transmitted through droplets, but some aerosol generation has also been observed. Aerosols are known to be generated by certain medical procedures (AGMP) such as intubation. However, in usual circumstances, the extent of aerosol generation, the load of virus transmitted by this means and its importance in spread of the disease are highly controversial.

The pandemic has caused more people to travel within their neighbourhoods and safely talk to neighbours. It would be great for the City to encourage people to spend more time outdoors through physical activity, and to get to know their fellow neighbours in order to create healthier and safer communities.

Comment from Consultation

At present there is evidence that there is some generation of aerosols in many circumstances, but there is little evidence that this is a significant mode of transmission. Overall, the risk of transmission from a case of disease to a contact ranges from 10 to 40 per cent for household contacts, seven per cent for sharing a meal, and only about 0.6 per cent for passing contact whilst grocery shopping, in one study.[27]

The virus has also been detected in feces, in 28 per cent of cases in one study,[28] although the extent to which this phenomenon contributes to the spread of disease is unknown.

There is also an indirect route of transmission, through surfaces and objects (fomites) that have become infected and which, when contacted, may transfer virus to another person when they touch the eyes, mouth or nose with unwashed hands. Virus has been detected on hard surfaces for up to six days after placement, but how much and whether viable is uncertain. Very large inoculums of 10^4 to 10^7 have been used, which would probably be unrelated to a real-life situation.[29] Survival is less on absorbent surfaces. Virus subjected to summer temperatures, humidity and sunlight has been observed to survive for only about seven minutes.[30] Epidemiological data on the transmission of COVID-19 by fomites cannot practically be obtained.

Virus is spread by some form of contact with an infected person, either symptomatic or pre-symptomatic. It is clear that transmission may occur from about two days before symptoms occur and for up to, commonly, about seven days afterwards, but sometimes much longer. It has also become increasingly clear that transmission may occur from those who never develop symptoms (asymptomatic). The incubation period (from acquiring the virus to manifesting the first symptoms of disease) is about five to six days.

It is from knowledge of these methods of transmission that public health interventions to prevent transmission are derived. Seeking to have all people maintain a distance of two metres between themselves and all other people (except, for reasons of practicality, members of the same household) reduces the likelihood of inhaling infected droplets, which rarely travel farther than that distance.

Transmission through fomites is addressed by means of guidance concerning respiratory hygiene and hand hygiene and avoiding contact with, and cleaning and sanitizing, surfaces. The most important element is frequent handwashing. Gloves are sometimes used and should be changed frequently, otherwise they may spread infection from one place to another. Frequent handwashing is often better than wearing gloves.

Respiratory etiquette consists of turning away and coughing or sneezing into the sleeve or shoulder; or using a tissue to cover the mouth and nose and then disposing of the tissue in a wastebasket, followed by washing hands or using hand sanitizer.

It is the second-order issues that require the most attention. How do we facilitate compliance with advice and provide the conditions to make continued adherence to the recommendations easier? The possibilities are many. Some measures may be put in place by retailers and providers of services, others by employers, but, most of all, spontaneously by members of the public. Other actions, regulatory in nature, are taken by the provincial government and the City. There is good evidence that much of the required change in behaviour will be accomplished by the public themselves, with or without action by governments. Comparison of data on retail sales and on mobility across the United States show that, regardless of early or late lockdown, or its extent, or the timing and pace of loosening restrictions, states showed similar changes in behaviours and the changes started before any official action. Similarly, comparisons of retail sales and mobility between Denmark and Sweden (Sweden took very little action to reduce risks) show little difference between the two countries.

In advising on preventive measures, especially those that restrict people's choices, the following should be considered:

- The burden of a proposed measure compared with the consequences of no action
- Achieving the objective by the least restrictive means
- Considering the possible inequitable distribution of the burden of preventive measures
- Assessing the potential for substitution by other risky actions

Reducing contact can be achieved by means in addition to requiring a two-metre distance. Strongly advising older people and those with medical problems to stay home except for certain essential trips is quite intrusive and burdensome but is justified by the high level of risk. However, it is challenging to find the best advice when many people who are older than 70 are fit and feel well, and many of them may even be employed or busy volunteering. Many workers, especially those normally working in offices, have been able to work from home. This is, of course, a particularly effective means of achieving distancing and has involved a large portion of the workforce.

Achieving spatial separation between those known to be infected, as well as their recent close contacts, and all others is important and is the justification for the self-isolation and quarantine prescribed by the case and contact management process.

Physical barriers, such as those made of Plexiglass, may be used when physical distancing is not possible. Little is known about their impact.

In cases where physical distancing may not be possible, other actions to mitigate risk have been introduced. For example, even though distancing is possible most of the time on the TTC/public transit during the lower ridership that has occurred during the pandemic, it is to be expected that, as ridership increases,

maintaining physical distancing will be challenging. The bylaw requiring a mask/face covering on the TTC aims to reduce the spread of COVID-19. Similarly, many workplaces have elevators, in which it is usually challenging to achieve distancing. Policies on masks/face coverings and restricting the number of people allowed on elevators are measures that are expected to reduce potential virus spread in these environments. Others who find distancing challenging include workers on assembly lines, grocery store workers, personal service and healthcare workers.

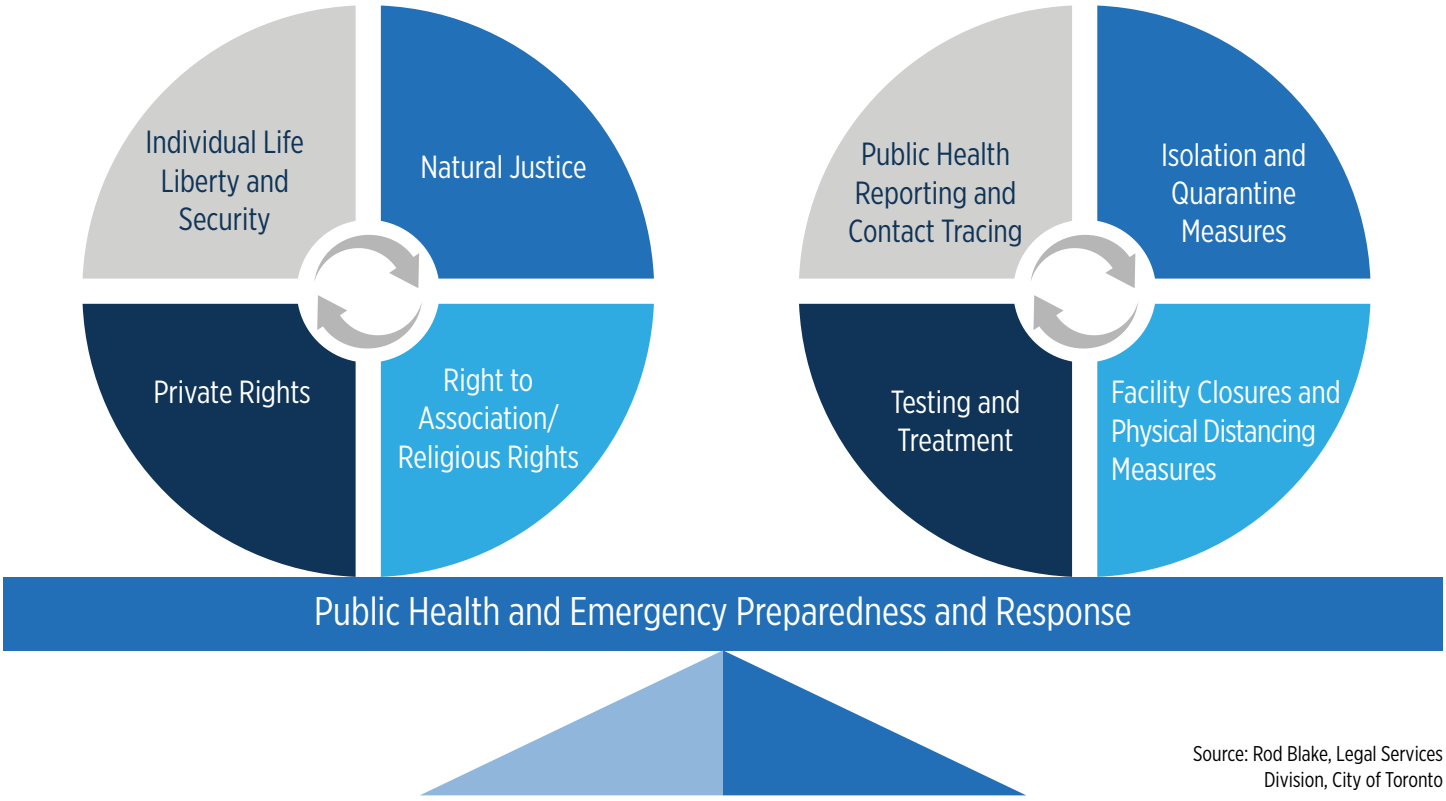
Cleaning and sanitizing regimes have been recommended, and some businesses draw attention to their elaborate protocols. While there are benefits to frequent cleaning of high-touch surfaces, the virus is short-lived in the environment.

Balance is vital in deciding upon measures intended to reduce transmission. The effectiveness of a measure may depend upon how burdensome or intrusive it is, or how difficult or expensive to implement. In some instances, there might be significant non-compliance. It may also affect some groups in society unduly or leave them without an alternative. The loss of one option should be balanced against the alternatives. Behaviours which are risky may be displaced to another activity. The feasibility of enforcement should also be taken into account. For the majority of measures, a reasonable level of public compliance might be expected, but, for some measures, it may be necessary to provide enforcement.

Throughout this process, it is essential to bear in mind that most measures intrude upon the autonomy of individuals. We must always balance individual rights against the public good.

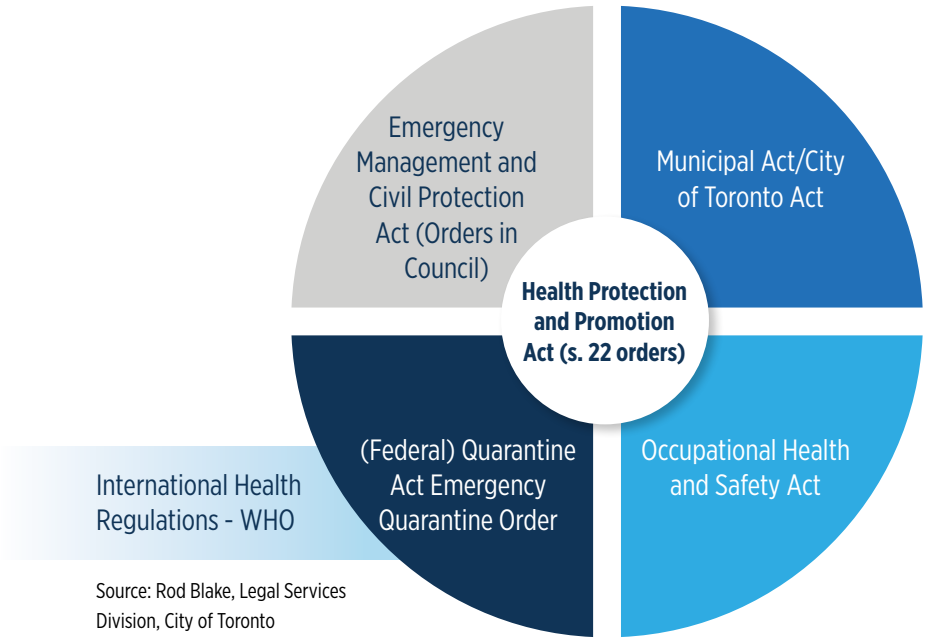
Deciding on the choice and exact wording of those measures that were mandatory in nature required extensive discussions with the City's Legal Services Division. Briefly, there are five broad areas of legislation available. There is variation in relevance, flexibility, practicality and ease of enforcement. The expectation is that most residents of Toronto would continue to follow the law, but occasionally, enforcement would be required. This approach, of course, works only if the requirements of the orders or bylaws are widely perceived to be reasonable and necessary, and if the efforts

Figure 14: Balancing individual rights and public interest in a pandemic



Source: Rod Blake, Legal Services Division, City of Toronto

Figure 15: The intersection of immediate legal jurisdiction exposed during a pandemic



Source: Rod Blake, Legal Services Division, City of Toronto

of all governments to combat COVID-19 generally continue to have the public's confidence.

The federal Quarantine Act that was invoked to close borders and to issue Mandatory Isolation Orders imposing a 14-day quarantine period on those entering Canada may be enforced by the RCMP and provincial and local police forces.

The Health Protection and Promotion Act, section 22, provides for orders respecting communicable diseases. During SARS, the ability to issue class orders was added. This enables the MOH to direct an order toward an entire class of people (e.g. those infected with COVID-19) and to direct them to take a stated action (such as not leave their homes for 14 days). Such an order was issued on April 1. These orders can be enforced only through application to a judge.

Once an emergency is declared under the Emergency Management and Civil Protection Act, the province can issue orders including in respect of the closure of non-essential businesses (Stage 1), followed by the gradual reopening of businesses and activities, under conditions set out in the orders (Stages 2 and 3). They have been applied at different times to different sets of health units, based on the progress in reducing the incidence to lower levels.

These have been the driving force and most important element of the population-wide measures to combat COVID-19. Some orders include a clause stating that the advice or instructions of public health officials must be followed. The CMOH has issued some documents labelled "Advice of the Chief Medical Officer of Health", and local MOHs have used this clause for, e.g. mandating facemasks. The legal position of this advice or instruction is not clear.

During this pandemic, the City of Toronto (under the City of Toronto Act) has enacted a bylaw requiring the wearing of masks or face-coverings in all indoor public places (by means of a policy and signage), and another adding certain additional restrictions to the provincial order for bars and restaurants. These may be enforced by bylaw officers or police.

Lastly, the Occupational Health and Safety Act, administered by the Ministry of Labour, Training and Skills Development, has issued many guidance documents for workplaces. In many circumstances, including businesses serving the public, employees would be subject to the provisions of the Occupational Health Act and the customers to those of health authorities. This has worked well, with some coordination between Labour and Health.

Some Examples

TORONTO TRANSIT COMMISSION

The TTC's ridership dropped dramatically early in the COVID-19 pandemic. People were working from home, or not working, or preferred to travel by car or by active means, and non-essential trips were not recommended. Ridership was as low as 15 per cent, but the service levels were kept at about 90 per cent, allowing riders to achieve distancing. There was concern that, as Toronto opened up, the maximum level of ridership consistent with the ability to maintain a two-metre distance, which was calculated to be 30 per cent, would be exceeded. Non-surgical masks or face-coverings were gaining favour as a means of source control (i.e. reducing dispersion of expired air and thus partially protecting others against transmission). While that approach was being considered provincially, it was decided to use the TTC's powers to enact bylaws to mandate the use of masks or face-coverings. The bylaw came into effect on July 2, 2020, accompanied by distribution of a million masks, mainly through existing channels used by low-income persons.

SCHOOLS

The reopening of elementary and secondary schools will not be examined in detail here, but the planning involves some of the same issues, but of course on a larger scale and with potentially serious consequences whatever the decision. The very significant need for children to learn and develop, intellectually, emotionally and socially, and the need for that to happen as much as possible in person, especially in the younger grades, cannot be ignored. A survey of parents by TDSB found that two-thirds of parents wanted their children to return to school in the fall, and three-quarters of students agreed (other surveys have yielded different results). That preference must be balanced against the potential long-term exposure of large numbers of children, with difficulties in implementing both the use of masks and physical distancing. The balance of the available evidence suggests that transmission among children, and between children and adults (in both directions) occurs at lower rates than between adults, especially for younger children,[31,32] although there is conflicting evidence and some recent evidence of outbreaks in schools in other countries.[33] One might also consider a stratified approach — where the school's catchment area has a high incidence rate (which frequently corresponds to high needs of other kinds), there is both a great need for in-person schooling and a higher risk of transmission. These schools might receive special consideration for additional protective measures, including smaller class sizes.

RESTAURANTS AND BARS

Restaurants and bars were closed as being non-essential businesses on March 17. Soon thereafter they were allowed to provide take-out/delivery service. In Stage 2, the use of patios for sit-down dining was permitted, with conditions such as maintaining distancing. Patios were presumed to be safer because of good air circulation and a warmer, more humid environment. Direct sunlight (UV) is known to reduce the viability of the virus on surfaces. One estimate is that the risk of transmission outdoors may be as low as five per cent of the indoor risk.

As Toronto was preparing to enter Stage 3, there was a wish to help all restaurants to return to full functioning, albeit still at a reduced capacity, and to increase employment. But reports were accumulating of very large outbreaks in many U.S. states, many of which were thought to have originated in restaurants and bars. There were also reports of large crowds assembling outside of some bars and/or on patios in Toronto, attracting large crowds of people who were not wearing masks and not distancing. Bars also combined several conditions probably associated with an increased risk of transmission: large numbers, potentially close contact, prolonged contact and being indoors. Toronto approached the provincial government offering advice about how to strengthen protections, and also brought in its own bylaw. The additional provisions include requiring patrons to be seated at all times, except when entering or leaving, visiting the washroom or paying; requiring masks, except when eating or drinking; specifying a cap of 100 on the total number of patrons, limiting the capacity of tables to a maximum of ten; and requiring the restaurant to record the name and contact information of at least one diner from each party in order to assist contact tracing, if necessary. These elements are now all present, some in the amended order and some in the bylaw.

The original thinking had been that bars were a particular concern because people in bars mingle and drinking alcohol might enable/encourage mingling. It is impossible to distinguish bars from restaurants, e.g. for licensing purposes. Rather than attempt to regulate the premises, it is potentially more effective to regulate the behaviour. Hence the attention to being seated, rather than wandering freely throughout the room which should give some assurance of maintenance of distancing. Closing restaurants and bars should be avoided, not least because there is ample evidence that risky behaviours would be transferred to parties in houses or on beaches, on boats and so on.

5.7 **Public Use of Masks and Face Coverings**

Since the beginning of the COVID-19 pandemic, Toronto Public Health has monitored the growing body of evidence regarding the effectiveness of non-medical masks/face coverings to prevent the spread of COVID-19. The evidence regarding a non-medical mask's ability to protect a person from COVID-19 infection is not definitive but it does suggest that a mask can act as a barrier to prevent the spread of respiratory droplets to other people from someone coughing, sneezing or talking while wearing the mask. Also, scientific models suggest that broad adoption of even relatively ineffective face masks may meaningfully reduce community transmission of COVID-19 and decrease peak hospitalizations and deaths.[34] It has also been postulated that more widespread wearing of masks in public may act as a visual cue that public health measures are still required. It signals that the COVID-19 pandemic is ongoing, that resurgence of local disease activity remains a threat and that everyone's vigilance is required.

This evidence on use of non-medical masks, particularly given the evidence of COVID-19 transmission by asymptomatic and pre-symptomatic cases, although inconsistent, supports the utility of universal public face mask policies to prevent the spread of the virus, including from those who are unknowingly infected. The use of a mask or face covering is therefore an inexpensive and non-invasive measure that may help prevent the spread of COVID-19.

A government-mandated intervention on personal decisions must be of demonstrable and significant benefit to public health and safety. Overall, Torontonians have complied with numerous public health measures that have, to varying degrees, restricted liberties during the city's response to COVID-19, likely prevented further economic hardship, supported social cohesion and saved lives.

The growing body of evidence of the effectiveness of non-medical masks, along with local normative social trends, have informed and led to City-mandated mask/face covering policies that have gained widespread compliance from the public. This acceptance may be facilitated by events globally, as there are currently more than 100 countries that have adopted some form of legislation for universal public masking.

Toronto Transit Commission Policy

Effective July 2, 2020, masks or face coverings became mandatory when on TTC premises or vehicles. The TTC Board voted unanimously to pass the policy on the recommendation of the TTC CEO and Toronto's Medical Officer of Health.

City of Toronto Bylaw

On May 28, 2020, City Council requested a report to the June Council meeting on the ability of the City to require the wearing of masks or face coverings by the public. At the June meeting, the City Solicitor's report was considered. The best option appeared to be Council's general authority to legislate for the health, safety and well-being of persons in the City. The Medical Officer of Health's report acknowledged the growing body of evidence on the effectiveness of masks to act as a barrier to prevent the spread of COVID-19, suggested that as Toronto continues to ease public health restrictions, additional public health measures such as masks should be considered to prevent a resurgence of COVID-19 cases, and recommended that City Council enact a temporary bylaw requiring the wearing of face masks/coverings in enclosed public settings.

Effective July 7, 2020, the City of Toronto enacted a bylaw requiring the use of masks or face coverings in indoor public spaces, until October 1, 2020, unless extended by City Council. It applies to all places accessible to the public, including retail businesses and services. It was later amended to also apply to the common areas of apartment buildings and condominiums. Exemptions for those who cannot wear a mask for medical reasons, children under age 2, and other reasonable accommodations are included in the bylaw.

5.8 **Case and Contact Management**

Case and contact management is an essential component of the response to COVID-19. Through this process, public health staff contact the person who has tested positive for COVID-19 to monitor their symptoms, ensure they are self-isolating, and identify and notify their close contacts so as to limit further spread of the virus.

The basic reproductive number (R_0) for a communicable disease is the number of people infected by each case of the disease. For COVID-19, it is generally accepted to be in the region of 2.5 – that is, each person with the disease will infect, on average, about two and a half others, although higher values have been reported occasionally. It is thought that infectivity is not evenly distributed, so that about 10 per cent of cases account for about 80 per cent of transmission. Of course, these numbers depend on particular circumstances but represent the average in the base case, i.e. before any preventive measures are put in place. In the presence of preventive measures, the reproductive number (now called the effective reproductive number – R_t) will fall below 2.5. When it falls below 1.0, the number of infections will gradually decline. Achieving an R_t of less than 1.0 is therefore an objective of public health efforts against COVID-19.

This decline can, of course, be accomplished purely by population-level interventions aimed at preventing the acquisition of infection generally. A case-based strategy, on the other hand, attempts to find cases as early as possible and then isolate them from all others so that the virus cannot find a new host. It is important to understand that population-based measures can drastically reduce the number of cases but will not hold them down to very low levels. Case and contact management works well to keep numbers low, and to prevent outbreaks from getting out of control, but, when numbers once again rise quickly, the capacity to follow up all cases quickly becomes insufficient. This has been seen recently in some American states.

The "generation interval" for COVID-19 (the average time between generations of cases) is about five days.[35] One case might therefore, when the R_0 is 2.5 give rise to more than 2.5 cases in five days, and 15 in 15 days. Were all of those cases allowed to spread the disease without any preventive measures, the numbers would soon be beyond control. Where policy measures are not fully effective, or where, against a background of a few cases each day, an outbreak occurs, case and contact management is essential.

The efficacy of case and contact management appears to be demonstrated by success in controlling the disease in Iceland, Singapore, Taiwan and South Korea, although some of these countries have experienced a second wave. The consensus is that it is most effective when started early in the progress of an epidemic. It is not possible to provide a strong enough case and contact management program to make a difference once the circulation of the virus reaches high levels. Successful control is unlikely unless it is possible to implement, and continue, a program that is able to contact and test all cases and all contacts. The methodology differs little from that employed for other communicable diseases, but the volumes of cases and contacts are unlike anything experienced by public health in the past. The main challenge to effective case-based control efforts is achieving sufficient scale. Wuhan (China) employed 9,000 for a population of 11 million. Massachusetts hired one thousand extra staff (15 per 100,000).

Overview of the Case and Contact Management Process

When a person is tested for COVID-19, the test sample is sent to a laboratory to determine if it is positive for the virus that causes COVID-19. Under the provisions of the Health Protection and Promotion Act, cases and suspected cases of COVID-19 are reportable to the local health authority. Toronto Public Heath's case and contact management process begins when a positive lab confirmation of a COVID-19 case is received. Public health investigators then immediately contact those newly identified with COVID-19 (i.e. the "case") to:

- Ensure the person is appropriately isolated;
- Identify close and non-close contacts of the person, dating back two days prior to the onset of symptoms and until the date the case is self-isolated;
- Follow up with all of the contacts identified to ensure they self-isolate (close contacts) or self- monitor (non-close contacts) for 14 days and provide education and instruction on when and how to seek medical care, if necessary;
- Follow up with the case for 14 days to monitor symptoms as the person recovers, ensure they continue to isolate, and answer any questions.

Case and contact management is labour intensive and complex. The number of contacts for each COVID-19 case can vary depending on individuals' living, working, and social situations. As the number of cases in Toronto increased over the course of the pandemic, the scale of case and contact management also increased, particularly when the number of new cases was more than 200 a day. In the early stages of the City's response, Toronto Public Health had 50 staff assigned to the case and contact management team. That team was gradually expanded to include approximately 550 staff, mobilized by redeploying staff from other teams and hiring additional nurses through the Registered Nurses Association of Ontario and other partners.

Various factors external to local public health authorities pose challenges to the case and contact management process. The most important of them is the delay between conducting a COVID-19 test and notification of the public health unit so it can begin the process of contacting the COVID-19 case. The test is performed at a hospital or testing assessment centre, and then sent to a laboratory for processing. The laboratory testing results are then shared with the ordering health care provider and the local public health unit where staff must review and extract results and then begin the investigation. The laboratory reports are typically received by fax, in one large report that can include hundreds of individual lab results. This process requires staff time to review, remove duplicates and follow up on any missing information needed to contact the case. Making this process more efficient to reduce the time between the testing and contacting the case is critical to reducing the spread of COVID-19. The sooner a case's contacts are informed of their potential risk and requested to self-isolate, the less the likelihood of further virus spread.[36]

When COVID-19 was at its worst we saw communities coming together in amazing caring ways. That is a strength upon which we can build.

Comment from Consultation

The provincial case and contact management database, called the integrated Public Health Information System (iPHIS), has been in use since 2005. It was found to be unsuitable for managing the high volume and rapid turnaround time required for case and contact management. In response, Toronto Public Health, in partnership with the Technology Services Division, developed and implemented a new system, the Coronavirus Rapid Entry System (CORES). This web-based system has increased the efficiency of the case and contact management process at Toronto Public Health. CORES has been developed with the ability to link Toronto Public Health directly to the Ontario Laboratory Information System (OLIS) resulting in additional improvements to the process. TPH has also implemented a pilot to locate TPH staff at assessment centres to rapidly assign positive cases to a case contact investigator; streamlined work processes from receipt of lab slips to entry into CORES; and expanded the use of CORES to institutional cases.

Toronto Public Health has been in active discussions with the province to improve case and contact management through policy, laboratory and IT solutions. In response, the province has launched a number of collaborative working groups and some improvements have already been implemented. The most significant of them has

been the introduction of a new case and contact management information system – CM-Salesforce. This system provides the ability to link with OLIS and offers other process improvements. There are plans for TPH to adopt this system eventually.

A further challenge is that self-isolation may not be feasible or safe for some individuals. For example, people experiencing homelessness face challenges in accessing space to enable safe and effective self-isolation. In response, Toronto has established three isolation facilities for people experiencing homelessness. In collaboration with federal and provincial partners, the City is also developing a voluntary isolation facility to support people who cannot properly isolate at home, such as those in housing that may be crowded or otherwise have insufficient space to properly distance from household contacts.

Technological solutions addressing the need for high-volume contact tracing are of interest: smartphone-based apps can detect proximity to other devices with the same app and can notify either contacts or the authorities and notify users of proximity to confirmed cases. They can also be used to monitor compliance with quarantine. There are also systems that use GPS location instead of proximity. The technology raises issues of privacy, with some controversy in France, Germany and the UK; it remains to be seen whether this technology will be as acceptable in Europe and North America as it is in Asia. The system developed jointly by Google and Apple leaves data on the smartphone, and thus addresses the privacy issue. There are also reports from South Korea that fatigue eventually sets in and messages are ignored. The Trace Together system used in Singapore is voluntary, and does not share data with the government, but only 20 per cent of smartphone users have installed it. Fraud and spam are also concerns related to the use of these technologies.

These systems can provide benefits in terms of speed of response and unlimited capacity. Their impact has, however, been disappointing in practice, and, apart from a few countries that were early adopters, the use of phone apps of this kind has not spread widely. The fundamental problem for proximity-based systems is that they are only effective if a large proportion of the population uses them. The largest uptake was in Iceland, at 38 per cent,[37] but contacts are recorded only if each user has the app installed and working and their smartphone with them and turned on. Other countries have much smaller use rates (Singapore is next at 28 per cent) so the chance of two apps being in proximity are not high.

Ontario has been a lead partner in the development of a system by the Government of Canada, which is offering a free app that can be used on Android and iOS devices. This app was released in late July as the COVID Alert app. It will require a great deal of promotion if it is to achieve the market penetration with the potential to make a significant difference to contact tracing. It will also require those with a diagnosis of COVID-19 to agree to provide access to the records on their phones.

There are simpler technologies that might be useful to case and contact management, especially if volumes again become challenging. It might, for example, be feasible to use automated telephone call technology for some follow-up calls to contacts.

5.9 **Testing**

Testing for the COVID-19 virus using PCR (a molecular testing technique) is essential for diagnosis of symptomatic cases and for confirmed and presumptive cases being released from isolation. It is now being extended to testing contacts and might in the future be used to screen workers in high-risk settings (something that would require frequent repetition). It was a matter of concern that Ontario at one time had the lowest rate of testing of any province or territory – about half that in Quebec. That situation in Ontario slowly improved until 20,000 to 30,000 tests were performed daily as of July 2020.[38] As well as the capacity for much wider use, there is a need for quicker turnaround and for point-of-care testing, possibly using samples other than nasal swabs. The system is considered complex and a well-running supply chain is essential.

Provincial targets for the turnaround of tests and their reporting were set at 60 per cent within 24 hours and 80 per cent within 48 hours. Those targets have never been met for Toronto tests and achievement is currently running well below target in spite of concerted efforts. This efficiency challenge may well impact the effectiveness of case and contact management and surveillance efforts.

The development of testing for antibodies is in its early stages. Even the better tests have sensitivities around 93 per cent and specificities from 93 to (allegedly) 100 per cent. While useful for population studies, these validity data (given the low population prevalence of antibody) would lead to too many false positives and false negatives. The former would provide false assurance of immunity, and the latter would lead to unnecessary exclusions from contact. A high specificity is essential. It is not yet known whether the antibodies detected provide effective immunity, whether there are cross-reactions with antibodies for other coronaviruses, or how long immunity lasts.

If there is COVID-19-specific long-lasting neutralising antibody, suitable tests would be useful to indicate immunity. There have been suggestions that this information might also be incorporated into so-called Immunity passports or certificates, possibly held as a verified QR code on a smart phone and used to indicate suitability for work by healthcare/long-term care workers or others. The feasibility and effectiveness of such systems remains to be proved.

There are other proposals to initiate or pilot schemes for periodic mass testing of, for example, workers or students in order to reduce the chances of pre-symptomatic individuals transmitting the virus, but it is too early to form a firm impression of their value.

5.10 **Screening**

Screening for symptoms of COVID-19 is an important and routine part of efforts to reduce risk. Passive screening is usually in the form of a poster at the entrance to a business, service or event listing the symptoms (information displayed may also include contact with a case, recent foreign travel or being under an order to self-isolate or quarantine) and asks that persons with one or more symptoms not enter. Active screening requires that those seeking entry respond in the negative to each symptom, orally or by checking boxes on a questionnaire. Active screening is used mainly in high-risk circumstances or for staff in restaurants, personal service settings, etc.

The symptoms of COVID-19 are quite non-specific overall, so many people who turn out to have other infections may inadvertently be refused entry. One exception is the sudden loss of the senses of taste and/or smell, which occurs in about 40 per cent of COVID-19 cases, usually early on, but rarely occurs otherwise. Including that symptom in the list of symptoms increases the sensitivity (correctly identifies more cases).

The effectiveness of screening questionnaires is potentially limited by dishonest or negligent answers. More importantly, questionnaires will not detect pre-symptomatic and asymptomatic cases. There is no good evidence of effectiveness.

Screening of temperature is sometimes used; however, the evidence suggests that the performance is poor;[39] cases may not have an elevated temperature when screened, and the measurement of body temperature by no-touch devices such as infra-red thermometers is erratic.[40]

5.11 **Communications**

Communicating with the public has already proven its worth. So far, the messages have been simple and frequently repeated – the "brand" for the current control measures – typified by the "stay the blazes home" comment of Nova Scotia's premier.

As the recovery progresses, the messages are more complex and nuanced. Some people disregard the rules—it would be helpful to understand their motivations in order to craft/deliver more effective messages.

5.12 **Public Health and the Recovery**

The Province of Ontario and the City of Toronto each have a role to play in leading the population of Toronto through the entire COVID-19 experience in order to simultaneously protect health while enabling a vigorous recovery from the social and economic effects. Roles and responsibilities are noted earlier in this report (section 4.2).

In late April, the provincial government released "A Framework for Reopening our Province". That report laid out principles and proposed actions for the emerging from the initial period of response to the pandemic. The period of the initial response, Phase 1, including the extensive closures of businesses and activities, was intended to "protect and support"; the second phase "restart" gradually loosened emergency measures, and the third phase "recover" was to rebuild the economy and facilitate economic recovery. The second phase (restart) involved gradually relaxing restrictions, allowing businesses to reopen and activities to move toward a more normal way of life. Lower-risk activities were re-introduced first, and throughout, conditions under which businesses and facilities may operate were set out in provincial orders.

The process regulated the sequence and pace of reopening, together with the conditions or required protective measures, in order to ensure, as much as possible, that there is no resurgence of disease. Phase 2 was divided into three stages, with progression from one stage to the next the subject of an order. This progression is a cabinet decision that takes into account the advice of the Chief Medical Officer of Health, which in turn, takes into account epidemiological data, advice from medical officers of health and the lapse of sufficient time to observe any adverse effects upon disease incidence.

The City of Toronto constitutes a large proportion of both the population and of the economic activity of Ontario. The City has an interest in the health and well-being of its population and in economic recovery. The balance between the interests and between the powers of Province and City is a delicate one requiring continual attention. After the Government of Ontario issues orders under EMCPA, the Chief Medical Officer of Health may provide additional guidance. Toronto Public Health has produced many documents providing guidance; these documents elaborate on the orders and CMOH advice as well as providing practical advice on options to meet the requirements.

The timing of provincial announcements has generally allowed little time for the City and businesses to prepare. TPH has developed guidance ahead of announcements, either to release upon the announcement, or, occasionally ahead of announcements in order to allow time for preparations (but with notice that some details may change).

The options for action on the part of the City are many and include using the existing public health powers in the Health Protection and Promotion Act (HPPA), such as a section 22 Class Order, that required all diagnosed or symptomatic persons and contacts to self-isolate. The order was issued by the MOH on April 1, 2020. This power is appropriate for specific and immediate threats to health but might be challenged if perceived to have been used to make policy. The City may make bylaws with respect to the health, safety and well-being of persons, and in July enacted a bylaw

that mandated business owners must have a policy and signage requiring all persons in indoor public places to wear masks. The Stage 2 Order (O.Reg 263/20), states, in section 4:

(2) The person responsible for a business or organization that is open shall operate the business or organization in compliance with the advice, recommendations and instructions of public health officials, including any advice, recommendations or instructions on physical distancing, cleaning or disinfecting.

This is the implicit authority for TPH's guidance documents and has been used explicitly by some other health units to mandate the wearing of masks in indoor public spaces.

The reopening of businesses under the orders is permissive – the City, for example, has the option to delay opening its services if it considers that delay the safer option, although the City generally follows the provincial schedule. The City may also modify programs, including online delivery and keeping staff working from home.

The Premier, the Toronto Mayor, the provincial CMOH and Toronto's Medical Officer of Health have all provided advice, including urging the public to take certain precautions. These communications may or may not be accompanied by a legal requirement. The "social circles" advice, issued to recommend that individuals limit the number of people they socialize with, for example, is voluntary. Overall, the public has responded well to the advice offered.

Public health officials at the Province of Ontario and the City of Toronto have also conferred through a variety of mechanisms and channels. The Public Health Measures Table has met twice weekly, bringing representative medical officers of health (regional chairs of the Council of Medical Officers of Health) together with the Office of the Chief Medical Officer of Health and Public Health Ontario. It reviews proposals for orders and guidance, in confidence, and provides advice to the CMOH. In addition to an Associate MOH, Toronto is also represented by the Public Health Consultant to TORR. Toronto Public Health is also represented on the Municipal Emergency Operations committee (MEOC) for consultations related to public health between the government and the Association of Municipalities of Ontario (AMO). Direct representation has also been made by Toronto's MOH and the Public Health Consultant to the CMOH Office, as well as through political channels.

The value of advocacy is illustrated by the regional variations in the stages of reopening. After the Stage 1 reopenings, Toronto and some other health units in the GTHA continued to have high case counts, while most other health units had only a handful of cases each week. The initial position of the provincial government was that all parts of the province should advance to Stage 2 at the same time. There was some trepidation that a difference in stage between areas might cause travel to adjoining municipalities in search of open businesses. The counter argument was that applying the same measures everywhere would either cause the

GTA to open too soon, risking a loss of control over cases, or would keep the rest of the province in the earlier stage too long, risking more economic damage. The GTHA MOHs developed their own dashboard of indicators and benchmarks at that point and argued for a regional solution, which was accomplished when most of the province entered Stage 2 on June 12, most of the GTHA on June 19, and Toronto and Peel on June 24, after consultations with MOHs. The municipalities of Leamington and Kingsville were experiencing a severe outbreak in camps for migrant farm workers and did not enter Stage 2 until July 7. Similarly, progression to Stage 3 was also timed to allow each health unit to be in Stage 2 for at least an equal amount of time.

The protective measures in workplaces are under the jurisdiction of the Ministry of Labour, Training and Skills Development, which has issued extensive guidance, industry by industry. In places where the public obtain goods or services, the occupational health guidance will apply to employees and the public health guidance to customers.

The local public input into the reopening of schools and post-secondary institutions flowed through the PHMT and were considered by the lead ministries: Education and Colleges and Universities respectively. TPH has been involved in the deliberations of the Toronto school boards and has also provided some advice to colleges and universities.

Reopening and Assessment of Risk

As businesses, facilities and activities are allowed to reopen/restart, there will be undoubtedly some level of risk. Preventive measures are intended to reduce this risk to acceptable levels, but it must be accepted that the risk cannot be eliminated entirely. The design of the measures starts with a rough estimation of the risk. This estimation is based upon what is known about the transmission of the virus in various circumstances. There may be a considerable error in the estimation of the risk, as there is much yet to be known about the transmission of COVID-19. It now appears to be the case that indirect transmission through surfaces is not a common (and may be a rare) mechanism, and that direct transmission through droplets is the single most important means of transmitting the infection. The occurrence of aerosols and their importance as a means of transmission remains controversial. In practical terms, it means that avoiding contact is crucial – numbers and proximity of contact, its duration, and being indoors are all important factors.

This assessment of the risk may be used to decide which businesses, activities and facilities should be opened in each stage, for each business to assess where its risk lies and where to direct mitigation, and as the first step in preparing guidance. The risk assessment indicates key areas for mitigation: for example, entering and/or leaving an event or establishment may increase the risk of contact. Mitigation measures most often include physical distancing, wearing masks as source control, avoiding pinch points by directing the flow of pedestrians, restricting certain activities, avoiding the touching of surfaces and objects by many people, cleaning and sanitation, and, if possible, recording attendance to facilitate follow-up if a case occurs.

The increased risks arising from reopening a particular business or activity must be balanced against the benefits, both social and economic. It is important to assess the net risk: sometimes not allowing an activity results in the substitution of another, or some other unintended consequence. The perception of risk by the public is also an issue. It is well known that risks that occur infrequently (e.g. in plane crashes) receive more attention than familiar everyday risks (e.g. motor vehicle crashes). COVID-19 is an unfamiliar risk with overwhelming coverage in the media. It will be important for the public to realize that reducing the risk of infection to zero is impossible in the short term, and any attempts to do so may increase the adverse effects disproportionately.

An example of the complexity of balancing risks and benefits was the decision on whether or not to operate children's summer

day camps. The program had to be heavily modified to allow for more supervision by means of a lower ratio of campers to counsellors, physical distancing, procedures for screening and managing children with symptoms, cohorting children, etc. This approach greatly increased costs, so that some private camps may have increased fees or chosen not to operate. Because of physical distancing, the available outdoor and indoor spaces could not accommodate as many campers. And, of course, there was a residual risk of transmission, and, even if children nearly always experienced mild disease, they could spread the infection to their families. That concern had to be balanced against the vital importance of providing opportunities for physical and developmental growth and social interaction and growth, and also of providing fun for children who had been kept largely at home for many weeks. There was also a benefit for parents, who might be able to return to the workforce. These benefits were set against the net risk – not all children would spend the summer safely at home, but some might be amusing themselves in the neighbourhood, without the supervision they would receive at camp.

TPH has produced three fundamental guidance documents to guide reopening businesses, programs and facilities through risk assessment and mitigation measures. There is one for each of businesses, City facilities and services, and the voluntary sector. In addition, more specific advice, which explains and elaborates on any advice from the CMOH, is produced when the reopening presents a higher level of risk and/or is complex. Examples included restaurants, places of worship and children's summer day camps. There are also modular fact sheets of wider relevance, such as those on cleaning and sanitation. All guidance is posted on the City's website and is also sent directly, where possible, to affected parties, through mailing lists and business associations, BIAs, etc. Several webinars have been offered and they have been heavily subscribed.

Even with careful reopening, protective measures and case and contact management, there remains a level of risk for certain groups within the population which is unacceptably high. That includes people in congregate settings such as long-term care facilities, homeless shelters, facilities for refugees, victims of violence, and children and adults with developmental disabilities, and prisons. It also includes those with a risk for poor outcomes – specifically the elderly and people with certain chronic medical conditions. (The issue of more general inequality of outcomes is discussed elsewhere.)

The congregate settings experienced high rates of infection and deaths before control over transmission was gradually established. Provincial orders prohibited staff from working in more than one institution, streamlined certain routine reporting requirements, and placed some homes under direct provincial control, increasing wage rates and eventually securing the assistance of military personnel for particularly hard-hit homes. The City arranged and obtained financial assistance for the use of hotel rooms to reduce the occupancy of homeless shelters enough to allow for physical distancing. Those arrangements will be necessary for the duration of the pandemic. The safety of congregate settings will depend on careful control of admissions and transfers, testing, adherence to distancing and sanitation measures, and vigorous response to outbreaks. Toronto Public Health has deployed a team to address outbreak management, case and contact management, and infection prevention and control in long-term care facilities.

The COVID-19 Monitoring Dashboard

It is possible to collect a great deal of data concerning the spread of the virus and when and where people become infected and the outcomes. Toronto Public Health may collect these data directly or obtain them from others such as Public Health Ontario or Ontario Health. The data can be collated and analyzed in many ways; a priority is to calculate and present a small number of key indicators relevant to the goals and to the timing of progress through the stages of reopening, then presenting them in a dashboard format. One set of indicators and targets has been agreed for all health units in Ontario.

Toronto developed and released a dashboard of these key indicators in June 2020 to provide a progress assessment of COVID-19 response. These indicators are organized into the following categories: virus spread and containment; laboratory testing and lab testing trends; health system capacity; and public health system capacity. Each category is assigned either a red, yellow, or green colour to reflect current status. Figure 16 provides an example of the COVID-19 monitoring dashboard.

Figure 16: COVID-19 monitoring dashboard examples

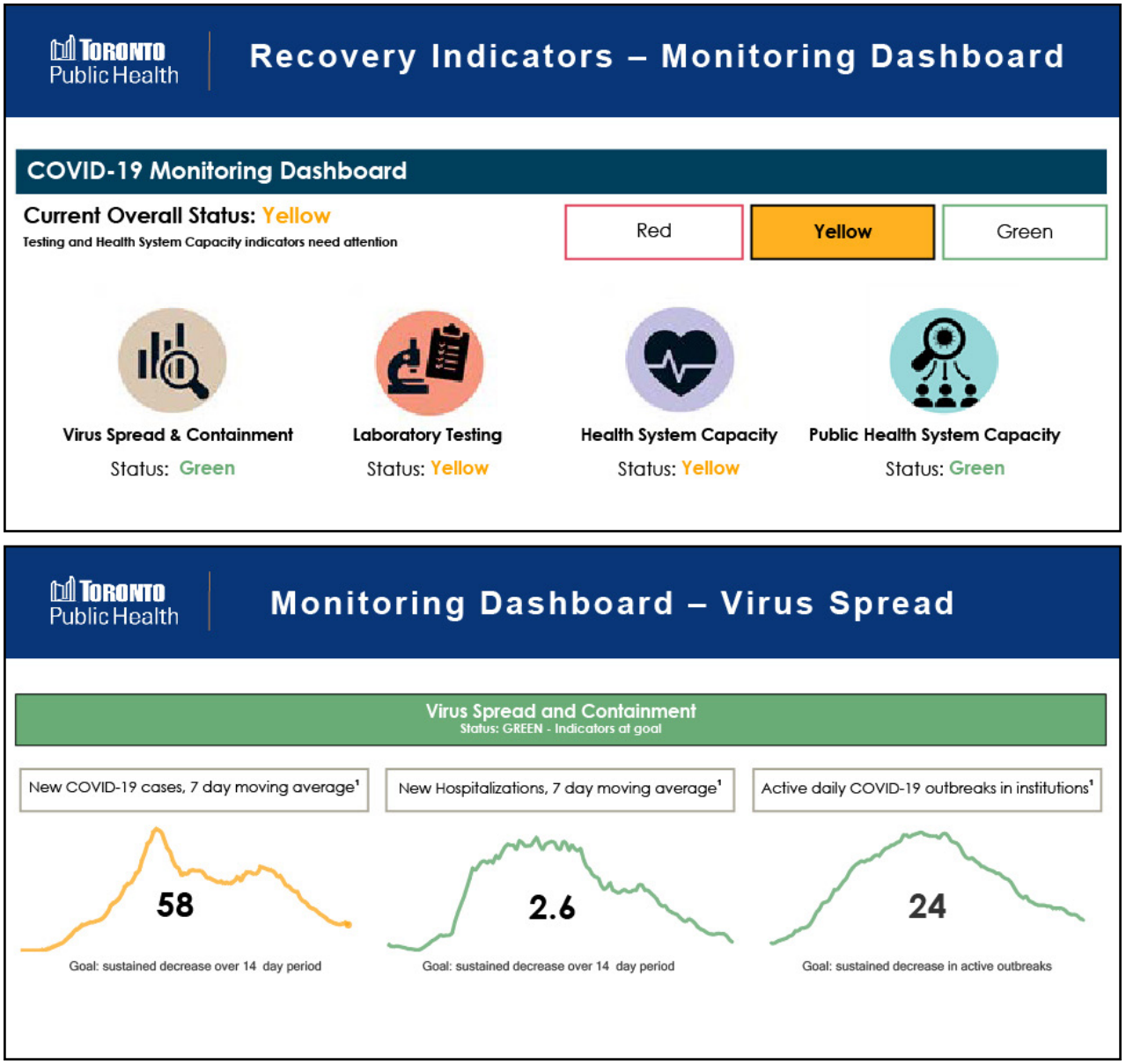
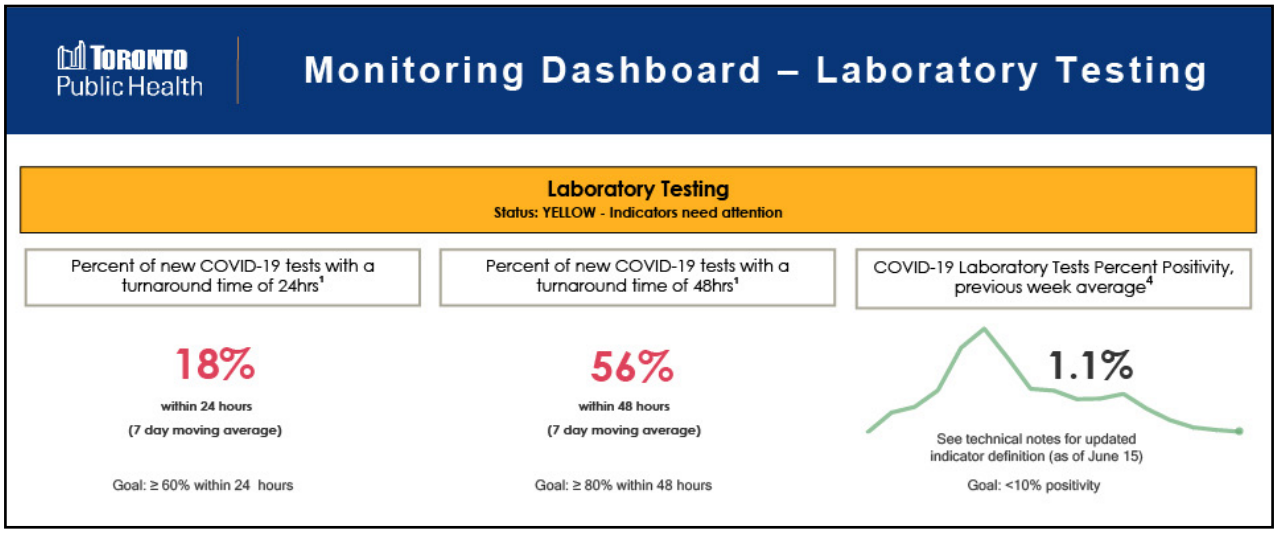
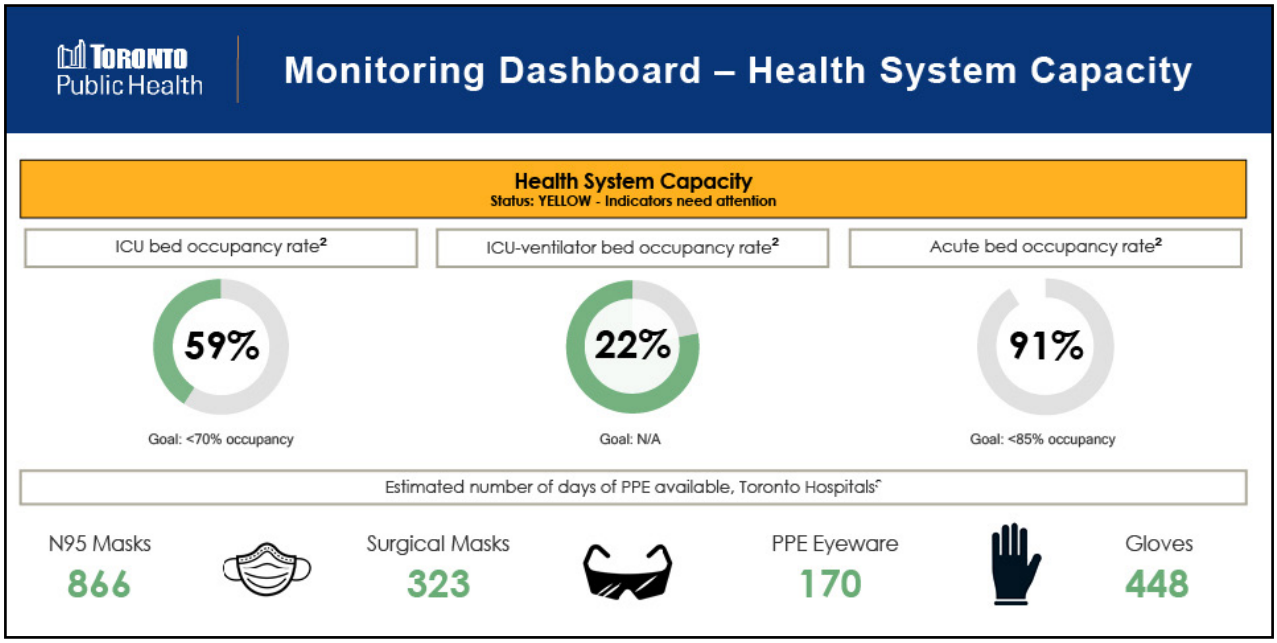
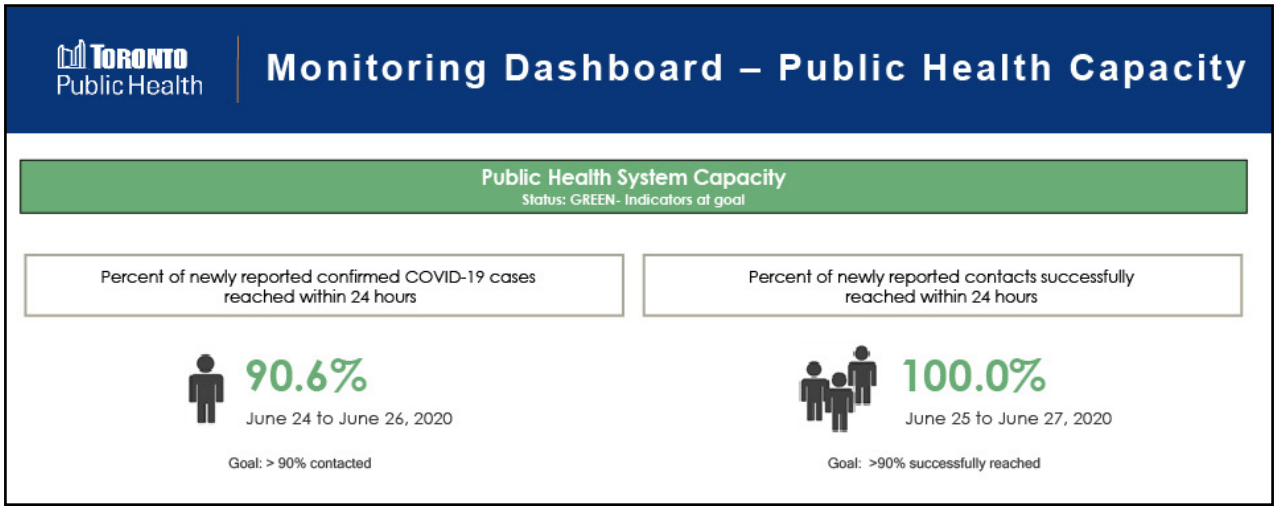


Figure 16: COVID-19 monitoring dashboard examples







5.13 **Long-Term Care**

The elderly and infirm people in long-term care (LTC) facilities and retirement homes, in Canada, Ontario and Toronto were affected severely by COVID-19. In the Greater Toronto Area, LTC residents were 59 times more likely to be infected than the general population and the case-fatality rate was 26.3 per cent. Adjusting for age and sex, this represents a case fatality rate from COVID-19 1.4 times that of the general population.[41] An Ontario-wide study[42] calculated a mortality incidence ratio of 13.1, compared to the community-living population 70 years of age and more. Staff were also infected: 38 per cent of all infected healthcare workers worked in LTC (this figure is an underestimate because not all workers in LTC were included from the beginning).

Canada does not fare well in international comparisons: the average proportion of all deaths occurring in long-term care (June 4) in 26 countries was 47 per cent, but in Canada was 85 per cent – the highest of any country studied.[43] The report of the Canadian military units called in to assist in LTC homes whose staff were mainly unable or unwilling to work revealed some shameful conditions. Canada spends less than the OECD average on LTC and has fewer than half the workers per 100 residents as Norway.[44] LTC workers suffer low wages and many (until the practice was banned) worked at more than one home, thus potentially spreading the virus. Turnover of staff is high. Canada's figure may be slightly inflated because some jurisdictions included all deaths occurring in LTC settings during the period, not just those with a diagnosis of COVID-19. The figure for Toronto is 67 per cent.

At one point, all City long-term care homes reported residents and/or staff with the virus. TPH provided assistance in managing outbreaks; expert infection prevention and control (IPAC) advice was supplied by hospitals.

Provincial orders raised wages and prohibited working at more than one facility, but more attention and investment will be required in the future. As the population of elderly and infirm persons increases, 78 per cent more LTC workers will be needed over the next 20 years (keeping the current staffing ratio).

Short-term action can be taken on wage rates and inspection and enforcement. Long-term improvements are not specific to COVID-19 or to other infections but should address the quality of life in the present facilities as well as their safety. Most importantly, the system must develop alternatives to LTC facilities for many who will need some form of care. It has been estimated that 40 per cent of LTC residents in Canada might be able to stay home if provided with the right supports.[45] Many options have already been discussed in Ontario and there are many examples of effective, innovative programs in Europe and elsewhere.

Why were Toronto's numbers so high?

Toronto has accounted for a high proportion (39 per cent) of Ontario's cases of COVID-19,[46] although its experience was not as severe as that in some other jurisdictions. Although Toronto's numbers were partly a consequence of its population, it did have a higher incidence rate than that for the province overall. It is commonly held that this situation is a consequence of Toronto's population density, but a review of rates across the world does not show a consistent association between population density and incidence rates. Some studies[47, 48] have shown a weak association with density; another,[49] with better control of confounders, showed a slightly negative association with density, but a positive one with the size of the metropolitan area. This information suggests it is the quantity of interactions rather than density that is important. It is of note that Peel Region, with a density much lower than Toronto's, experienced infection rates almost as high.

Toronto was affected early: that may have been due to the presence of Canada's largest international airport and the importation of cases. In Toronto, the number of cases was slow to decline to the level deemed safe for progression to the later stages of reopening. After the large number of institutional outbreaks was brought under control, community cases remained significant for many weeks. An explanation for that occurrence is not readily apparent, but it may have been due to the total population, which was subject to some degree of mixing, and which extended to other parts of the GTA.

5.14 **Unintended Consequences**

Some of the direct effects of COVID-19 are well known – a range of acute symptoms ranging from none through mild illness, a combination of respiratory illness and general fatigue much like influenza, to acute respiratory distress and death. Admission to hospital is required in a minority of cases, or, for even fewer cases, the use of a ventilator. With more experience, there is more evidence of other effects – a cutaneous manifestation in children, thrombosis in various organs, and some long-term effects so far not well defined.

Those who are most affected by the direct effects – working in circumstances that present a high probability of acquiring the infection – are healthcare workers. In Ontario, 17 per cent of all COVID-19 cases occurred in healthcare workers.[50, 51] As of June 22, 2020, 13 deaths were reported among healthcare workers in Ontario.[52] There were 1,887 cases among healthcare workers in Toronto, or 60.5 per 100,000 total population – the highest incidence rate in the province (note that the denominator does not reflect number of workers). These data are possibly affected by high rates of testing for healthcare workers and may be incomplete.

The attempt to prevent, and to a lesser extent treat, COVID-19 gives rise to a broad range of secondary effects. These effects are caused directly by the preventive measures, by the public's perceptions of risk, by the stress of isolation, by the suspension or reduction of services or by other means. Although they are usually adverse effects, they occasionally have a positive impact; and they may be temporary or long-lasting.

The widespread side effect of the lockdown and subsequent measures has been a loss of access to goods and services, and also of social opportunities. Changes in service delivery, the economic impact and issues of equity are discussed elsewhere in this report. For many people, the restrictions have been an irritant, to which there has been some adjustment, facilitated by online purchases and access to services, and the increased use of social media. This loss of utility has gradually improved as businesses and facilities reopen. The pandemic has also been a period of suffering, including for those already experiencing social isolation or mental health challenges, and likely compounded by a loss of access to treatment and support services.

The necessary protective measures' effects on the economy have been severe: between February and May 2020, 3 million Canadians lost their jobs and 2.5 million worked reduced hours, although there has been some recovery since then. The effects of changing employment patterns have had a differential impact on some groups. An example are the differences among groups in the feasibility of working from home and the implications it has on income during the pandemic and recovery, as well as the ability to reduce exposure to COVID-19 by complying with physical distancing requirements. The feasibility of working from home in Canada is greater for people with higher incomes and higher educational attainment.[53, 54]

Data are only now starting to become available, and there can be little doubt that changing employment patterns has had effects upon health. Those already in low-paid and/or tenuous employment, and the already-stretched owners of small businesses have been affected more than others. About four in 10 Canadian workers are in jobs that can be done remotely, but lower-paid workers are less likely to have that option available.[55, 56] We have seen, or can expect to see, impacts upon both mental and physical health.

I would like the City to address the issue of seniors housing by taking the following actions: securing financial support from higher levels of government, and make the city better in the following ways by providing safe, affordable and well managed senior housing options for the aging population.

Comment from Consultation

Food insecurity can be expected to become more prevalent during the pandemic, particularly given impacts on financial stability. A survey conducted by Statistics Canada in May 2020 found that almost one in seven Canadians indicated that they lived in a household where there was food insecurity in the last 30 days,[57] and it was higher for those in households with children than those living with no children. When compared to a previous survey, the results showed higher food insecurity during COVID-19 than a comparison time period in 2017/2018 (14.6 per cent versus 10.5 per cent). Many food bank programs closed in Toronto during the pandemic and nutrition programs based in schools have not been available due to school closures.

National surveys have revealed the mental health impacts of COVID-19. A survey in Canada (crowdsourced, so it may not be truly representative) found that about half of participants reported their mental health was either "somewhat worse" or "much worse" since physical distancing began.[58] Youth were the most likely to report worsening mental health. There is additional evidence to suggest that physical distancing is associated with negative impacts on mental health including stress and anxiety and that these effects are exacerbated by a longer duration of quarantine, infection fears, frustration, financial loss and stigma.[59] The potential for loss of employment, and the need to make alternate arrangements for child care and to supervise home learning, may contribute to increased levels of stress and anxiety, and those with fewer social supports can be expected to be particularly affected. It remains to be seen whether previous experience of the association of sudden loss of employment with increased rates of suicide will be borne out.

International data show an increase in reports of domestic violence (no data for Toronto currently available),[60, 61, 62] but that finding is inconsistent as a result of some reduction of services or other causes of a decrease in reporting. Pre-existing problems might have been exacerbated by unemployment and financial stress, enforced proximity for long periods, lack of child care and loss of supports. There have also been suggestions that long hours online might increase the risk of sexual exploitation.

In order to conserve beds, staff and personal protective equipment (PPE) for those suffering from COVID-19, hospitals drastically reduced their other services. Emergencies and obstetrical care continued, but all non-essential and elective services were discontinued until gradual resumption was permitted at the end of May 2020, according to specific operational requirements provided by the Ministry of Health. The offices of doctors, dentists and other health professionals were also closed for many weeks. Decreased vaccination coverage has been reported, likely influenced by the difficulty in accessing health care providers and public health programs. The vaccination situation will require a considerable program of catch-up immunizations in the future.

There has been a perception that medical care would be unavailable, or should not be accessed, or that it might present a real risk of contracting COVID-19. As a result, fewer people sought care for acute medical conditions. For example, research in the United States found a decline in emergency department visits during COVID-19 for acute conditions including heart attack and stroke.[63] An analysis of data from cardiac centres in Ontario identified a nearly 30 per cent reduction in visits to emergency departments for serious heart attacks between March and April 2020 compared with the same time period in 2019.[64]

Toronto Public Health was obliged to discontinue many services in order to redeploy staff to activities related to COVID-19. The list of discontinued services is long, and includes the Vulnerable Adults and Seniors Team, Investing in Families public health nurses, Healthy Babies Healthy Children, immunization clinics, sexual health clinics, most breastfeeding clinics, many environmental health programs and most dental programs. This situation constitutes an enormous loss in the future benefits normally flowing from these programs.

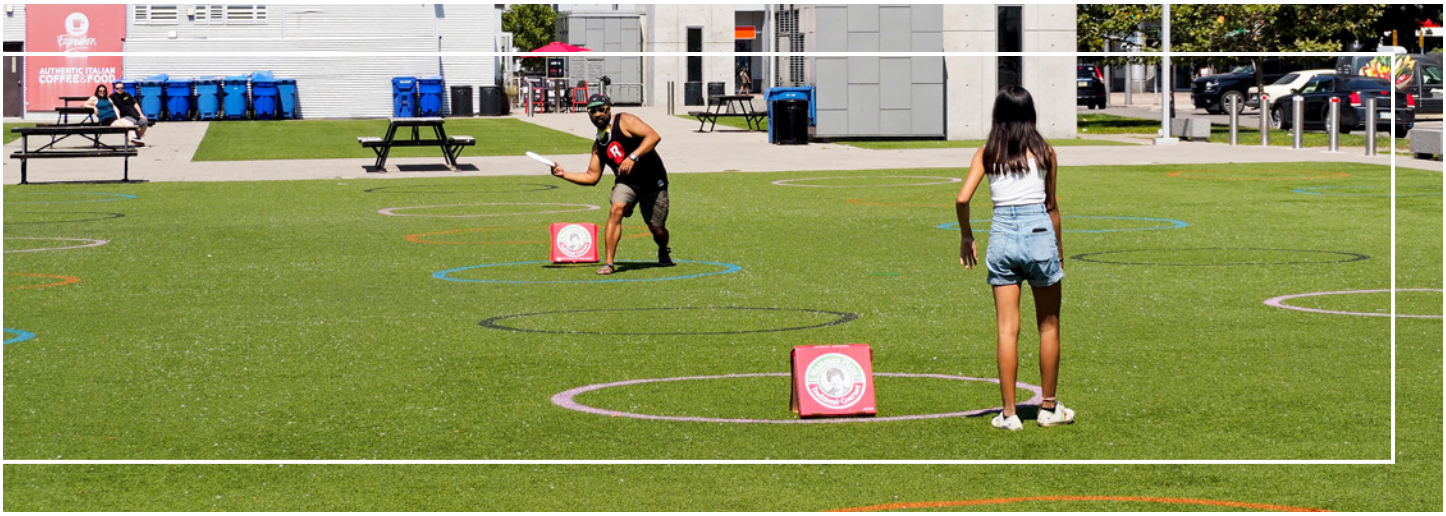
Current evidence suggests that children are less affected by COVID-19 directly than adults but are particularly at risk for the adverse effects of preventive measures. At an important time for growth, development and learning, the disruption of planned schooling and learning experiences has the potential for serious and perhaps lasting negative effects. Schools were closed as of the March Break. Online learning has not fully compensated for the cancellation of in-school learning, particularly in the earlier grades. Internet access is not available to all households; for example, approximately 94 per cent of Canadian households have internet access and of those that don't have it, the most commonly reported reason is cost.[65] Online learning for younger children also requires parental supervision. Providing it may be difficult for some families.

Licensed child care has been unavailable for several months and has reopened with reduced capacity. Summer day camps have opened late, with modified programs and reduced capacity, and overnight camps remained closed for the summer. This is a loss of valuable social and developmental experience, and children from disadvantaged circumstances will particularly miss out on the benefits it would have provided in a normal summer.

It is probable that there were changes in health-related behaviours during the initial lockdown phase of the pandemic, and that these may have persisted, at least in part. Data on these changes, however, are largely not available. Following advice to stay home is likely to have resulted in a widespread drop in levels of physical activity. Sixty-eight per cent of Canadians report more time spent online, 63 per cent more television watching and 22 per cent more time playing video games. Sports facilities, pools and athletic facilities and gyms have only recently reopened – and that also has had an effect on physical activity levels. All types of mobility fell at first, and most have recovered almost to prior levels, but the use of public transit has recovered only slightly and is still at only about one-quarter of the pre-COVID-19 levels. Using public transit is associated with higher levels of physical activity through the necessity of walking between destinations and transit stations or stops. It is clear, however, that cycling has increased. The City has increased the provision of cycling lanes and there has been a surge in sales of bicycles.

Evidence is emerging on the effects of the COVID-19 pandemic on substance use. Studies on alcohol use have found that trends in changes to alcohol intake are unclear; in some jurisdictions there are findings of increased use and in others decreased use.[66, 67] The Canadian Centre on Substance Abuse and Addiction found that 25 per cent of Canadians aged 35-54 reported increased alcohol consumption during the pandemic.[68]

A review on the impacts of COVID-19 on opioid and substance use noted that there is limited research evidence, however, the following effects were identified: reduced access to harm-reduction and treatment services; disruption to the supply of illicit drugs in Canada; and potential for an increased vulnerability for more serious effects of COVID-19 in people who use substances due to pre-existing conditions and vulnerabilities.[69] In British Columbia, there were 117 suspected illicit drug toxicity deaths in April 2020 and 170 in May – the highest ever in one month.[70]



The response to COVID-19 has produced some positive side effects. The City's Active TO program includes Quiet Streets (which enable physical distancing and encourage physical activity) and major road closures on weekends (which have received an excellent response from recreational cyclists). As part of Active TO, the City will also complete 40 kilometres of additional cycling lanes in 2020. Curb TO is a program to convert some curb lanes on City streets from car use to pedestrian use to facilitate distancing. The introduction of priority bus lanes on some high-use routes was recently announced. Overall, taking these programs together with Café TO, which promotes restaurant patios and simplifies and accelerates their approval, the effect is to move away slightly from a car-dominated urban form.

The COVID-19 experience has affected the City's approach to homelessness and shelters. Shelters are a congregate setting, in that persons from multiple families are living together in one dwelling. Long-term care homes and facilities for refugees, for victims of violence and for people experiencing physical and/or mental health challenges, as well as prisons and half-way houses, are also congregate settings. These settings present problems of an increased risk of transmission of the virus because of the difficulty of physical distancing, as well as an increased risk of transmission through shared objects and surfaces. For shelters, however, the risk is higher still, because of occupants being in close contact at all times.

Shelters were severely affected by cases of COVID-19. In response (as of July 20, 2020), the City created more than 30 new or expanded facilities, including 18 hotels and additional temporary sites (and in community centres, now returned to normal use) to accommodate people experiencing homelessness and allowing the shelters to provide more space for each resident. Other measures – screening, contact tracing, isolating symptomatic persons, sanitation, etc. were also put in place. The City also instituted a program of clearing encampments and providing those people experiencing homelessness with hotel accommodation. More than 600 people sleeping outdoors have been provided with interim accommodation. Altogether, 3,500 people have been moved to new temporary shelter places, hotel programs or interim or permanent housing. More than 1,300 have been moved into permanent housing through the Rapid Access to Housing Initiative, housing allowances and rent-geared-to income housing. This experience/achievement can form the basis for a continued program of providing for the homeless in the future.

Some changes resulting from efforts to contain COVID-19 have effects that are necessary in the short term but possibly harmful in the long-term. Businesses have switched from reusable containers and cutlery to disposables, and there has been an increase in single-occupancy car use as commuters avoid the use of public transit.

Overall impacts of the pandemic have included an acceleration of change, especially in the workplace, the economy (e.g. changes in the retail sector), in technology and in how services are provided, including those of all levels of government. A more complete and widespread understanding of inequalities, particularly concerning health and its determinants, may be one of the most important outcomes.

5.15 **Perspective**

Pandemics have occurred throughout history: examples include the Black Death (bubonic plague) in 542 and, most notably in 1345-48, right up to the end of the nineteenth century. A hundred years ago, the Spanish Flu epidemic of 1918-1920 killed at least 25 million people worldwide; more recently, in 2009, there was a H1N1 influenza pandemic.

From that perspective, COVID-19 is the most significant health event in a century. It has already infected millions worldwide and caused half a million reported deaths, as well as massive disruption of the economy, services, travel, the healthcare system and way of life. But there are perspectives that show different results. In British Columbia it is possible that there will be more deaths from opioid overdoses than COVID-19 in 2020. Deaths from circulatory diseases and cancer continue and will almost certainly each exceed deaths due to COVID-19 during 2020. Theoretically, although no good data are available, deaths from non-COVID causes might increase as a result of the impact of COVID-related measures upon healthcare services.

Taking a broader perspective on the COVID-19 pandemic, one can observe that it does not completely differ from other diseases in that both upstream and downstream approaches are possible. Upstream approaches – those seeking to prevent the occurrence of the disease at the beginning – can have a positive influence upon many diseases at once, are cost-effective and sustainable, and tend to have positive effects on equity.

Public Health has a widely acknowledged role – indeed, a leading role – in preparing for and managing outbreaks of infectious disease. The lesson from COVID-19, even more so than previous epidemics, is that health on its own constitutes only a part of the story.

COVID-19 has revealed great disparities in its impact across groups defined by socio-economic status, age, co-morbidities, ethno-racial groups, occupation, housing situation and many other characteristics. It is also known that these same characteristics are associated with many other aspects of health. It is clear that the observed disparities in the incidence of outcomes of COVID-19 are not immutable, neither are they specific to COVID-19, although this disease appears to be associated with these factors to an unusual degree.

There are two causes of the ill-health and death that result from COVID-19: one is the SARS-CoV-2 virus; the other is the underlying state of health and its risk factors and determinants, both for society as a whole and for those members of society who are disadvantaged.

Not only is it necessary to continue to develop an understanding of COVID-19 and the distribution of risk across society, it is also time to initiate actions that will both mitigate the risks and address the underlying determinants of this virus and many other diseases.

Public Health Infrastructure

Most people understand that public health has an important role in the prevention of infectious disease, but beyond that there is less understanding of its equally important other roles. Public Health has been defined as:

The science and art of promoting health, preventing disease, prolonging life and improving quality of life though the organized efforts of society. It combines sciences, skills and beliefs directed to the maintenance and improvement of health of all people through collective action. The programs, services and institutions involved tend to emphasize two things: the prevention of disease and the health needs of the populations as a whole.[71]

It is worth recalling that public health in Ontario had started a process of budget cuts and reorganization immediately before the pandemic. It is hardly likely that the current pandemic and response would prompt a reconsideration of public health's role in protecting the public against the pandemic and other infectious diseases. Yet it is vitally important to recognize the role that public health can and must play in maternal and child health, environmental health, the prevention of chronic diseases and injuries, and in reducing inequalities in the opportunity to enjoy good health. Reduced budgets and new organizational structures diminish the roles of healthy public policy, and of public health's role in policy, in favour of a "one-person-at-a-time" strategy.

The key to understanding public health lies in the relationship between the health of individuals and the health status of populations, especially for the chronic, non-communicable diseases that account for the majority of morbidity and mortality. One-patient-at-a-time interventions, whether curative or preventive, may produce good results in individuals but often have a limited effect upon the burden of the condition in the population. It is often impossible to reach those most in need; there are not enough resources to tackle the problem one person at a time, and the benefits are seldom sustainable over time. Some well-used interventions, such as education for individual behaviour change, have very low efficacy. The important health problems cannot be solved one person at a time.

It follows that public health is the part of the system that focuses on the health of populations and sub-populations. As Quebec's Public Health Act (s.5)[72] says: *Public health systems must be directed at protecting, maintaining or enhancing the health status and well-being of the general population and shall not focus on individuals except insofar as such actions are taken for the benefit of the community as a whole or a group of individuals.* Public health started out by preventing infectious conditions of individuals from affecting the population. Today that role continues, but it is also necessary to address the full range of causes by working on the determinants of, and risk factors for, ill health. It involves influencing and collaborating with a wide range of organizations outside the healthcare system, responding not to demand but to need, and achieving results often only in the longer term.

These efforts, which may involve constraining the autonomy of individuals, must involve public consultation and public governance.

Given the focus on populations, the goals of public health can be thought of as:

- Maintenance and enhancement of the health status of the population
- Reduction of disparities in health status
- Preparation for, and response to, health emergencies and outbreaks of disease

Public health has long been a system involving both provincial and local activities. In Ontario, local roles include health status assessment, surveillance, establishing local priorities and strategies, local program management (including planning, adaptation to local circumstances and evaluation), program delivery, developing relationships within the community, collaborating with local NGOs and other groups, local policy and accountability to provincial and local funders and to the local communities.

Policy is a vital tool to influence the environment – facilitating healthy choices, influencing determinants and reducing exposures to hazards. It has never been used exclusively at the provincial level in the past, either in Ontario or elsewhere. Some policies are intrinsically local in nature: education and urban planning, for example, have provincial frameworks, together with local decision-making by school boards and municipalities, and other provincial policies must be implemented locally. Many innovations in public health policy have local origins. There is a pattern of one or a few progressive health units innovating, and then adoption elsewhere, and finally progression into provincial law. Tobacco control is an example – it has been driven by the local level for more than 40 years; food menu labelling and regulating minors' access to tanning beds are other examples.

Public health has extended its activities beyond infectious diseases for many years. Scurvy, lead poisoning, nasal and scrotal cancers, pellagra, rickets and more were all understood and acted on more than a hundred years ago, and effectively eliminated through public policy. Toronto, under its Medical Officer of Health from 1920 to 1929, Dr. Charles Hastings was a pioneer in mandating the pasteurization of milk.

To experienced public health professionals, the cuts to the funding for public health announced in 2019 were the continuation of a cycle of fluctuating funding identified by Dr. David Naylor in his report on a previous epidemic of a novel virus affecting Toronto —"Learning from SARS": "Public health is taken for granted until disease outbreaks occur, whereon a brief flurry of lip service leads to minimal investments. … This cycle must end." National Advisory Committee on SARS and Public Health, October 2003

An example of the neglect referred to is the information system that Ontario health units were using at the start of the pandemic – iPHiS. That system was developed 17 years ago. Toronto found it difficult to use it for the volumes it was experiencing, so had no choice but to have the City's Technology Services team rapidly develop a new system during the early part of the pandemic.

There must be a reconsideration of proposed cuts in funding for local public health units. Changes are required in several aspects of Ontario's public health system, but these must be more than an exercise that is focussed on reducing costs. A stronger, more coherent system requires a provincial strategy, a clear set of roles and a joint planning system for provincial and local components. There must be a proper understanding of the nature and importance of population-level interventions. Governance should have the strongest possible connection to municipalities – in Toronto's case, that would mean a continuation of the present structure of Toronto Public Health as part of the City government, with a Board of Health, which has worked so well during the pandemic. Success will depend upon recognizing that a public health system that balances provincial and local roles is most effective and it is best achieved by working together.

There is no lack of evidence for public health's cost-effectiveness.[73] A review in the U.S. in 2014[74] showed that a 10 per cent increase in local public health spending was associated with a reduction in the death rate of between 1.1 per cent and 6.9 per cent. Another review,[75] showed a median cost-benefit ratio for public health programs of 8.3 ($8.30 benefit for each dollar invested). The return on investment is even more favourable for the prevention of disease by means of policy actions (such as those limiting tobacco marketing and use, or the fluoridation of drinking water), or changes to the environment (such as building infrastructure for active transportation).

5.16 Future Course of the Pandemic

As restrictions are gradually lifted and the people of Toronto begin to renew their acquaintance with at least some of their customary pleasures, it is tempting to focus one's thoughts on the current relief from the earlier more widespread disease and death and to ignore the threat of a resurgence of transmission. SARS-CoV-2 will present a significant threat to our way of life and to the capacity of the healthcare and public health systems until herd immunity has been achieved. That will require probably at least 60 per cent of the population to be immune and can be achieved only through experiencing the natural course of the infection or by means of the development and manufacture of a reasonably effective and lasting vaccine and its distribution to vaccinate most of the population.

Many candidate vaccines are in development, but it will likely take at least another nine months until one or more can be tested, approved and manufactured at scale, followed by a massive program of distribution and administration (perhaps of two doses). Vaccines may have been shown to induce the production of antibodies, and some have been shown to be neutralizing (i.e. to inactivate the virus), but the vaccines may not be effective in all cases and they may be short-lived. On the other hand, there may be cellular-mediated immunity that may respond when infection initially occurs. Overall, one may be hopeful, but there may be disappointments along the way.

Although transmission in Toronto is currently at a low level, as is the case for most of Canada, there is some circulation of the virus, and importation from the United States or another province or country, although a low risk, is nevertheless possible. As has been the case with so many aspects of this pandemic, the future is uncertain. The possibilities may be described in three scenarios. There may be a continuation of case counts at about the same level, fluctuating only a little, for the rest of the pandemic – this is perhaps the least likely scenario. Second, there could be a series of outbreaks, most likely occurring in bars or restaurants, house or beach parties, or workplaces. Third, there could be a second wave, with case counts approaching or even exceeding those seen in the initial outbreak, and with the accompanying risks of overloading the healthcare system. Many novel viruses have returned in a second wave within about six months so it is a possibility with COVID-19, although it is not known whether the continuation of preventive measures might affect the risk. There could also be some combination of those patterns.

5.17 **Public Health Action for the Balance of the Pandemic**

The strategy for the rest of the pandemic should resemble the strategy to date: move cautiously and gradually, and continue to be informed by the epidemiology. It will also be necessary to maintain good communications, both with healthcare stakeholders and the general public. Retaining the confidence of the public as the virus continues to be transmitted and as the necessary protective measures persist will be challenging. From now onward, however, we will have the benefit of experience to call upon for the difficult decisions, as well as an increasing body of evidence. Systems to gain access to and to review the evidence – from systematic reviews to jurisdictional scans to commissioned original research – should be put in place.

What we need to know

It is a commonplace to acknowledge there is much more to learn about COVID-19. It is only with the experience thus far that we can understand the complexity of managing the pandemic and the measures necessary to mitigate its effects. There is obvious potential to mitigate a second wave more effectively than the first, using experience gained, in Toronto and elsewhere, and the evolving knowledge base. At present, there are still critical gaps in our understanding; there is often some evidence, but it may be incomplete or inconsistent, including:

- The distribution of emitted virus between droplet and aerosol particles under a variety of circumstances – breathing, speaking, shouting, singing, playing a wind instrument and exercising vigorously
- The risk of transmission by aerosols, the viral load of aerosol particles, and their movements, outdoors and in rooms of various sizes
- The effects of buildings' HVAC air-circulation systems upon transmission and recommendations for ventilation and the design and use of HVAC
- The transmission of SARS-CoV-2 among children (by age-group) and between children and adults
- Critical factors in the transmission of the disease in high-risk workplaces and the effectiveness of the available preventive measures.
- Critical factors in transmission, and the effectiveness of preventive measures in long-term care and other congregate settings
- Super-spreader events and the distribution of infectivity amongst cases of COVID-19 (k factor)
- The proportion of true asymptomatic infections in the population and their infectivity
- The effectiveness and duration of protection of vaccines
- The factors (e.g. contact time, proximity, mask use, outdoors/indoors) and their values that best predict infection, for case and contact management
- Much more rich detail about high-risk populations and circumstances associated with risk (e.g. housing, employment, mobility).

Those uncertainties constitute just a fraction of the many needs for data and evidence concerning COVID-19 and its prevention.

Until there is a solution to the pandemic, it will be necessary to continue the basic measures (mainly distancing, avoiding crowded indoor spaces and wearing masks indoors) and other restrictions for higher risk settings. A continuation of a program of communications will also be necessary to remind people about and reinforce preventive actions.

Further actions will be necessary if there is any form of resurgence, and the extent of those actions will depend upon the source (outbreak vs. generalized in the community) and the severity. Toronto Public Health is developing plans to address outbreaks and sudden increases in spread in the community. A strong system of surveillance, possibly using new sources of data, will be required, and the case and contact management system should be maintained with a level of staffing sufficient to handle several moderate outbreaks at the same time. Plans should be in place to respond to outbreaks in high-risk settings, including long-term care and retirement homes, shelters, childcare centres, schools, post-secondary institutions and high-risk workplaces.

Beyond the management of outbreaks, including contact tracing and management, infection prevention and control practices in the affected places (and similar ones) should be strengthened. If there is increased community transmission, there should be enhanced communications and enforcement to reinforce preventive behaviours such as wearing masks, distancing, hand hygiene and gathering restrictions. There may be other specific measures available in future, as informed by epidemiology, research and experience. Some local measures may need to be mandated, either through a bylaw or by an order of the Medical Officer of Health.

In the event of a full-blown second wave, it would be necessary, under provincial direction, to reinstate certain closures of businesses and activities – in effect rolling back the recovery plan to earlier stages, although there may be a variation of the measures on the basis of experience in Ontario and in other jurisdictions and considering emerging science. It would also be necessary to augment the staffing of the case and contact management teams. The healthcare system and long-term care homes will also be responding to the demands placed upon them by resurgence.

Toronto should work with the Ministry of Health to develop pre-set criteria for action to combat any resurgence of disease. The data elements should include the positivity rate for PCR testing, a sharp increase in the number of untraceable cases, and possibly some syndromic surveillance data (such as absenteeism in selected sites) to facilitate early recognition and response.

Plans should be drawn up for a rapid expansion of the case and contact management teams, taking into account the experience in the first phase, including accessing redeployed TPH staff, other City staff, volunteers, newly hired staff, and staff from other organizations (depending on feasibility). It should also confer with the Ministry of Health regarding the possibility of using the Case and Contact Information System to reallocate the responsibility of follow-up from health units with many cases to those with few cases (i.e. "load-sharing").

As shown in recent experience in the U.S., it is difficult to trace and manage the contacts of every case once the numbers increase, for example beyond 100 each day for Toronto. The World Health Organization advises performing contact tracing when cases are sporadic and widespread community transmission is not occurring. It recommends focusing on household contacts, healthcare workers, high-risk closed settings, vulnerable contacts and case clusters.

Contact tracing is less effective when contacts are difficult to trace, the incidence of infection is high, or when a large proportion of transmissible infections are asymptomatic. If many cases are asymptomatic and many contacts are untraceable, it may not be possible to reach a threshold for which a contact tracing program is able to keep pace with the spread of an outbreak and lower the transmission rate. Because COVID-19 is sometimes transmitted via the respiratory route, possibly during "super-spreader events", it will not be possible to accurately identify all exposed contacts. TPH should consider drawing up criteria for setting aside universal case and contact management in favour of selective follow-up.

There are issues that should continue to be discussed with the Ministry of Health. One is PCR testing. The emphasis so far has been on maximizing the number of tests performed: to some extent this can be understood as a reaction to a lack of access to testing in the early days of the pandemic, when some symptomatic people were refused testing. Now, testing is available for all those with symptoms, and there have been invitations for asymptomatic persons to undergo testing.

The news media have concentrated their attention on the absolute numbers of tests performed. Although testing of asymptomatic persons is justified in certain high-risk circumstances, the value in widespread testing of low-risk, low-prevalence populations is questionable. Even when there may have been contact, if testing is performed too soon it is highly likely to return a false negative result. Even with tests with a high level of specificity (ability to correctly identify a negative), there is a surprisingly high occurrence of false positives when testing a population with a low prevalence of disease. Available testing capacity is more effectively directed toward areas and groups known to be at a higher risk of infection. Doing so may necessitate relocation of testing centres and/or using mobile or pop-up testing facilities with extended hours to enhance access. There may be a reluctance by some people to undergo testing, perhaps as a result of misunderstanding or myths, language barriers or other reasons. Health Commons Laboratory has conducted pilot programs working with communities at higher risk of infection at the grassroots level to promote and facilitate the uptake of testing, with promising results. The ministry should look again at its testing strategy to redirect efforts toward those in most need of a test.

TPH should continue to work with the Ministry of Health to reduce the turnaround time for tests and to meet the targets.

Toronto Public Health must continue to manage COVID-related issues and be prepared to respond rapidly to outbreaks while providing some other essential public health services. However, just as hospitals have reinstalled many non-COVID services, there are many services formerly provided by TPH but suspended since the start of the pandemic for which there is still a need. As restaurants reopen, they must be inspected; the reopening of schools in September will require some staff to be assigned back to regular duties. Strenuous efforts will be necessary to restore the previous levels of immunization and to meet the requirements of the Immunization of School Pupils Act.

Other programs and services are directed toward infectious disease control, including STI clinics, while others have longer-term outcomes but are nevertheless important. Additional challenges will include being prepared for a possible increase in COVID-19 activity arising from the return of students to schools and to post-secondary institutions in September, to be followed shortly thereafter by the season of respiratory viruses, including influenza. Finally, preparations will be necessary at some point for the distribution and administration of a COVID-19 vaccine. This is a challenging program and it will require strong financial and organizational support.

Clean, safe, free programming including parks, library programs, EarlyON programs and access to community centres is essential to young families, especially when everything else is closed and there is nothing else that we can do to entertain our families.

Comment from Consultation

5.18 **The Longer Term—Working Upstream**

The City is our environment. This is where we live: where we sleep, eat, work, raise families, grow, learn, play and pray. Within the concept of the environment there are many component environments – economic, social, commercial, work, physical, built, natural, cultural and others. Together they will shape the opportunities available to each person and shape their day-to-day choices. Either directly, as with air quality, or, more often indirectly, as with the options for travelling from place to place, they will affect everyone's health. Historically, public health started in cities. Cities presented more opportunity, but also more hazards. The infrastructure to provide pure water and the safe disposal of sewage was the start of the sanitary movement, which provided the greatest leap forward in life expectancy in history.

What are the corresponding opportunities today? They include providing housing that is large enough for each family, in good condition and is affordable; options for those who are currently homeless; a balance of sizes of apartments; more choice in rental apartments. More is provided elsewhere in this report, together with some thoughts on how this undertaking may be accomplished and where funds might be sought; and it is informed by those with expertise and those with lived experience.

The built environment is increasingly recognized as an important influence on health.[76] There can be little doubt that much physical activity has been engineered out of our modern lives, and that is in part an explanation for ever-increasing rates of obesity and diabetes. Cities can be designed in such a way as to reduce travel by car and to promote active forms of transportation such as walking and cycling. Children once again need the opportunity to walk or cycle to school as their parents did. Utilitarian active transport requires modest investment in building a connected network of separated bike lanes and bike paths, particularly directed along commuter routes. Toronto has made progress, including with the lanes opened during the pandemic, but this city lags behind Vancouver and Montreal. Cycling infrastructure has been demonstrated to be an investment in health with a return of between 1.2 and 3.8 to one.[77]

Public transit is also an investment in health. A review performed for GTHA medical officers of health found that the Metrolinx Big Move would provide a positive return on investment from the health benefits alone.[78]

One vision of Toronto is of a city of complete neighbourhoods, each close to amenities, including schools and attractive green space, and with good connections provided by public transit. Complete streets would meet the need for users of all ages and abilities, with deep sidewalks, places to sit and safe crossings. Each mode of transport – walking, cycling, public transit, wheelchairs and taxis would use the space, not just private cars and trucks. Some streets would be "pedestrianized", and there would be gathering places, cultural space, good architecture, quality paving and many trees. The urban form would be more supportive of social connectedness and good mental health. There would be an overall improvement of the public realm. A reduction in car traffic would help to reduce emissions and noise. Employment would be located nearby. Children should be able to use active transport to school and to play on some streets safely. Of course, not all elements would be possible in all places. Although many would associate this type of urban form with central Toronto, most elements can be used anywhere, and the areas more affected by COVID-19 should also be considered.

This vision requires density of dwellings and employment, but that does not necessarily mean a continuation of the current extent of construction of highrise buildings. Most cities in Europe achieve high densities with very little highrise building, but rather with consistent "gentle density" of low- and mid-rise multi-family buildings.

Neighbourhoods with higher walkability have been shown, in Toronto, to be associated with reduced occurrence of low levels of physical activity, obesity and diabetes – which are now widespread and worsening problems.

Is this of relevance to COVID-19? Yes, in that obesity and diabetes both place people at higher risk for poor outcomes, and poor air quality has been associated with a greater risk of acquiring COVID-19.[79] But the real benefit comes from creating a city that supports health and reduces the inequalities that underlie at least part of the unequal experience of COVID-19.

6 Office of Recovery and Rebuild

6.1 Introduction to Toronto Office of Recovery and Rebuild

In consultation with the Mayor's Office, Toronto Public Health and the Senior Leadership Team, the City Manager established Toronto's Office of Recovery and Rebuild (TORR) on April 24, 2020 with a mandate to:

- Coordinate a city-wide approach for recovering and rebuilding from COVID-19 informed by public health advice and best practices,
- Undertake a broad engagement of stakeholders, residents, communities, businesses, Indigenous communities and City Council members on what is needed to recover and rebuild,
- Leverage the subject matter, service and operational expertise that resides in City divisions, agencies and partners, and
- Prepare recommendations for the City Manager, informed by public health evidence and best practices, to support the recovery and rebuild for Toronto.

The following themes were initially developed as a way of coordinating the work of the Office:

- **Business & Culture** focused on economic support and recovery for Toronto's businesses and cultural industries.
- **Resilience & Climate Change** focused on climate change and resilience. This theme continues to advance initiatives associated with the City's Climate Emergency Declaration, the TransformTO Climate Action Strategy and the Resilience Strategy.
- **Community & Strategic Alliances** focused on City-community partnerships and forging alliances with NGOs, institutions, Indigenous communities, faith groups and labour, and engaging vulnerable communities, City and sector partners.
- **Government & Financial Renewal** focused on examining expenditures, revenue strategies, the role of municipal government and its relationships to other governments and identifying and developing innovative approaches that support recovery and position the City for long-term fiscal sustainability and effective governance.
- **Inspire Toronto** focused on inspiring the City, strengthening civic pride and engagement and driving economic and cultural development through creativity with the intent to inspire hope.
- **Divisional and Agency Preparedness** focused on City divisions, services and program preparedness, as well as advice, support and engagement with City agencies, to ensure business continuity and response, and strategies for restarting or restoring services. This work was informed by a framework adopted by the City's senior leadership and detailed in Section 7.

In order to capture perspectives on issues that crossed over or intersected with other themes, City subject matter experts, including those on resilience, Indigenous affairs, equity, agency and intergovernmental relations and engagement, worked with the theme leads.

6.2 Engagement Strategy

The Toronto Office of Recovery and Rebuild's (TORR) engagement strategy was designed to support accessible and informed engagement with the public and a diversity of stakeholders, communities and organizations to support decision making by the office, the development of this report and recommendations to the City Manager. Given the dynamic nature of the pandemic and ongoing work the City will undertake to support residents, communities and business to recover and rebuild, this input will continue to serve as a resource for the City and its agencies and partners. It will be posted to toronto.ca/open for public/community use as well.

The work of TORR was guided by the advice and direction of public health officials. Since the health and safety of residents remains the City's top priority, TORR's consultation relied primarily on online collection of input and virtual meetings to maintain physical distancing and limit the handling of paper forms. Roundtable discussions were held by video conferences, several online surveys were launched and the City's 311 call centre accepted input in multiple languages and by phone.

TORR staff sought input through online surveys, invited participation through stakeholder, sector and community roundtables and discussions, undertook research, and engaged divisional and agency staff. TORR also received and analyzed input from community-led discussions, email and mailed submissions and Council advisory bodies. The public survey launched May 29, 2020 to gather feedback on residents' top challenges, priorities and ideas closed on July 15, 2020 and was completed by almost 12,000 respondents.

More detailed information about engagement activities and results are provided in the **Engagement Summary.**

Communications and Promotion of Engagement

The engagement was supported and promoted through information, communications and outreach including the City's website, a RecoveryRebuild website, the City's Get Involved consultation portal, social media, news releases, communications through City divisions and City councillors, and online advertisements.

Staff also worked with existing City networks including partners, institutions such as universities and colleges, think tanks, industry groups and community contacts to promote the City's and its partners' surveys and to encourage residents and organizations to host their own virtual meetings. The City engaged Social Planning Toronto to conduct a separate survey and discussions specifically to enhance engagement with local organizations representing Indigenous, Black and equity-seeking communities.

Coordinated engagement

Even before the establishment of TORR, the City received input from residents, community organizations and businesses through many different avenues, including through City councillors and 311. For example, in March, the Mayor established an Economic Support and Recovery Task Force and roundtables on Business and Community Contributions; Children and Youth; Cultural and Arts Communities; Recovery and Restart; Small Business BIAs; Social Services and Housing; Upper Education and Industry (including Green Industries and Academics Roundtables); and Workers and Labour. This feedback helped the City respond to the crisis, provided valuable insights to TORR and, along with the consultations by TORR, will help shape future actions to recover and rebuild. These actions will include ongoing engagement with community partners and groups, Indigenous communities, residents and businesses to seek input throughout the different phases of recovery and rebuild.

TORR also built on input from City engagements and consultations conducted prior to, and during, the pandemic. For example, the Climate Change and Resilience section of this report looked to input from the City's recent Resilience Strategy and TransformTO consultations. The Government and Financial Renewal section looked to input from the City's governance review and Long-Term Financial Plan consultations as well.

Engagement by Theme

TORR engagement was both broad and broken out by theme to engage stakeholders and gather feedback on a wide range of issues and on specific topics. City Council requested that TORR include a diversity of voices including organized labour, women, Black communities, Indigenous communities and racialized communities, people with lived experience of poverty, people living with disabilities, LGBTQ2S+ and other socially marginalized groups in the City's recovery and rebuild strategies. The City engaged and partnered with Social Planning Toronto, which conducted outreach and consultations through a survey and discussions specifically with local organizations representing Indigenous, Black and equity-seeking communities. Additionally, presentations were provided and feedback gathered from the Toronto Francophone Affairs Advisory Committee, the Aboriginal Affairs Advisory Committee, Toronto Music Advisory Committee, Film, Televisions and Digital Media Advisory Board, and the Toronto Accessibility Advisory Committee.

1. ***Equity, Vulnerable Communities and Partnerships***
   Engagement under this theme included working through 77 existing tables involving more than 1,000 participants. These tables, established to support a variety of initiatives to provide supports to vulnerable and equity-seeking communities and groups, include:

   - *TO Supports Work Group Tables* – addressing specific issues such as housing and homelessness, income support, family support, food access, mental health, safety and well-being, and social connection.
   - *Community-based Sector and Resident/Neighbourhood Response Tables* – City/Community Response Tables and outreach through the Community Coordination Plan's 13 tables and 400 community organizations.
   - *City-led and City Supported Groups* - a range of tables and networks that include residents and other stakeholders that provide advice and inform a range of City policies and initiatives to address issues experienced by vulnerable groups and communities, including For Public Benefit Steering Committee, Toronto Seniors Strategy Accountability Table, Poverty Reduction Strategy Lived Experience Advisory Group, Toronto Strong Neighbourhoods Residents Advisory Committee and Planning Table, Local Champions Network, Confronting Anti-Black Racism Partnership and Accountability Circle, Toronto Youth Cabinet, Newcomers Leadership Table, Community Safety Table and TCHC Tenant Representatives.
   - The City's Indigenous Affairs Office led and advised on opportunities to seek Indigenous perspectives and recommendations.
   - Facilitation by the City's Confronting Anti-Black Racism Unit and Partnership Accountability Circle and Black Resilience Cluster, to reach out to almost 40 external organizations that specifically serve, support or are part of Black communities, and partnership with Social Planning Toronto to engage Black individuals and residents.
   - Outreach to more than 69 external organizations that specifically serve or support people with disabilities and partnering with Community Living Toronto to engage individuals with developmental disabilities.
   - Engaging more than 66 external organizations that specifically serve, support or are part of LGBTQ2S+ communities to seek their input, perspectives and recommendations.

2. ***Business***
   Engagement within this theme was focused on 11 sector-based tables, through the support of The Toronto Region Board of Trade, including Labour and Indigenous representatives, supported by a steering committee composed of senior leaders from across business and culture. The sector-based tables include:

   - *Film, Music and Live Events* - Live venue owner/operators, industry association leaders, production company leaders, entertainment company leaders
   - *Technology / Innovation* – Leaders in innovation/start-up hubs, financing companies, business incubators and venture capital firms
   - *Large Retail, Grocers and E-commerce* – Leaders in large industry and community associations, shopping centres, large retailers, big box retailers, and franchise chains
   - *Main Street Business* – Business Improvement Area (BIA) leaders, digital retailers, innovation hub leaders
   - *Manufacturing* - Small, medium and large-scale manufacturing leaders (chemicals, tech, paper products, metal stamping, pharmaceuticals)
   - *Travel and Tourism* – Leaders in the tourism industry, major events, hotel leaders and hospitality associations
   - *Financial* - Financial industry leaders

- *Health Services* - Health professionals, innovation hub leaders, pharmaceutical association leaders, long-term care association leaders
- *Energy* - Public power generation and distribution leaders
- *Infrastructure* – Leaders in engineering companies, large transportation companies (airline, rail, airport authority), large telecom companies and large construction companies.

3. ***Culture***
   Building on consultations done by the Mayor's Task Force on Arts and Culture, TORR engaged 12 tables representing youth (people under 30), creators of interactive digital media, heritage (museums, galleries and heritage sites), publishing and literary industry, LGBTQ2S+, Black cultural workers, Indigenous cultural workers, cultural workers living with disabilities, Francophone cultural workers and, film industry, music industry, and people of colour.

4. ***Resilience and Climate Change***
   Engagement focused on hearing the perspectives of community organizations and experts across all sectors including buildings, energy, transportation and finance. Over 130 representatives from approximately 76 groups participated in meetings on climate change and climate resilience, and related TORR themes.

   Conversations with existing tables, organizations and networks included the Clean Air Partnership/Clean Air Council (representing 30 GTHA municipalities), the Green Sector Development table of industry leaders from the green/clean tech sector (led by Economic Development and Culture Division), as well as consultation with the Toronto Climate Action Network (TCAN) and ClimateFast. The climate and resilience work of TORR is also informed by previous stakeholder and public consultation in 2019 on TransformTO, the City's climate action strategy and consultation and engagement during the development of Toronto's Resilience Strategy in 2018 and 2019.

5. ***Governance and Financial Renewal***
   Stakeholders from the development, finance, technology and community sectors met with staff to discuss impacts and trends in digital, development, real estate and property taxes. Stakeholders included the City of Toronto Digital Infrastructure Plan Community Advisory Group (CAG), the Building Industry and Land Development Association (BILD), the Toronto Regional Real Estate Board (TRREB), the Toronto Industry Network and property management firms and real estate investment trusts. Input was also drawn from business tables and the Mayor's Economic Support and Recovery Task Force.

Data and Reporting Strategy

City staff collected and analyzed a significant amount of data from these engagements to inform the recommendations in this report. This report presents preliminary findings, and the data will be posted to the City of Toronto's Open Data website to support ongoing analysis and consideration of priorities and opportunities to support ongoing pandemic response, recovery and rebuild strategies.

Engagement Methods

Virtual Discussions | Online Surveys | Virtual Roundtables | Stakeholder Meetings
Discussion Guide | 311 (phone) | Council Advisory Bodies | Email

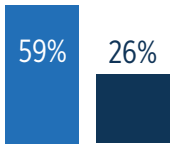
Public Survey

May 29-July 15, 2020

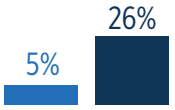
13,796 respondents

46% Homeowner
46% Renter
8% Neither

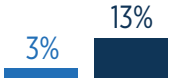
Employed full-time:



Employed full-time remotely:



Unemployed or looking for work:



City Partner Organization Survey

Completed submissions from **243 community agencies:**

- Health and mental health
- Children
- Youth
- Seniors
- Services and supports for racialized residents
- Employment and training
- People with disabilities and people experiencing homelessness
- Women's programs and services

Mayor's Economic Support and Recovery Task Force and Councillor Roundtables

Mayor Tory hosted
20 virtual meetings
with **200+ stakeholders**

8 Councillor-led roundtables, multiple sessions, multiple stakeholders

Engagement Conducted for City by Social Planning Toronto

965 Survey respondents

41 discussions with **380+** participants

Theme Discussions

- Business
- Culture
- Inspire Toronto
- Climate Change and Resilience
- Equity, Vulnerable Communities and Partnerships
- Governance and Financial Renewal
- City Divisions and Agency Preparedness

240+ theme-based **roundtables** and **meetings** with stakeholders, individuals, and organizations including:

- **Business leaders**
- **Small businesses**
- **Arts and entertainment organizations**
- **Artists**
- **Women's organizations**
- **LGBTQ2S+ organizations**
- **Racial equity organizations**
- **Environmental groups**
- **Persons with disabilities organizations**
- **Youth**
- **Housing and homelessness organizations**
- **Multiservice community agencies**
- **Seniors organizations**
- **Indigenous organizations**
- **Food security organizations**
- **Post secondary institutions**
- **Newcomer organizations**
- **Organized labour**

Input from 5 Council Advisory Bodies:

- Film, Television and Digital Media Advisory Board
- Aboriginal Affairs Advisory Committee
- Toronto Accessibility Advisory Committee
- Toronto Francophone Affairs Advisory Committee
- Toronto Music Advisory Committee

57 submissions on Recovery and Rebuild: Email | Phone | Mail

Outreach and Promotion

- Websites: **www.toronto.ca/RecoveryRebuild** and City's public engagement portal **www.toronto.ca/consultations**
- Through City's community networks and partners and City Councillors
- City social media channels, online advertisement, media releases

6.3 **Coordinated Research**

A coordinated research strategy supported the City's ability to respond effectively to COVID-19 and will be important to the City's ongoing recovery and rebuild efforts. Early in the pandemic, a team was established in TORR to coordinate resources, initiate and coordinate research requests and rapid jurisdictional reviews across divisions, agencies and other City teams.

The City leveraged its existing research capacity and significantly improved coordination across the organization by identifying where duplication existed (e.g. multiple jurisdictional reviews) and identifying the best match of skills and knowledge to identify research gaps and new requests. Staff integrated research resources, such as data, dashboards, jurisdictional and evidence reviews, and established regular communications on findings and requests, and linked researchers across divisions. Research and analysis – such as on public health trends, risk factors and the impact on vulnerable populations during the pandemic – supported decision-making by identifying how to best match resources to those most in need. City staff applied best practices and lessons from other jurisdictions, academics and experts in the development of recommendations for City reports including from the Toronto Office of Recovery and Rebuild.

The City's COVID-19 response and recovery work highlighted the deep and sophisticated research capacity that existed pre-COVID-19 to inform service delivery, policy, regulation and preparations for emergency interventions that have been put into use during the phases of the pandemic so far. Research was undertaken on issues such as community supports, child care, seniors, technology, finance, government renewal, economic development and culture, Indigenous peoples, transit and transportation, emergency management, public health and mitigating the impacts on vulnerable communities. Research also focused on preparing for any potential resurgence of COVID-19.

City staff have established a partnership to conduct recovery-focused research with Toronto's post-secondary institutions: Centennial College, George Brown College, Humber College, OCAD University, Ryerson University, Seneca College, University of Toronto and York University. Research has been initiated related to public health, scenario planning and forecasting, vulnerable populations, communities and neighbourhoods, and climate change and green recovery. Examples of research projects include the association between socio-demographic characteristics and COVID-19 incidence, hospitalization and death; plausible futures for economic and labour market trends; regional supply chain viability for PPE; analyzing who in Toronto has limited digital access; and air quality impacts related to COVID-19.

All post-secondary institutions have been involved in this research partnership. Multiple institutions are partnering together on some projects, while on others a single institution is engaged with the City. Participation varies based on the institutions' expertise and capacity, as well as alignment with the City's research objectives. Research outputs are expected before December 2020 for some projects, while other projects are longer term. This is the beginning of a long-term partnership with Toronto's post-secondary institutions to support the City's research needs.

Coordinated research and analysis will be critical to informing strategic recovery and rebuild policies and actions, and the City will benefit from continuing to improve its current approach to research and analysis across service and policy areas. A whole-of-government research, analysis and reporting team would support evidence-informed decision-making and maximize the research expertise within City divisions, agencies and corporations. Divisions are exploring the benefits of a centralized resource to leverage data and insights and apply them to recovery planning.

6.4 **Research: Social Determinants of Health**

The social determinants of health are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies, development agendas, social norms, social policies and political systems.[80] The social determinants of health, such as gender, education, income, race/ethnicity, employment and working conditions, Indigeneity, food insecurity, social exclusion, and housing have a significant impact on our health.

During the COVID-19 pandemic, there has been increasing evidence that the social determinants of health are associated with the risk of COVID-19 infection. For example preliminary evidence in Toronto shows the rate of COVID-19 cases is higher in areas with a higher percentage of people with lower-income, lower education levels, unemployed people, newcomers, and people from racialized groups compared to areas with the lowest per cent of each. Emerging evidence from other jurisdictions also demonstrates an unequal social and economic burden of COVID-19.[81]

The British Columbia Provincial Health Officer stated that "inequalities in the distribution of the social determinants of health are undermining Canadian society as a whole. However, they can be addressed through investments in affordable housing, early childhood development, equal access to higher education, improved literacy, and work place initiatives including onsite childcare and good maternity and paternity benefits, that promote more equality of opportunity and less societal disadvantage".[82]

Addressing the social determinants of health is one of the domains of the policy framework for public health programs and services in Ontario.[83] By addressing the social determinants of health and aligning public health and healthcare goals, there is greater potential for population health gains and healthcare related savings, particularly from high-cost use from within and outside the healthcare system.[84]

Economic growth is affected by public goods (such as infrastructure), finance, demographic parameters, income distribution, and social norms, among other factors, all of which also contribute to social cohesion (a society that works towards the well-being of all its members, fights exclusion and marginalization, creates a sense of belonging, promotes trust, and offers its members the opportunity of upward social mobility). This is important background for developing an economic case for financing the social determinants of health.[85] Persistent inequities of health outcomes are a costly economic deadweight in terms of lost productivity, foregone tax revenue, reduced consumer spending and higher expenditures on income assistance, social services, health care and security. Inequities impose economic as well as social and individual costs.[86] Reducing health inequities has the potential to reduce economic inequities by increasing labour market participation and associated economic growth.

The health sector is the largest expense item in the Ontario Budget ($63.5 billion in 2019, about 41% of total program spending). Analysis in 2019 from Ontario's Financial Accountability Office shows that balancing the provincial budget without raising new revenue would require spending $8.6 billion less on health care by 2022-23.[87] Health care spending is likely to be even higher than previously projected due to COVID-19. Research also shows that the majority of health care expenditures are spent on conditions that are largely preventable. However, to date, only a small proportion of investment is made by federal and provincial governments in the social determinants of health to control 'downstream' health care costs.[88, 89, 90] In Toronto, for example, housing unaffordability, poor quality housing, and housing instability, are associated with a range of poor mental and physical health outcomes and can result in significant costs to the health care system.[91] Helping people stay housed has also been shown to significantly reduce costs in other sectors, including healthcare, law enforcement, mental health, and emergency services.[92, 93] The following section details key findings from research undertaken for this report.

Value of upstream investments in the social determinants of health

Through a systematic review of the literature, Masters et al. (2017) concluded that most public health interventions are substantially cost saving.[94] Public health interventions at a local level averaged a Return-of-Investment (ROI) of 4, meaning that every dollar invested yields a return of $4 plus the original investment back.

The National Collaborating Centre for Determinants of Health reviewed public health evidence in Canada and highlighted the following key messages:[95]

- There is irrefutable evidence that people living in disadvantaged circumstances are, on average, less healthy. Recent evidence suggests that growing poverty, exclusion and substandard housing are reflected in increasing mortality and morbidity rates, as well as increased health care costs.
- The evidence suggests that the health care sector can achieve better health outcomes for less money by spending more of its dollars on work that builds healthier communities, social supports and environments -- these are upstream and equity investments.

Reducing social and economic inequities saves health care costs

Research on the economics of public health intervention demonstrates that inequality contributes significantly to health care costs, and that reducing social and economic inequities would save health care dollars. Evidence suggests that growing poverty, exclusion and substandard housing are reflected in higher mortality and morbidity rates, and increased health care costs. For example:

- The Public Health Agency of Canada estimated that 50% of the $200 billion spent on health care annually is associated with the 20% of Canadians with the lowest income.[96]
- The Ontario Association of Food Banks estimated that poverty-induced health care costs an estimated $2.9 billion a year in Ontario, and $7.6 billion per year in Canada.[97]
- Fitzpatrick et al. found that those who experience food insecurity and substandard housing are associated with the greatest healthcare costs.[98]
- The report from the "housing first" pilot project found that providing stable housing to people experiencing homelessness with high levels of chronic mental and physical illness impacted health service use, including shifts away from emergency room services and outpatient visits.[99]
- A large number of international studies have found that members of racialized groups experience poorer health outcomes compared to members of non-racialized groups and that experiencing racial discrimination contributes to poor health outcomes.[100]

Analysis by the Canadian Institute for Health Information (CIHI) has shown an inverse relationship between socio-economic status and hospitalizations, where lower socio-economic status is associated with higher hospitalization rates.[101]

The social determinants of health are a public good that needs cross-government investment

Investment in the social determinants of health is beyond the public health and heath care sectors alone. Public health units play a critical role in addressing the social determinants of health, in addition though many policy levers that positively impact health outcomes lie within the jurisdiction of other disciplines. Policy change is required in transportation, housing, and education, amongst others. This requires investment at all levels of government.

Researchers suggest that the funding for interventions related to the social determinants of health has long been inadequate, and some attribute this phenomenon to the fact that spending on the social determinants of health is often equated with the notion of "public goods".[102]

Investments in public goods deliver benefits across people and sectors simultaneously, and benefits are not limited to those who pay directly for them. The theory of and experience with public goods suggest that they can be undersupplied in a free market, even in cases where the market is dominated by non-profit health care providers and governments at every level. This undersupply is called the "free-rider problem," experienced by investors who cannot easily prevent nonpayers from benefiting and thereby limiting their return on investment. This phenomenon is related to the "wrong pocket problem," in which "investments from one part of the government are not reimbursed by the benefits that accrue to another part of government, discouraging cross-agency investment".[103] In other words, compared to other levels of governments, municipalities often spend the most on the social determinants of health, however, as these efforts result in savings in the health care system (which is within the jurisdiction of provincial and federal governments), municipalities do not receive the primary benefit.

Municipal Role in Health

While the social determinants of health can be linked to population health, there is less analysis on the connection between different governments' investments in the social determinants of health and associated economic benefits generated across governments. For example, investments made to increase options for safe, affordable housing can positively impact population health, however, there is limited research that pinpoints how the resulting economic benefits -- such as program savings and tax increases – accrue across municipal, provincial, and federal governments.

Municipal governments in Ontario are deeply invested in the public health and health care systems.[104] Municipal involvement includes direct, legislated funding and service delivery, as well as indirect and non-legislated efforts to address local gaps in health services. It includes municipal services that contribute to health outcomes, such as:

- Co-funding and delivering provincial health programs like public health, long-term care, and paramedic services.
- Investing in accessible communities to serve persons with disabilities.
- Delivering social services, housing and recreation programs that promote healthy living, health equity, and address socio-economic factors that influence health outcomes.
- Representing local health interests to health institutions and the provincial government.

According to the Association of Municipalities of Ontario, municipal governments contributed $2.1 billion for health costs in 2017, an increase of 38% over eight years. This does not include support services, like social services, housing, and recreation. Despite the evolving municipal role in health, there has been little corresponding change to municipal input into health policy, planning, and funding decisions. In addition, there is little protection against rising costs. Municipal governments often question whether it is appropriate for them to pay for health services from the property tax base, especially since they have little say on how these dollars are spent. Already stretched, the property tax base barely covers mandated responsibilities within the current fiscal environment, including municipally required public health programs, let alone the provincial responsibility for health services.

The social determinants of health and health inequities in Toronto

Income and health inequities

Torontonians do not all have equal opportunities to be healthy. Some people are more vulnerable to poor health because of their education, housing, work, income and experiences of racism, sexism and other kinds of discrimination.[105] Research reported by Toronto Public Health shows that low income groups in Toronto often have worse health, and health inequities in Toronto have not improved over time. For example, when compared to the health status of the highest income group:

- Men in the lowest income group are 50% more likely to die before age 75. The relationship between income and premature mortality has not changed over time and inequities have persisted.
- Women in the lowest income group are 85% more likely to have diabetes.

During the pandemic so far, there is evidence of disparities in COVID-19 infection. Ontario data shows a higher percentage of COVID-19 positive tests in neighbourhood quintiles with the lowest income compared to the highest income. As we move towards recovery, it is important to consider the policies of income support, social assistance and social support services that can support a healthy population.[106]

Health equity benefits the entire community. To promote a healthy city for all and address the root causes of health inequities in Toronto, a broad range of supports and resources are needed from different levels of governments. These solutions also require collaborative efforts from all sectors that have an impact on health.[107]

Housing and health inequities

Housing is a key social determinant of health. A significant body of evidence shows that the relationship between housing and health is multifaceted, complex, and that housing has strong interactions with other social determinants of health. Research and the lived experience of people in Toronto demonstrates that housing unaffordability, poor quality housing, and housing instability, are associated with a range of poor mental and physical health outcomes and can result in significant costs to the health care system.[108] Helping people stay housed has also been shown to significantly reduce costs in other sectors, including healthcare, law enforcement, criminal justice, and emergency services.

High demand and low supply of affordable housing affects all Torontonians. But, at the intersection of health and housing, several populations are particularly at risk and face challenges.

Seniors: Some groups of seniors face significant challenges in the housing market. In 2010, female seniors (65 years and older) living alone had the second highest incidence of unsuitable housing (38.1 per cent in of all household types in Toronto are in core housing need).[109, 110]

Low-income families with children: Lone-parent households, particularly female-led, had the highest incidence of core housing need of all household types in Toronto in 2010. Female lone-parents had almost twice the incidence of core housing need compared to all household types (40.8 per cent versus 21 per cent).

People with mental health and/or substance use issues: Under-served populations living with mental health and substance use needs are intensifying Toronto's affordable housing and shelter emergencies, and require unique community-oriented mental health services, such as consumption and treatment sites, harm reduction training and supplies, and increased access to counselling and psychotherapy services.[111]

People with chronic illnesses and/or disabilities: For people with chronic illnesses, physical or developmental disabilities, housing stability is associated with increased adherence to medication and treatment regimes and more appropriate use of health and social services.[112]

Indigenous people: Indigenous people have a higher incidence of core housing need compared to non-Indigenous people in Toronto (27.9 per cent versus 20.9 per cent in 2010).[113]

LGBTQ2S+ people and youth: People who identify as lesbian, gay, bisexual, trans, queer, and two-spirit (LGBTQ2S+) also face significant housing-related barriers in Toronto, including homelessness.[114]

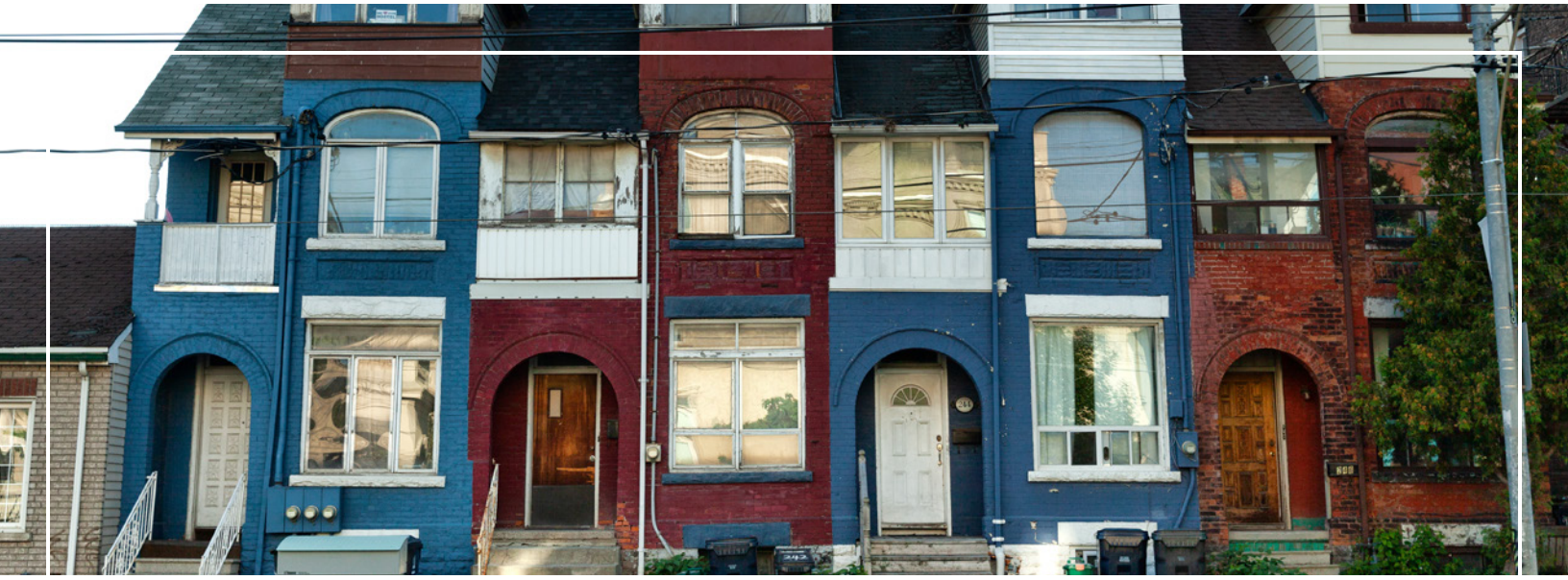
No single approach will address all the unique needs for stable, affordable housing that supports health, and a continuum of options is needed. However, small, targeted initiatives, can yield greater collective impact, and assist in making progress on improving health outcomes related to housing.[115]

Making progress requires a cooperative, multi-sectoral approach, and investment from all levels of government. The City of Toronto has identified a clear need for federal and provincial funding to allow the City to act on its commitment to increase housing options for Torontonians, in particular housing for vulnerable populations. Under successive provincial governments, municipalities have had to take on increasing responsibilities for housing costs.

Moreover, income and housing are parts of interrelated socioeconomic inequities in Toronto. There are similar findings in other areas such as transit access, low-income and underserved neighborhoods, and vulnerable populations. Acting on the social determinants of health, the City of Toronto has invested extensively in a variety of programs, including income supports, municipal expenditures on equity, confronting anti-black racism, and poverty reduction. These municipal investments demonstrate the City of Toronto's commitment to tackle these issues which impair the ability for more residents to effectively participate in the labour market and contribute to the prosperity of Toronto, Ontario, and Canada.

The social determinants of health have significant implications for economic and health outcomes and the health care system itself. Inequities contribute significantly to health outcomes, as evidenced by the disproportionate impact of COVID-19 on vulnerable populations, and in turn economic outcomes. Addressing the social determinants of health can provide a high return-on-investment, and policy interventions play an important role in addressing the social and economic inequities that directly contribute to poor economic and health outcomes. While the literature reviewed does not quantify the impact of municipal investments in the social determinants of health on economic outcomes, there is strong support for how municipal investments in areas such as housing, transit, and recreation have significant benefit to health and economic outcomes.

> **A key priority needs to be open reflection, and a fundamental shift in our processes to incorporate an indigenous perspective – this needs to be a priority – You can only help in the recovery by listening to those who aren't ever heard.**
>
> Comment from Consultation



6.5 **Indigenous Lens on Recovery and Rebuild**

The City of Toronto has the largest Indigenous population in Ontario and the fourth largest in Canada. Agencies serving the Indigenous community in Toronto estimate that there are 70,000 to 100,000 First Nations, Métis and Inuit residents living in Toronto.

Before the pandemic, the Indigenous community in Toronto faced many vulnerabilities. Given the ongoing impacts of colonization, structural and institutional racism, government policies and practices and intergenerational trauma, Indigenous Peoples face a disproportionate risk of being deeply affected by the pandemic, in a multitude of ways.

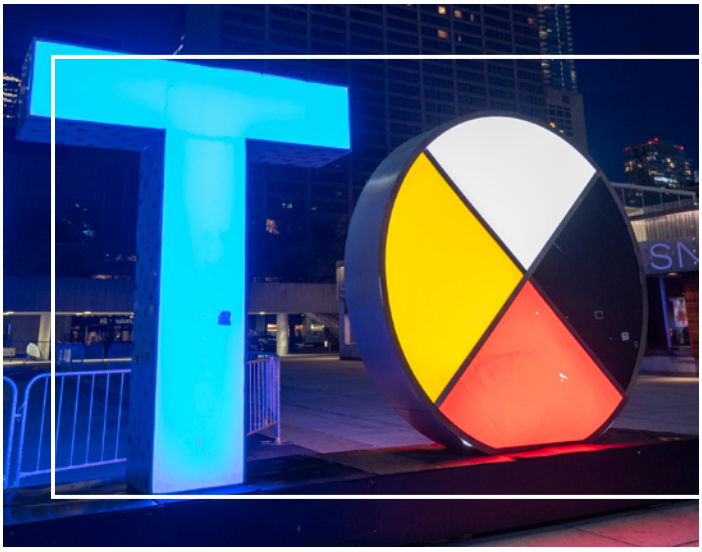
In the Our Health Counts Study (2016), the largest urban Indigenous population health study in Canada, where Indigenous organizations owned and controlled the data, reported the following findings:

- Over 90 per cent of Toronto's Indigenous population lives below the (before tax) low income cut-off;
- There is a persistent overrepresentation of Indigenous people in Toronto's homeless population, especially among individuals staying outdoors. Approximately one in three Indigenous adults are precariously housed or experiencing homelessness;
- Over one-third of Indigenous adults reported giving up key needs (groceries, transportation) in order to meet shelter/housing-related costs at least once a month.

In addition, Indigenous Peoples face ongoing challenges with respect to food security, access to land and waters for ceremony and other traditional uses, and culturally appropriate mental health and child-care supports.

All of the above challenges are further exacerbated by the COVID-19 pandemic.

The City has adopted a number of commitments to Indigenous Peoples, including the *Statement of Commitment to the Aboriginal Communities in Toronto*, and adopting the United Nations Declaration on the Rights of Indigenous Peoples in response to the Calls to Action resulting from the report from the Truth and Reconciliation Commission. The City's *commitment to Indigenous Peoples'* acknowledges Indigenous Peoples' inherent right to health, and self-determination is necessary to meaningfully protect their communities. That is especially true of those most vulnerable, including the Elders, knowledge keepers, women and youth who are essential in ensuring cultures, languages and stories survive the global health crisis.



The City's Statement of Commitment identifies seven distinct goals to be fulfilled. These goals include internal and external education, working with Indigenous partners, increasing representation and civic engagement, enhanced Indigenous recruitment and retention, and working with all levels of government to advocate for the needs of Indigenous communities in Toronto.

Since early in the pandemic, the Toronto Aboriginal Support Services Council (TASSC), a coalition of Indigenous organizations providing a variety of critical services to Indigenous People in Toronto, has undertaken tremendous advocacy work and in doing so, has connected with various City divisions to identify available funds and resources. TASSC has also been a key participant in the Mayor's Roundtable and task forces, as have other Indigenous organizations.

During times of immense pressure and drastic changes to the typical ways of doing business, efforts toward reconciliation are threatened and potentially ignored. It is imperative that the City continue to work toward fulfilling and expanding on its commitment to Indigenous peoples, lands and waters throughout the COVID response and recovery stages.

Indigenous input is needed when making decisions about Indigenous communities' well-being. The engagement process was the beginning of the COVID-19 recovery and rebuild plans to be co-created with Indigenous leaders, service providers and community members.

Indigenous Engagement

As mentioned, the effects of colonization, displacement and inter-generational trauma have had a profound effect on Indigenous Peoples; Indigenous Peoples face particular challenges with respect to housing and culturally supportive services including health (and mental health) care, child care, and access to space for cultural and ceremonial purposes. The pandemic and the resulting public health restrictions have made these challenges even more pressing.

Members of the Indigenous communities and organizations have been engaged at various tables as part of the TORR engagement activities. *While efforts were made to gain Indigenous perspectives on the myriad of issues and challenges raised by the pandemic, it is understood that the conversation is ongoing and that more targeted engagement will be necessary over the coming months.*

As part of the Mayor's Roundtable, the Social Services and Housing, Children and Youth and Arts Community Task Forces directly engaged Indigenous organizations and leaders and purposefully provided recommendations specific to Indigenous communities. Indigenous perspectives have been reflected in many of the other task force discussions and a targeted engagement with Indigenous business leaders also took place.

The Social Services and Housing Task Force recommended the following:

- Ensure that all funding decisions in this area be informed by an equity and reconciliation lens, and that the priorities of Indigenous organizations be supported;
- Indigenous Peoples are one of the groups most vulnerable to COVID-19, therefore, it's essential that Indigenous voices are included in all economic recovery decision-making tables;
- Work with Indigenous social service sector and other Indigenous leaders to ensure Indigenous representation on all recovery tables and committees;
- Ensure equitable resource allocation to Indigenous organizations servicing diverse needs;
- Support the development of an Indigenous-specific social services referral system, with partners including Findhelp/211 and TASSC;
- Maintain the commitment to develop and fund the implementation of the Tkaronto Indigenous Prosperity Plan, an Indigenous-led Toronto Poverty Reduction Action Plan; and
- Uphold the 2010 Statement of Commitment and the Aboriginal Education Strategy, Aboriginal Employment Strategy, Indigenous Health Strategy, Indigenous Overdose Strategy, Meeting in the Middle Strategy, Ontario Urban Indigenous Action Plan, the Truth and Reconciliation Commission's Calls to Action, the Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls, and future efforts including the City of Toronto Path to Reconciliation.

With respect to Indigenous children and youth, the City's Children Services Advisory Committee, along with the Indigenous Affairs Office, was engaged. Discussions resulted in specific recommendations to address the unique needs and challenges

I would like the City to address the needs of indigenous people by taking the following actions: Engage with Indigenous People. Learning from Elders and Traditional knowledge Keepers…Adding these type of programs will help put the city back on the right path.

Comment from Consultation

faced by Indigenous families and children living in care (Indigenous and Black children are overrepresented in the children-in-care and justice systems). The recommendations include:

- Increase funding and/or access to culturally appropriate programming to meet the needs of Indigenous children and youth for recreation and outdoor sport. This initiative could include enabling particular Indigenous organizations to book parks and other greenspaces for safe and scheduled activities with children, youth and families;
- Consideration should be given to Neighbourhood Improvement Areas (NIAs) and vulnerable communities when planning for the reopening of recreation centres, outdoor pools and amenities, parks, summer camps and community programming;
- Increase access to funding and programming that support the specific cultural needs of Indigenous children and youth in outdoor recreation and sports;
- As soon as possible, find new ways to resume services for children-in-care and incarcerated youth such as virtual supervised visitations or phone counselling; and
- Indigenous and Black communities require culturally responsive strategies to resume court-ordered access visits for children in care. That could be accomplished through scheduling outdoor spaces in which to conduct visits.

Indigenous artists who participated in the Arts Community Roundtable noted that while they faced similar challenges experienced by other artists, because they tend to be already more vulnerable due to lack of financial and cultural supports and access to space, they have been hit particularly hard by the effects of the pandemic.

A targeted discussion also took place with representatives from the Indigenous business and entrepreneur community. Much of the feedback was consistent with feedback from consultations with other small businesses, as the challenges are generally the same. Like other businesses, many Indigenous businesses have pivoted or adapted to online or virtual formats during the pandemic. Some of the participants did, however, note the challenges and barriers many Indigenous entrepreneurs and businesses face in accessing procurement opportunities with the City. For example, it was noted that many Indigenous businesses get "lost" in social procurement programs, as Indigenous Peoples are not an equity seeking group; separate Indigenous procurement streams should be established and greater support provided to help Indigenous businesses navigate through procurement processes. In addition, many Indigenous small businesses that are focused on artisanal goods and local tourism have suffered disproportionately. Moreover, some Indigenous "businesses" do not fit the typical business model parameters – many rely on in-person knowledge transfer and connection, and unique adaptations and considerations may be necessary in the recovery and rebuild efforts.

The discussions with Indigenous community to date are just the beginning of an ongoing conversation. In order to ensure that a lens of reconciliation is present in the City's recovery and rebuild efforts. Indigenous voices need to be engaged in an ongoing and meaningful way as the work toward recovery and rebuild evolves and moves forward.

7 Critical City Services

The City's Response to the COVID-19 pandemic

Since the onset of the pandemic, the City of Toronto's divisions, agencies and corporations have worked with the Province of Ontario, community organizations and businesses to monitor the spread of COVID-19 and ensure dates and timelines of reopening and restart were appropriate and safe for residents, staff and businesses. The City has demonstrated resilience in expanding its remote and digital capabilities, modifying services so they can continue to be delivered in a way that reduces physical contact.

In a matter of weeks, the City increased its remote-enabled workforce by almost 20 per cent in order to both reduce occupational health risks and maintain remote service provision. To help local businesses and artists access free digital ordering and e-commerce platforms, the City established several new partnerships, initiatives and programs, such as the ShopHERE and CurbTO programs, to minimize the economic impact of the pandemic. Many divisions enthusiastically embraced new forms of virtual and contactless service delivery, from virtual tribunals to social assistance case management, while ensuring client access and communication was multi-tiered and not geographically bound. The City is leveraging the lessons learned and momentum from its COVID-19 response to enhance and accelerate the development of its digital service infrastructure to better serve residents and businesses during and after the pandemic.

City Services – Restart and Readiness

In-step with the "Ontario Framework for Reopening our Province", the City created a COVID-19 Restart Roadmap to ensure the resumption of services and to support businesses and community organizations to reopen safely.

Many City services were maintained during the response period, and any City services that could be effectively delivered by staff working from home have continued to be delivered remotely, with about 10,000 staff working from home. Priority services on the COVID-19 Restart Roadmap that have required staff to return to the workplace all undergo a comprehensive series of assessments and planning exercises to ensure that operational procedures meet health and safety requirements. Assessments include occupational health and safety reviews, facility occupancy evaluations, and personal protective equipment (PPE) impact assessments.

City staff have also been working with City agencies and corporations to ensure they are aligned and have been supported with their restart efforts through information and coordination, public health and program guidance, PPE and face covering provisions, and other supports. Communication strategies, corporate signage, resources and playbooks were also developed to support City divisions, agencies and corporations through response and recovery stages.

As of July 2020, approximately 90 per cent of the City's services are active.

A robust planning exercise is now underway to plan for operational and service continuity, including an exercise to support business continuity via digital services in the event of a resurgence of COVID-19 cases.

Modified services as a pathway to reimagined services

The City is dedicated to ensuring that the programs and services that residents and business rely on will be maintained. While the pandemic has created tremendous challenges for the Toronto Public Service (TPS), it has also amplified the TPS's ingenuity, adaptability and imagination. Out of necessity, the City has had to modify and adapt its services to meet the needs of Torontonians during the crisis. The City is now future-proofing its service delivery, using many of these delivery changes as a basis for re-imagined workplaces and customer experiences.

Many City services had to quickly transition to modified or remote service delivery to support communities and businesses to navigate hurdles of contactless or reduced-contact services required to reduce the spread of COVID-19.

That undertaking has created an opportunity to reimagine how the City will provide services in the future. Many innovations emerged in recent months: streamlined curbside pickup (CurbTO) and patio licensing (CaféTO); virtual Council and Committee meetings; online business licensing; remote tribunal hearings; increased call centre resources; and an increasingly remote-enabled workforce. The City continues to accelerate its Digital Government strategy through the digitization of customer services, processes and experiences and through expanding its mobile and remote-capable workforce.

The City is pursuing new models for partnerships, collaboration and better access for vulnerable populations. Re-imagined experiences will elevate the Toronto Public Service's responsiveness and resiliency and drive equity-based outcomes.

Critical City Services

7.1 **Child Care**

Impact of COVID-19 on the Child Care System

Prior to the COVID-19 pandemic, Toronto Children Services' was near completion of a five-year service plan (2020-2024) that was informed by significant consultation with families and care providers. Since the onset of the COVID-19 pandemic, child-care services have been affected significantly. All care centres had to shut down between March 17 and June 12 by provincial orders, except the opening of special emergency child-care services for essential workers. Since the lifting of the provincial order on June 12, some child-care centres in Toronto have begun to reopen with modified public health protocols and reduced numbers.

Emergency Child Care

On March 17, the Province declared a state of emergency and, among other measures, ordered the closure of all licenced child-care centres. On March 28, the province authorized the provision of emergency child care for children of essential and critical service workers, at no cost to parents, fully funded by the province. The City launched an online application that same day. Emergency child-care spaces were made available to workers deemed eligible by the province and access was provided on a first come, first served basis. Front-line health care workers and first responders were prioritized for available spaces.

Between March 31 and May 26, Children's Services opened eight emergency child-care centres for children (from birth to 12 years old) for eligible, essential and critical workers, with a total capacity of 236 children at any given time.

From March 31 to June 29, emergency child care was provided daily to 274 families and 394 children in the City's directly operated centres and staffed with City child-care workers.

Given the challenges in ensuring physical distancing when caring for young children, additional measures were implemented to maintain a healthy and safe environment in collaboration with Toronto Public Health and Occupational Health and Safety.

On June 12, the order closing child care across the sector was lifted and the province announced that Emergency Child Care and associated provincial funding would end on June 26. Since then, Children's Services has worked with families to find care in child-care locations that had reopened, including 11 of the City's Early Learning and Child Care locations.

Toronto's child care offerings

As of March 1, 2020, 1,050 licensed child-care centres were operating in Toronto, providing a total of 79,520 child-care spaces. Toronto's Children's Services (TCS) division operates 46 centres directly that include 2,306 spaces. The remaining centres are operated by non-profit or commercial entities.

About 800 staff work in City-run centres. Including supervisors, registered Early Childhood Educators (RECEs), housekeeping staff and casual workers such as child-care aides, daycare and recreational assistants, and food services workers. In non-profit or commercial centres, a similar mix of staff run the child-care centres, but often with a smaller proportion of registered ECEs than in a City-run centre.

Role of the City

Since child-care centres have reopened, the City, as the service system manager, has increased communication with child-care providers, including providing clarification and guidance regarding provincial guidelines. The City worked with Toronto Public Health to provide required training for centres to reopen safely. The reopening/recovery working group developed Guidelines for Operators to use when considering how to place children with smaller overall cohort sizes. Children's Services has been working with school boards to discuss shared space considerations for child care and recreation programs.

There will be a need to ensure that access to reopened spaces will not just favour parents who are working and will also support the vulnerable families and communities who have been hardest hit by COVID-19.

Licensed Child Care – Toronto Overview

- 1,058 licensed child-care centres with 80,168 spaces
- 429 child-care centres located in elementary schools
- 18 licensed home child-care agencies offering about 3,550 spaces in 950 private homes
- 47 City operated child-care centres and one City operated home child-care agency
- 21 organizations (including the City) providing service and support for children with extra needs enrolled in licensed child care
- 40 per cent of system restarted as of July 15, 2020

Intergovernmental Considerations for Child Care

The federal government committed $625 million as part of broader federal funding toward child care across the country. On August 14, 2020, the province announced that Ontario's share would be $234.6 million. Funding will be used to procure and deliver face coverings directly to operators and licensed home child care agencies, and also provided directly to operators to help them comply with the Province's reopening operational guidance or local public health requirements. Toronto's 2020 allocation from this program will be $47.5 million. Toronto City Council called for a national child care strategy at its June 2020 meeting and endorsed the need for tri-government investment.

In the short term, Toronto's Children's Services Division is supporting the reopening of more than 700 child-care centres across the city in order to return child care to its previous capacity. In the long term, the City will continue to lead the Growth Strategy that strives to increase licensed child-care spaces, improve affordability for families and support the child care workforce.

> **The closing of schools and daycare centres served as a reminder of the important role child care plays in offering vital support to families. … it is the availability of child care that allows for parents to work and to contribute to the economic stability and recovery of the city, the province and the country as a whole.**
>
> Comment from Consultation

The City continues to be committed to improving the affordability and access to child care for its residents. However, the City recognizes that this support requires investments from both the federal and provincial governments and looks forward to a National Child Care Strategy and the provincial Child Care Plan.

Stakeholders have indicated that committed and ongoing provincial and federal funding is required to ensure the sustainability of the child-care sector, and to support access for parents and families during the reopening and recovery period. Access to child care is key to the reopening of the Toronto economy and ensuring an increased ability for people to enter the workforce and contribute to growth and prosperity.

Given the significant role the City plays in coordinating and supporting the restart and sustainability of the child care and early years sector, and the increased staffing needed to meet public health and other requirements, the City has also asked the province to consider deferring its planned reductions to administrative cost-share funding for child care in 2021 and 2022.

7.2 **Long-Term Care**

Outbreaks are common in congregate living settings and unfortunately, respiratory infections can be easily transmitted in an institutional environment where residents can be frail, older and have many complex chronic conditions. Mitigation actions that are implemented during an outbreak include active surveillance and precautions, testing of residents and staff, isolation, physical distancing, meals served on trays rather than in dining rooms, hand hygiene, and use of personal protective equipment. To address staffing needs, the City's Seniors Services and Long-Term Care (SSLTC) reassigned divisional and management staff to support essential operations; maximized frontline staffing and overtime hours; expedited hiring for key positions (e.g. nursing students for PSWs), redeployed staff from other divisions and used external agency staff to support frontline operations.

In terms of the direct impacts of COVID-19 on the residents of the City's long-term care homes, 251 residents tested positive for COVID-19 (9.5 per cent of total population) and, unfortunately, there were 70 deaths (2.7 per cent of total).

Pre-COVID-19 Long-Term Care (LTC) Snapshot

Under provincial legislation, the City of Toronto is required to establish and maintain a long-term care home. The City directly operates 10 homes serving 2,641 residents with 24-hour resident-focused care, including permanent, convalescent and short-stay admissions. Care, services and programs enhance quality of life by responding to individual resident needs, and include:

- nursing and personal care,
- behavioural support programs,
- medical services,
- dietetics and food services,
- recreational programming,
- spiritual and religious care,
- volunteer programs, and
- diverse and inclusive care and services.

Given the unique diversity and need for inclusion in the city, and to support the needs of these diverse communities, care and services at select homes include language, religious and cultural partnerships such as Buddhist, Cantonese, Farsi, French, Hispanic, Ismaili, Italian, Japanese, Jewish, Korean, Mandarin, Polish, Portuguese, Russian and Ukrainian. The division is considered a leader in terms of its LGBTQ2S+ and Transgender inclusivity and cultural competence. SSLTC continues to improve its culture, staff training, programs and services, and policies to create a more inclusive, equitable long-term care environment for all residents and staff, including Black, racialized and other equity, diversity and inclusion groups.

> **I would like the City to address the issue of seniors housing by securing financial support from higher levels of government, and make the city better by providing safe, affordable and well managed senior housing options for the aging population.**
>
> Comment from Consultation

City-operated homes have residents with more complex needs and often with financial limitations. These residents are often not accepted by operators other than the City's LTC homes.

City homes compare favourably to national and provincial averages for all publicly reported indicators. Given the City's direct experience and knowledge of preventing and mitigating the spread of COVID-19, learning will be shared to better protect residents, clients and staff from future outbreaks. SSLTC leadership, residents and families will be actively involved in upcoming sector reviews, including:

- Independent Commission into Long-Term Care
- Patient Ombudsman investigation into the resident and caregiver experience in LTC homes with COVID-19 outbreaks, and
- Ontario Ombudsman investigation into Ministry of Health/ Long-Term Care oversight of LTC homes during the pandemic.

The City of Toronto has long invested additional funding beyond the provincial allocation for long-term care (approximately 20 per cent), which contributes to the vibrancy of City homes, quality jobs for staff, and high-quality care and programs for residents. However, increased provincial funding, including to support adequate staffing levels, was identified a critical need for COVID-19 and continues to be a priority.

Seniors Services and Long-Term Care division, along with Toronto Public Health, has been focused on preventing and mitigating COVID-19 to ensure a safe environment for the more than 2,600 residents in the City's 10 directly-operated LTCHs.

In response to the high risk the COVID-19 pandemic posed for LTC residents, the City introduced enhanced active screening early, including taking and recording temperatures of all staff entering a City home. Masking protocols were enforced, and all non-essential visits were suspended. Enhanced infection, prevention and control practices and procedures, including staff education, high-touch cleaning and disinfection, helped prevent the spread of COVID-19.

Despite best efforts, the virus has been extremely difficult to contain. At one point during the pandemic, all City long-term care homes reported residents and/or staff with the virus. A total of 251 residents tested positive (9.5 per cent of total population) and unfortunately, there have been 70 deaths (2.7 per cent of total). However, as of August 4, 2020, there are no positive resident cases of COVID-19 in City LTCHs. And, as highlighted in multiple media reports, municipal LTC homes such as City of Toronto homes have fared better than privately run LTC homes in terms of COVID-19 spread and outcomes.

Staffing is a serious issue across the long-term care sector. In response, SSLTC reassigned divisional and management staff to support essential operations; maximized frontline staffing and overtime hours; expedited hiring for key positions (e.g. nursing students for PSWs), redeployed staff from other divisions and used external agency staff to support frontline operations.

In June 2020, City staff made 16 recommendations in a report to the Mayor based on experiences and learning from the pandemic. Staff's detailed report on management of the COVID-19 pandemic in the City of Toronto's long-term care homes can be found at https://www.toronto.ca/wp-content/uploads/2020/06/97d7-ssltc-covid-19-response.pdf

[Address the issue of] healthy aging in place [by] advocating for increased provision of home care with the provincial government, ensuring that our seniors have choice about where and how they live.

Comment from Consultation

As the City moves into a recovery phase, staff will complete a comprehensive review, examining all areas of its operational response, with a view to identifying short- and long-term strategies for improvement and change, considering key issues including:

- **Human Resources:** effective leadership and management, reliable clinical care, robust human resource strategy for return to work and staffing shortages.
- **Infection, Prevention and Control:** awareness and adherence to infection, prevention and control standards, clear protocols, process and expectations, supply and correct use of personal protective equipment, testing process and capacity.
- **Partnerships and Sustained Operations:** communications protocols in place with residents, families, staff on/offsite, caregivers, clear roles and responsibilities, outbreak management process and protocol in place, and local partnerships.

This comprehensive and systematic review will inform the City's next steps as we reimagine the future of long-term care homes.

7.3 **Housing**

As many residents struggle to secure and maintain affordable, suitable and stable housing, there is a growing need and demand to increase the availability of permanent housing and to enable housing affordability.

Vulnerable populations, including low-income individuals, people with mental health and addiction challenges, seniors, women fleeing violence, Indigenous people and people with disabilities, are particularly at risk of experiencing housing challenges.

Shelter, Support and Housing

Shelter, Support and Housing Administration (SSHA) worked with Toronto Public Health, other orders of government, the healthcare sector, and the community not-for-profit sector to develop and implement appropriate measures to protect Toronto's homeless population, prevent the spread of COVID-19, and care for clients who test positive for the disease.

The City implemented a three-tier approach to protect people experiencing homelessness, focused on prevention, mitigation and recovery. The aim of the response has been to stay ahead of the pandemic and continue to adapt and evolve as the situation changed. At the outset of the pandemic, SSHA (in consultation with Toronto Public Health and Inner City Health Associates) conducted an impact assessment to determine the greatest areas of risk and prioritize actions. The initial objective was prevention, with the goal of keeping COVID-19 out of the shelter system for as long as possible. This work included guidance, training and resources to all service providers on required Infection Prevention and Control measures to protect staff and clients. SSHA also provided PPE for frontline shelter workers and advocated to other levels of government for the provision of these critical supplies. Additional funding was provided to shelter operators for the purchase of PPE and to extend operating hours for shelters not operating 24/7 to remain open during the day.

A large portion of the considerable strain on the emergency shelter system was due to requirements around physical distancing and, in the case of persons testing positive, isolation. The average cost to operate a shelter bed in Toronto was $3,347 a month pre-COVID-19. That cost has now grown to approximately $6,667 per bed per month as a result of the increased response required to protect clients. Further pressures on access to shelters resulted from the closure of provincial services (such as detox and crisis beds) and discharges from correctional facilities of individuals directly into homelessness without adequate housing plans in place.

> **I would like the City to address the issue of housing by taking the action of fast-tracking the building of below market affordable units to open asap. Modular housing is one example and make the city better in the ways of ensuring that those who work here can afford to live here...**
>
> Comment from Consultation

SSHA worked closely with service providers to help them increase physical distancing measures where possible, including reducing or eliminating the use of bunk beds. Many of the City's shelter sites have been able to meet the increased physical distancing guidelines of two metres but in other cases additional space and support was required.

Beyond the impacts to the shelter system, the City mobilized resources to ensure that those facing housing instability and the most vulnerable would be protected during the pandemic. This includes:

- A COVID-19 response strategy for outreach and encampments that includes access to safe indoor space, shelter and housing; education and infection prevention; and harm reduction and encampment health and safety. The interim housing program noted above and securing additional hotel rooms to ensure people have access to safe indoor space.
- Opened 11 City-operated facilities with showers, washrooms and drinking water for people experiencing homelessness.
- Providing an additional investment of $2 million to the Toronto Rent Bank that, along with changes to program rules (i.e. increased maximum loans, deferred loan repayment, etc.), will support approximately 750 households in rental arrears with no-interest loans of up to $4,000 to help them remain in their homes.

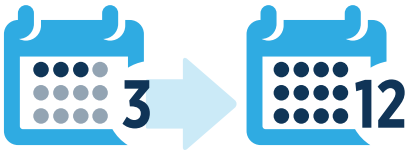
Shelter Response Highlights

Responses to COVID-19 by City of Toronto's Shelter, Support and Housing Administration Division

SSHA secured 33 temporary locations, primarily in temporarily vacant hotels, resulting in **3,037 spaces**

These actions assisted **24-hour service** providers and directly operated shelters meet physical distancing guidelines and provide isolation and recovery options for the homeless population.

These spaces currently operate on short-term leases from **three months to a year in length**.



$5 million (approximately)

The monthly cost associated with renting these spaces and providing service. Paid through grants from the province until the beginning of June, and now funded entirely by the City.

Since the onset of the pandemic, the City has achieved the following (to July 20, 2020):

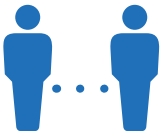
More than **30 new** facilities opened.

1,309 people moved into **permanent housing**.

547 people provided space for isolation with **medical supports**.

More than **600 people sleeping outdoors** were moved to interim housing.

3,500 people moved to ensure physical distancing



599 clients transported for testing.

418 clients who tested **positive for COVID-19** were provided isolation spaces to recover.

Toronto Community Housing Corporation

TCHC supported its tenants throughout the COVID-19 response period. In mid-March, TCHC extended local on-site building staff hours to seven days a week, 10 hours a day to enhance cleaning protocols in all high-touch areas and essential common rooms (such as laundry). Staff closed all non-essential common rooms and coordinated food-bank programming and food hamper delivery. The Community Safety Unit increased support, particularly in areas where local agency support has been withdrawn and an added security presence is required. At select sites, after-hours restrictions were implemented to reduce unwanted non-resident access. The Seniors Housing Unit (SHU) implemented a call-out to all tenants to provide COVID-19 information from Toronto Public Health and gather information about grocery and medication support needs. SHU also conducted wellness checks (door knocks) for tenants who could not be reached by phone. Programs were similarly established in the Family portfolio with vulnerable tenants. SHU staff made additional efforts to check on tenants identified as high risk. More than 19,000 households were reached, with connections to supports and services provided where required.

As part of COVID-19 recovery efforts, services and amenities for tenants have gradually reopened in TCHC communities where it is safe to do so. These include in-suite non-urgent repairs, sports courts, playgrounds, cooling centres, community gardens and swimming pools. TCHC continues to monitor and assess the safety of restarting services, tenant programs and amenities, and will continue to gradually reopen them safely.

Rental Affordability

Working closely with the City's Advisory Group on the Protection of Affordable Rental Housing as well as the Social Services and Housing working group led by Deputy Mayor Bailão, the City is gathering feedback from renters and landlords regarding the most pressing issues they are facing. Some of the key concerns include immediate challenges renter households face to pay their rents as well as the risk of delayed evictions for renters who will not be able to pay back multiple months of accrued rent as the moratorium on evictions is lifted. The City continues to work with other orders of government to expand rental assistance programs to provide short- and medium-term relief to renters and to advocate for putting measures in place to prevent economic evictions after the crisis. The City has also created targeted communication and outreach materials for renters and property owners to inform them of relevant health and safety guidelines and available social and financial support services. The City is also working with supportive housing providers to find alternative arrangements for their tenants who are living in congregate living situations to allow for physical distancing.

Expediting HousingTO 2020-2030

While continuing to provide emergency immediate responses to COVID-19, it is also crucial to increase investments in affordable and supportive housing to address chronic homelessness.

The pandemic has shown that the lack of access to affordable, suitable and adequate housing is as much of an individual health risk as it is a larger public health risk. The pandemic has also highlighted the fundamental interdependencies in the housing, health, social and economic systems.

Prior to the onset of the COVID-19 pandemic, Toronto City Council had adopted and begun to implement the City's 10-year HousingTO Action Plan 2020-2030. Throughout the pandemic the City continued to pursue this aggressive agenda to build 40,000 affordable housing units, including 18,000 supportive housing units over the next 10 years.

This work has accelerated planning for the following key projects, despite the need to adapt approval and engagement processes to ensure physical distancing:

- Continued implementation of Housing Now Phase 1, which seeks to activate 11 City-owned sites, with financial incentives from the City, to create approximately 10,000 new residential units with an estimated 3,700 affordable rental units;
- Launched Housing Now Phase 2, to add six additional sites estimated to yield up to 1,710 new residential units, including up to 620 affordable rental units;
- Continued work on 48 other active affordable rental housing projects with more than 3,900 units under development; and
- Accelerated progress to achieve 250 modular housing units in one year, in collaboration with the Government of Canada and the Province of Ontario.

Those efforts will result in approximately 300 affordable rental units to open in 2020, with an additional 1,012 affordable rental units expected to be ready for occupancy in 2021. The Modular Supportive Housing project aims to get 110 new homes open by September 2020.

We must prepare for many people who have lost their jobs and who are behind in their rent to be supported to live (financially), to look for work and to prevent evictions from their housing. This is a top priority.

Comment from Consultation

7.4 **Income Support**

Pre-COVID-19 Poverty Snapshot

Prior to COVID-19, poverty was already a widespread and persistent challenge in Toronto, with one in five adults living in poverty. Poverty was concentred among particular groups (Indigenous and equity-seeking communities including Black Torontonians, racialized youth, new immigrants, people with disabilities, vulnerable seniors) and in specific parts of the city. High levels of poverty reflect the rise of precarious, low-paid employment and inadequate income supports with limited Employment Insurance coverage and social assistance rates that leave people in deep poverty. Prior to the pandemic, many of the City's Toronto Employment and Social Services Division's (TESS) clients already reported significant barriers to employment

Impact of COVID-19 on Poverty

The pandemic has exposed existing weaknesses in Canada's and Ontario's employment and income security systems. The pandemic has increased poverty and unemployment, disproportionally impacting low-wage and racialized workers, with most job loss among those in temporary and low-paid work. The pandemic is resulting in dramatic increases not only in unemployment but also in challenges with debt levels, housing stability, food insecurity and worsening mental health and addictions.

Toronto is facing an unprecedented economic shock amid the global COVID-19 pandemic. Between February 2020 and June 2020, total employment across Toronto declined by 224,650; many employed Toronto residents are working reduced hours. Among the hardest hit have been workers in accommodation and food services, and information, culture and recreation sectors.

It is anticipated that the recovery will be slow and many of the sectors hardest hit will not see the return of employment levels that existed before COVID-19. Overall, the expectation is that there will be fewer jobs available and more clients facing barriers to employment. Many of those who are willing and able to work will need retraining for different opportunities.

Intergovernmental approach

To inform longer term COVID-19 rebuild efforts, City staff will be working to identify the social supports and economic opportunities needed by vulnerable residents and communities, and funding needed from the other governments. No order of government trying to assist low-income residents should work at cross purposes with other orders of government. Programs should be aligned and appropriately funded and should remove any barriers to participation.

CERB, for example provided several features of an improved employment and income security program that many economists, social policy practitioners, advocates and municipalities – including the City of Toronto itself – have called for over many years. The requests include broad, uniform coverage, a flat, simple and adequate benefit structure, and streamlined delivery through the CRA.

The delivery and funding responsibility for on-going employment and income-support financial benefit payments to individuals must be aligned to the right order of government.

- With an aging population and a now fully exposed crisis in long-term care, provinces will face enormous pressure for the next two decades at a minimum, to make significant new investments in primary health care, long-term care, child care and public health.
- Delivering income support payments through the CRA/ federal tax system would help to ensure that very low income Canadians, especially those who are single, benefit fully from the various tax credits and tax-administered benefits to which they are entitled but which they are not yet accessing, believing – incorrectly – that it only makes sense to file a tax return if you owe taxes.
- Moving to a Standard Flat benefit rate for social assistance in Ontario would significantly lessen the pressure on Toronto's shelter system by making it much easier for shelter users (in receipt of Ontario Works financial assistance) to afford alternative accommodation. The related elimination of RGI rent scales associated with the adoption of a Standard Flat social assistance benefit rate would free up as much as $80 million a year for Toronto to invest in other critical services for low incomes residents, including supportive housing, child care and long-term care.
- With adequate federal funding, provinces and municipalities can focus more attention and resources on those elements of the social safety net that involve the delivery of integrated social and health services (in situ) to communities, nested in specific places (e.g. child care, healthcare, long term care, housing, etc.) and administer financial program requirements and assist very low income residents regain the trust, confidence, skills and supports they need to effectively pursue, secure and maintain employment.

These past few months has taught us so much about what is essential and what is not, and access to food is absolutely essential and building local food sovereignty is good for the local economy, public health and there is a lot of research out there that proves gardening is beneficial for mental health!

Comment from Consultation

7.5 Food Security and Food Access

Food Insecurity

Many people in Toronto are at high risk of food insecurity during the COVID-19 pandemic, including those who already face existing barriers to food access due to financial constraints. In 2017, almost one in five Toronto households experienced marginal to severe food insecurity, with the majority of food insecure households being employed. Racialized residents face amplified and structural barriers to food access. Black households are 3.5 times more likely to be food insecure than white households in Canada, and Indigenous households are also disproportionately impacted by food insecurity. The use of food banks was on the rise in 2019, especially in low-income neighbourhoods in North York (nine per cent increase) and Scarborough (eight per cent increase).

Food insecurity surged during the pandemic for vulnerable residents and those who faced loss of income, shelter and community supports. 211 Toronto, a community information service, reported an alarming increase in average daily calls related to food security in April 2020 (almost 14x increase compared to February 2020). Toronto Public Health conducted an analysis of the association between socio-demographic characteristics and the rate of COVID-19 cases, and found:

- Areas with the lowest income group (the quintile with the highest proportion of people living below the low-income measure) had the highest rate of COVID-19 cases.
- A higher COVID-19 case and hospitalization rate for areas with a higher percentage of people from racialized communities, newcomers to Canada, people with lower education levels, and unemployed people.

These same groups experienced higher risk for food insecurity during COVID-19. Other food insecure groups during COVID-19 include:

- **Vulnerable residents** (e.g. homeless, shelter residents, etc.)
- **Seniors**
- **Individuals with mobility issues**, quarantined and/or in self-isolation
- **Households in the inner suburbs** and tower neighbourhoods of Toronto

Neighbourhoods with the highest burden of COVID-19 (Northwest Toronto) also face disproportionate levels of food insecurity and have higher populations of Black residents. Several wards, including those in North Etobicoke (Ward 1), North York (Wards 6, 7, 17) and Scarborough (Wards 20, 21, 22, 24, 25), experienced significant surges in requests for emergency food services.

North Etobicoke
(Ward 1)

- The Albion Public Library was the first Toronto Public Library (TPL) site to host a pop-up food bank, holding one in partnership with North York Harvest starting on March 25 due to the rise in food-bank clients in the Rexdale neighbourhood. The Albion Pop-up food bank remains operational.
- Mount Olive-Silverstone-Jamestown received more than 100 deliveries of emergency food hampers from the Red Cross between April and June 2020.

North York
(Wards 6, 7, 17)

- North York Harvest Food Bank reported that its food bank at the Herb Carnegie Arena served the most clients in its food bank network during COVID-19. The number of clients steadily rose from March until May. The week of May 18, North York Harvest served over 900 individuals and 430 households out of the Herb Carnegie Arena.
- Black Creek and Glenfield-Jane Heights neighbourhoods received more than 300 deliveries of emergency food hampers from the Red Cross between April and June 2020.

Scarborough
(Wards 20, 21, 22, 24, 25)

- Four of the TPL pop-up food banks were located in Scarborough (Cedarbrae, Kennedy/Eglinton, Agincourt and Steeles).
- The City of Toronto, GlobalMedic and the University of Toronto Scarborough launched CARES – Collective Action and Response for Everyone in Scarborough -- due to high food insecurity in Scarborough. CARES packaged food for distribution to food banks across Scarborough.

Emergency Food Interventions

The City's Emergency Operation Centre convened a virtual Food Security Table of key partners involved in emergency food provision, including City staff, Daily Bread Food Bank, North York Harvest Food Bank, Red Cross, Salvation Army, Second Harvest, United Way Greater Toronto and FoodShare Toronto. The Food Security Table coordinated an emergency food response for Toronto focusing on the most vulnerable communities. The Food Security Table resulted in number of unique food interventions:

1. **Supporting Food Banks and Emergency Food Providers**
   The City addressed food bank closures by opening alternative distribution sites in partnership with Toronto Public Libraries (TPL). This unique partnership with the City and community food partners resulted in the opening of 12 pop-up food banks supported at TPL locations in high-need areas across the city, supported by a library distribution centre which is normally used for books. City staff created a COVID-19 Resource Map to assess needs at the neighbourhood-level and help determine the locations of emergency food interventions. The intervention was supported by more than 150 library staff. These sites pack and distribute over 3,000 hampers a week. As of July 14, 11,574 households and 32,571 individuals were served through TPL food bank locations.

2. **Food Delivery for Seniors and other Vulnerable Residents**
   Responding to the Province of Ontario's recommendation for everyone over the age of 70 to self-isolate, the City worked with the Red Cross and other partners to provide food-hamper delivery to seniors and others in need who were/are unable to leave their homes. The Red Cross accepts calls at a dedicated hotline for residents who require this service. The service is available for qualifying clients who do not have alternative access to food and are not receiving assistance from another community food program. As of July 17, 13,458 food hampers were delivered to seniors/persons in isolation with Red Cross.

3. **Community Kitchens for Meal Preparation and Delivery**
   City staff, in partnership with Second Harvest and United Way, developed a community kitchen model to support large scale meal production and delivery for vulnerable residents. This response made use of existing inspected kitchens in community agencies and kitchen incubator space to produce meals at a large scale. Second Harvest provided food to these sites and oversaw the distribution of meals to vulnerable residents through member agencies. Various partners participated in the meal production using their catering kitchens, including Hawthorne Food & Drink, Maple Leaf Sports and Entertainment (MLSE), Feed It Forward and Kitchen 24. As of July 17, 254,225 prepared meals were distributed by MLSE. As of July 22, 8,795 prepared meals were distributed by community partners, restaurants and donors.

4. **Donation Matching**
   The Food Access team matched food-related donations and offers to community partner agencies. To date, staff leveraged over $628,000 from grocery stores for Toronto's food banks and community agencies. Through this initiative:

- More than 100,000 non-surgical masks were distributed to food banks.
- Grocery cards were mailed out to families with children (re-purposing the student nutrition grants) representing over 2.5 million meals.
- As part of the TO Supports Investment Fund, $4.97 million was distributed to more than 50 community-based agencies to continue to provide support to vulnerable communities. About $2.3 million of this fund was allocated to agencies and community organizations working on food access during COVID-19.

Food Security

The Food Security Table convened by the City's Emergency Operations Centre, coordinated an emergency food response for Toronto focusing on the most vulnerable communities. The Table resulted in a number of food interventions:

Food Security **Table partners** included:

- Daily Bread Food Bank
- North York Harvest Food Bank
- Red Cross
- Salvation Army
- Second Harvest
- United Way Greater Toronto
- FoodShare Toronto
- City Staff

Supporting Food Banks and Emergency Food Providers

The City addressed food bank closures by **opening alternative distribution sites in partnership with Toronto Public Libraries (TPL)**. This unique partnership with the City and community food partners resulted in **12 pop-up food banks** at TPL locations in high-need areas across the city, a COVID-19 Resource Map to assess needs and determine emergency food locations.

Supported by more than **150 library staff**.

Packed and distributed over **3,000** hampers a week.

11,574 households **32,571 individuals** Served through TPL locations, **as of July 14.**

Food Delivery for Seniors and other Vulnerable Residents

The City worked with the Red Cross and other partners to provide **food-hamper delivery to seniors and others in need who were/are unable to leave their homes**.

A Red Cross dedicated hotline for residents was available for clients who do not have access to food or a community food program.

13,458 food hampers were delivered to seniors/ persons in isolation with Red Cross, **as of July 17**.

Community Kitchens for Meal Preparation and Delivery

City staff, with Second Harvest and United Way, developed a community model to support large scale meal production and delivery for vulnerable residents. Use of existing kitchens in community agencies and kitchen incubator spaces. Second Harvest provided food and oversaw distribution to vulnerable residents through member agencies. Various partners provided their catering kitchens, including Hawthorne Food & Drink, Maple Leaf Sports and Entertainment (MLSE), Feed It Forward and Kitchen 24.

254,225 prepared meals distributed by MLSE, as of July 17.

8,795 prepared meals distributed by community partners, restaurants and donors, as of July 22.

Donation Matching

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as part of the TO Supports Investment Fund, **$4.97 million was distributed to more than 50 community-based agencies** to continue to provide support to vulnerable communities. About $2.3 million of this fund was allocated to agencies and community organizations working on food access during COVID-19.

7.6 **Mental Health Support Strategy (MHSS)**

The City developed a mental health support strategy to support residents during the COVID-19 pandemic. Measures put in place to slow the spread of COVID-19 have created stress and anxiety for many individuals, anxiety that may be compounded by financial loss and loss of critical supports. To assist residents experiencing stress and anxiety due to being isolated, quarantined, experiencing financial hardships or other mental health stressors, the City partnered with the following key mental health service providers to support the mental wellbeing of Toronto's most vulnerable. The MHSS has brought together 12 mental health partners providing services to diverse resident populations with a particular focus on supporting Indigenous, Black and racialized Torontonians.

- Across Boundaries for Black and Indigenous People/Persons of Colour (BIPOC)
- Caribbean African Canadian Social Services (CAFCAN) for Black residents
- Family Services Toronto
- Gerstein Crisis Centre
- Hong Fook
- Kids Help Phone and Crisis Text Line powered by Kids Help Phone
- Native Child and Family Services of Toronto (NCFST) for Indigenous residents
- Ontario Psychological Association for frontline workers in community agencies
- Progress Place Warm Line
- Strides Toronto
- The Access Point, and
- Toronto Seniors Helpline.

Residents can call 211 to access support and get connected to one of 12 primary mental health service partners for direct phone support. Mental health service information is also available at 211toronto.ca. These mental health support services are free to all residents. The Mental Health Support Strategy also redeveloped the City of Toronto Mental Health page to provide more targeted mental health support and guidance to Torontonians accessing the website. www.toronto.ca/home/covid-19/covid-19-protect-yourself-others/covid-19-mental-health-resources/

The MHSS hosts a regular biweekly partnership table meeting to facilitate ongoing learning, communication and coordination among partners.

As of July 29, the MHSS had facilitated 24,977 calls since its launch.

The MHSS will focus on finalizing the establishment of the MHSS grassroots mental health initiative, development of the MHSS reflection/evaluation document, and the launch of an Indigenous and anti-Black racism learning process for all 12 MHSS partners.

The MHSS team has identified the need to sustain the structure until December 2020 in the event of a second wave and to respond to the potential spike in mental health challenges that may occur in the fall and early winter. As a result, the MHSS will look to establish a partner-led MHSS model with three key partners that have the capacity to assume the lead of the MHSS with ongoing presence and support from City of Toronto staff. Through this model, the MHSS would continue to sustain itself through fall and winter 2020. The transition to a partner-led model will take place over August and September.

Mental illness through isolation – facilitating outdoor group activities such as street markets, park events, fireworks displays by reminding people that we are not alone and that the community still exists– and is in fact stronger for having gone through this together. It's important to rebuild our communities both in terms of economy but also in terms of societal links, in a safe way, as both will benefit folks' mental wellbeing.

Comment from Consultation

7.7 **Parks, Forestry and Recreation**

On the recommendation of the Medical Officer of Health, community centres and amenities in parks, including parking lots, playgrounds and fitness equipment, were closed, signed and caution-taped to encourage physical distancing. A bylaw regulating physical distancing in City parks and squares was established, and an interdivisional enforcement team put in place to educate the public and ensure physical distancing. To prevent the yearly crowds that attend High Park for the cherry blossom bloom, Parks, Forestry and Recreation (PFR) worked with Municipal Licensing and Standards, Toronto Police Service, Strategic Communications and Transportation Services to close High Park to pedestrian and vehicle access for the duration of the bloom. Residents were able to experience this year's cherry blossom season through digital livestream events and videos.

Through the three provincial stages of reopening, PFR has worked with the restart team, the Emergency Operations Centre and other divisions on the process to resume its services and is currently operating modified programming at its community centres, pools and camps. As of mid-August, PFR restarted additional community recreation services, including playgrounds and issuance of permits to sports groups and other users for the use of community centres, sports fields and gathering spaces, in accordance with the Stage 3 conditions.

7.8 **Support for Local Businesses**

Toronto's small and medium-sized businesses are at the heart of Canada's economy. There is no doubt that local restaurants, tech-startups and the entertainment industry have all been severely impacted by COVID-19. Over the course of the last few months, Economic Development and Culture has put programs in place to help business owners stabilize their operations and begin their rebuild. This work has largely happened across four key themes: new and enhanced programming; business outreach, advice and support; COVID-19 mitigation and reopening support; and rebuilding and re-imagining Toronto's economy. Some highlights include:

New and Enhanced Programs Activated

- **New Programs** – More than 25 innovative new programs launched to support Toronto businesses, including targeted, sector-based initiatives.
- **Collision from Home** – About 32,000 participants from 140 countries attended the online tech conference. EDC supported 15 virtual international delegations to promote trade with 520 participants from 26 countries.

Business Outreach, Advice and Support

- **Sector-based Roundtables** – Over 30 sector-based virtual roundtables supported by EDC as part of Mayor Tory's and the Toronto Region Board of Trade's outreach, with more than 350 business and community stakeholders participating.
- **AdviceTO** – Thirty-five weekly online group mentoring sessions held for Toronto businesses with more than 2,100 participants attending over 10 weeks.
- **ChatBot** – A total of 7,737 questions and answers developed for the ChatBot across 6 City Divisions, with an over 80 per cent answer success rate.
- **BusinessTO Support Centre** - 730 one-on-one virtual support sessions were held with businesses accessing the City's support and advice centre.

Mitigation and Reopening

- **CaféTO** - 420 restaurants and bars supported in accessing additional outdoor spaces across 35 Business Improvement Areas.
- **Digital Main Street** - 3,189 businesses supported with virtual assistance, with another 3,002 online retail stores being built under ShopHERE utilizing 1,000+ volunteer web developers and students from 27 countries.
- **Reopening Webinars** - Six reopening support webinars hosted in coordination with Toronto Public Health, with a total of 1,781 business participants in a range of targeted sectors.
- **Restaurant Ordering Platform** – A total of 946 local Toronto businesses supported in using Ritual ONE, resulting in a projected $1.4 million+ in total commission-free orders/ sales in 2020.

Rebuilding and Reimagining

- **Sector-based Action Plans** - Six new coordinated strategy development action plans in preparation, focusing on: Technology, Entrepreneurship, Manufacturing, Restaurants, Retail and Community Economic Development (to be completed in fall 2020).

7.9 **Strategic Partnerships**

Strategic partnerships help the City develop and implement innovative programs, leveraging resources to amplify a collective response to community needs. During the COVID-19 emergency, the Toronto Office of Partnerships (TOP) strengthened strategic collaborations with public and private sector organizations, philanthropists and residents. These partnerships bolstered the City's responses to communities in need.

When the Mayor declared a State of Emergency on March 23, TOP established a Donations Coordination Task Force, within the Emergency Operations Centre, to facilitate the donation of funds, services and products, engaged Toronto's eight public sector universities and colleges to assist with modeling, research and expert advice and reached out to healthcare partners for assistance with clinical health supports.

The Donations Coordination Task Force activated DonateTO, the City of Toronto's online donation platform that provided a one-stop solution for businesses, public sector organizations and residents to donate products, services and funds for pandemic relief. The task force also established a Partnerships Table to reach out to corporate Canada and collaborate with community organizations to develop and implement a donation distribution strategy.

That work resulted in gifts of goods, services and funds valued at more than $4 million, directly contributing to the delivery of vital, community-focused services. Donations included face coverings/ masks, food supports, household items for vulnerable individuals who needed to isolate, space for the expansion of critical services, toys for children, and technology products that helped youth stay on track with their schooling and helped seniors stay connected with others.

The City also worked closely with institutional partners including Toronto's eight universities and colleges as well as with healthcare providers. These strategic partnerships resulted in faculty and students supporting the City with economic and clinical modeling; students supporting track and contact tracing efforts and the development of 17 research projects focused on themes including Public Health, Transit and Transportation, Scenario Planning and Forecasting, Supporting Vulnerable Communities, Climate Change and Planning and Adapting Public Spaces, which will continue to assist Toronto's recovery and rebuild efforts.

Beyond the immediate success of DonateTO and the Task Force collaborations, the City built new and stronger relationships with public sector institutions, philanthropists, corporate Canada and residents, which will support future partnerships the Toronto Office of Partnerships will steward to explore new opportunities for the City to reimagine and rebuild in close collaboration with its partners.

7.10 **Mobility**

The COVID-19 pandemic resulted in direct impacts to the transportation system and mobility in general in Toronto. In anticipation of recovery, the City responded by implementing and modifying programs that support city-building efforts and the City's mobility goals. The City also built in measures to be able to scale and be flexible to adapt if the nature of the pandemic changes.

I would like the City to address the issue of availability of transit by taking the action of working with provincial and federal government to plan and fund more subways, LRTs, Express bus lanes and make the city better...

Comment from Consultation

During the onset of the pandemic, essential travel and peak hours shifted to earlier times, resulting in ridership levels that made physical distancing difficult on public transit. Delays on roads were significantly reduced. During the week of July 25-31, there was an average improvement in city-wide travel times of 37 per cent and 44 per cent during a.m. and p.m. peak times. Total weekday cycling volumes have remained largely in line with historical volumes, but with shifts in time-of-day profiles – to mirror weekend-type travel patterns for cycling and bike sharing.

Considerations for managing the city's transportation system during the pandemic and post-COVID-19 recovery include travel requirements of essential workers, public transit, and changes in demand for single-occupancy vehicle travel and potential traffic congestion implications over time if physical distancing is maintained.

It is important to provide safe access to transit and other travel options for work and daily activities, including grocery shopping, getting to medical appointments, volunteering, and other destinations. Safety, a common thread throughout the public survey, will become more important as more people use active transportation (e.g. cycling, walking). This trend can also be supported by increasing public awareness of the benefits of reducing automobile traffic.

Transit reliability, speed and reduced crowding in neighbourhoods with vulnerable populations, such as people with low incomes, women, youth and racialized groups, have the potential to improve access to economic development opportunities, City and other government services and spaces, food, health services and recreation. Many respondents to the public survey would like the City to address crowding, with some encouraging the City to make transit free and accessible.

Transportation initiatives should be sustainable and resilient, including but not limited to supporting public transit, active transportation and demand management to adapt to and mitigate the impacts of climate change. Public survey respondents are interested in "sustainable" and "green" transportation.

Public survey findings also reiterated the importance of green space and parks and, more specifically, the "equitable access to green space". Many asserted that there is not enough green space, parks or space for walking and biking.

Active Transportation

In response to the COVID-19 health crisis, the City accommodated more space for residents to be outside of their homes while physical distancing and taking part in physical activities, including increased space for pedestrians, people queuing for shops and services, and for cycling.

Adaptations to the city's public transit, roads and public spaces are required to support ongoing and long-term requirements for physical distancing.

For example, ActiveTO was launched to increase the space people can use to get around the city (e.g. by walking and biking) to allow for physical distancing. It was evaluated against several factors, including population density, equity, access to greenspace and traffic volumes. ActiveTO initiatives included:

- Quiet Streets as a means of turning streets into shared space by installing signage and temporary barricades to encourage only slow, local vehicle access. As of June 10, 32 Quiet Street Routes were installed on 65.27 km of roadway.

- Major Road Closures - short-term closures (i.e. weekends and holidays) of major streets adjacent to trails that provide more space for walking and cycling.
- An expanded cycling network allowed people to bike safely, connect to priority areas, and mirror major transit routes as a response to a decrease in TTC ridership and to reducing demand on public transit that would otherwise put pressure on social distancing. The City Council-approved plan is the largest one-year expansion of on-street bike lanes ever in Toronto, with 40 km of lanes approved for accelerated installation in 2020.

ActiveTO Stats – Saturday May 23 Counts

ACTIVETO STATS – SATURDAY MAY 23 COUNTS

21,000
Cyclists counted on **Lake Shore Blvd West** at Ontario Dr, compared to 21,000 cars pre-COVID weekend.

4,700
Cyclists counted on **Bayview Ave**, north of River St (with another 3,400 cyclists on the Don Valley Trail alongside).

5,000
Cyclists counted on **Lake Shore Blvd East**, east of Coxwell Ave, compared to 12,200 cars pre-COVID weekday.

4,400
Pedestrians counted on **Lake Shore Blvd West** at Ontario Dr.

1,000
Pedestrians counted on **Bayview Ave**, north of River St (with another 750 cyclists on the Don Valley Trail alongside).

5,400
Pedestrians counted on **Lake Shore Blvd East**, east of Coxwell Ave.

The different levels of government needs to come together with a coordinated efforts to solve issues related to housing. COVID-19 has shown us how the lack of affordable housing options in Toronto has made it challenging for our most vulnerable residents.

Comment from Consultation

Transportation Innovation

The City is also exploring partnerships in its recovery strategy. An example of a strategy is Transportation Innovation Zones (TIZ). TIZs in rights-of-way will:

1. Help the City and the public understand emerging transportation technologies by allowing them to be transparently tested in Toronto
2. Support economic development by facilitating appropriate private and academic sector-led research and development in a real-world setting, and
3. Provide an area to focus City-led testing of transportation technologies and materials.

Transit/TTC

The Toronto Transit Commission (TTC) is a critical service in Toronto today, supporting the City's economic vitality, employment growth and social cohesion. It also connects Toronto's diverse communities to economic and social opportunities through an integrated network of transit services, including subway, bus, streetcar and Wheel-Trans modes. The most heavily used transit system in Canada and the third largest in North America, the TTC serves approximately 530 million riders annually. Further development of the transit network is important for the City to achieve its broad range of economic, social and environmental city-building objectives. Before the COVID-19 pandemic, transit played a pivotal role in keeping the city moving; each day enabling hundreds of thousands of people to travel to essential destinations including employment, grocery stores, pharmacies, healthcare facilities as well as to access leisure and recreational activities. There is a strong reliance on the transit network in Toronto, with approximately 46 per cent of all trips in the downtown and 28 per cent of all trips city-wide made by transit.

Available and affordable public transit can effectively reduce poverty through increased access to social and health services, community resources and economic opportunities. The inability of a portion of the population to easily move throughout the city decreases the economic and social returns on transportation investments. It hinders economic growth and prosperity, counteracts government efforts for efficiency, and may contribute to health inequities within the population.

Throughout the pandemic response, and despite the considerable drop in ridership, the TTC has remained committed to maintaining transit services with a special focus on serving neighbourhood improvement areas because reliable, safe transit is particularly important for Toronto's vulnerable communities. Many Toronto residents do not have options other than transit for getting to work, school and home, which was evident on the TTC during the pandemic. Rates of ridership did not decline as much for those riding the bus, with 36 per cent of bus customers continuing to use the TTC system compared to 19 per cent of subway customers. Supporting and improving the transit network helps to address inequities in the city and provides better service to those who need it the most. Therefore, while conventional system ridership experienced 15 per cent of normal levels, transit service was maintained at approximately 80 per cent overall. In addition, the demand-responsive service plan ensured additional resources were added to key routes when required to ensure physical distancing guidelines were followed.

As of July 31, the TTC continued to see ridership peaking about an hour earlier when compared to pre-pandemic ridership levels. Transit demand continued to be higher in areas outside of the downtown core, especially the northwest and southeast areas of the city. The downtown core continued to see less increase in transit use due to the continuation of work-from-home for the majority of downtown offices. Since Toronto entered the province's Stage 2 and Stage 3 of reopening, the increase in transit trips has been more evenly distributed across the city as shopping malls opened.

March 2-6 Average Weekday Boardings (Pre-COVID-19)

Bus	1,381k
Streetcar	350k
Subway	1,429k
Overall	**3,160k**

July 6-10 Average Weekday Boardings (During COVID-19)

Bus	547k	(40%)
Streetcar	105k	(30%)
Subway	375k	(26%)
Overall	**1,027k**	**(33%)**

This information is based on PRESTO taps on all modes and automated passenger count (APC) data for buses.

With the continued service and the significant drop in ridership, there has been enormous financial stress put on the TTC. Gradual recovery is expected to place an ongoing strain on TTC operations and its ability to support Toronto's broader economic recovery. During the pandemic, the TTC has been experiencing an average impact of $90 million per month.

Financial impacts are likely to continue into 2021 given that some level of pandemic response measures is expected to continue for both staff and transit riders, including remote working arrangements; physical distancing and other safety measures as well as ridership behaviour and service demand.

7.11 **Growth and Development**

COVID-19 will continue to have significant fiscal, economic and social impacts, with major short- and long-term consequences, to the city and Toronto's development industry. Over the next 10 years, the estimated value of development activity in Toronto is over $200 billion and ensuring that activity resumes quickly post-crisis is critical to Toronto's economic recovery. The City developed a Concept 2 Keys (C2K) program to improve how the City of Toronto attracts, facilitates and regulates development activity. C2K builds on the End-to-End Development Review undertaken by the City prior to the pandemic, with an expanded scope and accelerated timelines.

The emergency, and the associated economic impacts, have required the City to adjust its processes and accommodate and innovate to meet new challenges. In the past few months, C2K worked closely with the development community and soft launched a new online intake portal for a range of development applications. Currently, the C2K team is expanding the portal by adding additional application types and preparing for a broader public launch.

Construction

The City of Toronto's Building Division will support Toronto's economic recovery by supporting the construction sector and redirecting resources from enforcement to enabling development. Digitizing services will be critical because industry stakeholders want access to services on demand, without having to go in person to City offices. That means providing easily accessible information on the status of applications, including any outstanding requirements that might be holding up approvals.

Toronto Building is in the middle of a program review that will focus on better meeting the needs of developers and the construction sector, shifting its organizational culture and providing the public and industry stakeholders with clear protocols and online tools to assist them with their applications. The City will aim to eliminate multiple reviews and will bundle approvals on small projects to fast-track the process of permit issuance.

Housing Development

Toronto still faces substantial housing needs across all types, tenures and levels of affordability. Diversifying the variety of type and form of housing permitted in the city's neighbourhoods would, among other solutions, increase housing choice and access for residents.

It will be important for the City to consider ways to leverage market investments as part of its recovery strategy while being responsive to expectations and needs of diverse communities and ensuring the needs of residents to live in safe, affordable, accessible and livable neighbourhoods are met.

Options for expanding the City's parks and public spaces are limited, so creative options for acquiring new assets, as well as innovation in how available public spaces are used, will be necessary to respond to restrictions and meet health requirements while living in a COVID-19 environment. The City has seen an increase in the use of parks during the emergency as residents seek safe alternatives to staying indoors, engaging in social distancing outside to reduce the risks of contact and contamination, and to mitigate the impact of isolation.

Mobility and Transit Support the City's Growth Plan

Input to TORR's engagements identified the need for an expanded, connected transit network as central to the city being able to respond to current and future growth and development, including an expected 500,000+ new residents over the coming decades. A well-developed rapid-transit network will be essential for Toronto's economic competitiveness and for the region's competitive success as a whole.

The City's Official Plan, the Provincial Policy Statement, 2020 and the Growth Plan for the Greater Golden Horseshoe each contain policies to encourage the development of complete compact communities with strong transit connections. Such communities make more efficient use of infrastructure and reduce the need for travel and the associated environmental impacts.

Reliable, safe transit is particularly important for Toronto's vulnerable communities. Supporting and improving access to the transit network will help address inequities in the city and provide better service to those who need it most.

Effective and reliable transit also helps address Toronto's congestion. A high-quality transit system enables more people to move through the city more easily and efficiently than the congestion that comes from a reliance on cars.

7.12 **Public Engagement**

Civic engagement is a core service of the City. It supports public and stakeholder involvement in visioning, issue identification, solution development, implementation and monitoring. It is an integral part of good governance and informs staff and City Council decision-making and virtually all City programs, policies and services. City-led engagement activities are diverse and number in the hundreds each year. Engagements include in-person and online methods, surveying, broad policy and issue-specific discussions, local and city-wide consultations, public appointments, polling, legislated public meetings, workshops and planning charrettes, and partnerships.

Over the years, the City has adopted an approach to engagement that provides the flexibility to achieve a variety of engagement objectives with diverse populations and a wide range of approaches. City divisions, agencies and corporations resource and lead most of their own engagements. That has helped them build considerable stakeholder knowledge and engagement expertise in areas such as environmental assessments, planning considerations, co-development and relationship building with Indigenous organizations and communities, and partnerships with vulnerable and equity-seeking groups. The City Manager's Office has played a support and convening role, leading city-wide engagements when directed by Council, providing training, research and a community of practice for City divisions and agencies to share experiences, learn from each other and collaborate on complex or large engagements.

Public feedback, lessons from other Canadian municipalities, and research all suggest ways that cities, including Toronto, can evolve civic engagement to better meet the needs of their public, staff and Council[116]. The public is committed to participating on a wide range of issues with their local government, but a lack of trust and connection, uncertainty about how feedback will be used by decision-makers, and other systemic barriers to participation are keeping the City from always achieving a truly high standard in its public engagements.

The City needs a more responsive and coordinated approach, a larger toolbox of engagement and data management methods, and the ability to meet equity and accessibility objectives and the growing public expectation and interest in playing a greater role in local and city-wide decision-making. This expectation includes meeting communities' unique needs, including respecting self-determination of Indigenous peoples and honouring commitments the City has made with respect to the United Nations Declaration on the Rights of Indigenous Peoples

A sustained investment in public engagement, including establishing a corporate lead, would increase the City's ability to deliver regular engagements as well as urgent or unscheduled engagements during difficult times such as during a pandemic or emergency. During the pandemic, the City leveraged its divisional expertise and relationships with community organizations to form ad-hoc working groups that led responses on a range of critical issues. With TORR, new staff groups and community partnerships formed to plan and implement significant community engagement on recovery and to restart divisional engagement on time-sensitive matters such as development and capital planning. This work was challenged by the lack of consistent divisional policies, training and staff resources to quickly resume engagement and manage public and internal feedback. Protocols, training, policies and tools would support effective, timely, quality engagement and new and strengthened relationships with residents, communities and partners.

We need to see more people of colour in leadership and as representatives in training programs.

Comment from Consultation

An effective toolbox of engagement and data management methods

In recent years, divisions and agencies have explored new methods such as online discussion platforms, telephone town halls, storefront, mall, park and street pop-ups, partnership tables, civic juries and training programs for resident leaders to build civic literacy and partnerships in delivering engagements. Often, these approaches gather valuable feedback and strengthen relationships for a particular project, but the lack of corporate-wide coordination and shared resources and tools have also led to unsustainable pilots, procurement delays, consultation fatigue or frustration, uneven distribution of resources and learnings, and inconsistent experiences for the public. Similarly, the City and the public would benefit from a coordinated approach to managing and gaining insights from participant information and feedback. Engagement data should be managed in ways that protect privacy, enable the City to proactively reach out to stakeholders on issues that they identify are important to them, support Open Data commitments, and share relevant data. Examples of engagement data include stakeholder networks and feedback on common issues across divisions and agencies to continuously improve relationships and engagement.

An equitable and accessible model

The perspectives of equity-seeking, Indigenous, Black and vulnerable individuals and communities are typically under-represented in policy and decision-making processes compared to other populations, due in part to the need for customizable engagement approaches that account for differences in mobility, culture, language and other socioeconomic factors. As staff engage greater numbers and a growing diversity of people through a wider range of methods, the public have expressed concerns that methods are still inaccessible, that the City engages the same groups and individuals in a piecemeal rather than coordinated manner, and that their own input does not influence decision-making.

The pandemic has exacerbated some barriers to participation. For example,

- Physical distancing and facial covering requirements and limits on numbers of people that can gather significantly affect the City's ability to engage in person at meetings, community fairs and events. Even when in-person methods can be modified and delivered safely, many people may avoid such interactions, particularly people who are hesitant to travel on public transit or are more vulnerable to COVID-19.
- Digital tools such as online surveys and web-based platforms offer ways to reach people, particularly when they cannot gather in person, but the City must consider how these platforms can be accessible and safe spaces for community conversations, and where other engagement methods may be preferable or can complement digital methods.
- Individuals and communities in Toronto who have been disproportionately impacted by COVID-19 may be less likely to participate in engagement activities, including those living in long-term care, people experiencing homelessness or food insecurity, and some racialized communities. It is critical that engagement methods or stigma do not limit the participation of these individuals and communities.

How do we do any of this if those that are struggling are not part of the power structure?

Comment from Consultation

The City must strengthen its engagement approach to build trust and relationships through a consistent, accessible and high-quality engagement experience for the public and stakeholders. Engagement benefits Council and City divisions by ensuring purposeful processes, resulting in timely, applicable input that supports informed decision-making.

More accessible touch points for community members to engage and influence decision making processes, such as citizen assemblies, town halls, and community governance boards both online and in person with public health safety protocols, [will] foster democracy at the local level.

Comment from Consultation

7.13 Agencies and Corporations

Purpose of City Agencies and Corporations

City Council has chosen to deliver services through agencies and corporations for a variety of reasons, including:

- Meeting legislative or objectivity requirements
- Leveraging City resources by attracting funding
- Meeting objectives beyond core municipal services
- Operating in a commercial market environment
- Adding expertise and experience
- Engaging local community and diverse perspectives to guide service delivery
- Limiting the City's liability

The City's agencies range in purpose and function and generally fall into three broad categories:

- Service agencies, which include agencies where legislation limits Council's authority;
- Quasi-judicial bodies; and
- Business Improvement Areas

A full list of the City's agencies and corporations is available at www.toronto.ca/city-agencies-corporations-copy/.

Governance of City Agencies and Corporations

City Council has authority under the City of Toronto Act, 2006 to establish, change and dissolve City agencies and corporations, with some exceptions. City Council delegates authorities and defines the governance structure, mandate and relationship between the board and the City, and requires agencies and corporations to follow policies, procedures and reporting requirements established by the City. Three agencies -- the Toronto Police Services Board, Toronto Public Library Board and Toronto Board of Health -- are governed in accordance to provincial legislation specific to their responsibilities. This legislation results in restrictions to Council's authority over agencies under the City of Toronto Act. City Council approves the budget of City agencies and appoints members to its board, and in some instances appoints its chair.

City Council is also the shareholder of City corporations, appoints members to their boards and establishes their mandate, and reporting and other requirements. Given the differing history and mandate of each entity, City agencies and corporations operate with various degrees of autonomy and independence from City Council.

COVID-19 Response by Agencies and Corporations

The City's agencies and corporations are often called on to support City-wide objectives, and often seek guidance and support from the City to ensure they are aligned with one another and with the City's priorities. The response to the pandemic provided many examples of this relationship and the key role City agencies and corporations play in the city's well-being:

- Toronto Police Services assisted with bylaw enforcement;
- Toronto Community Housing Corporation provided housing for homeless people living outside;
- Toronto Public Library enhanced access to its online collection and provided space and staffing to offer food hampers to families;
- Some Association of Community Centres (AOCCs) community centres modified their food programs and offered virtual services to vulnerable clients;
- Toronto Public Health led and continues to lead the City's COVID-19 health response;
- The Toronto Transit Commission (TTC) continued to provide its essential service with modifications to ensure emergency workers could travel to workplaces; in doing so, the TTC has run a significant deficit to ensure that its vital transit service continues to be provided.
- Business Improvement Areas worked closely with stakeholders and the City to support main-street and small businesses.

To support City agencies and corporations in fulfilling their emergency response activities and manage their operations through the pandemic, the City provided the following support:

- public health advice,
- access to PPE,
- emergency cash flow,
- facility playbooks to close, run and reopen facilities safely,
- occupational health and safety guidance,
- governance advice and supports,
- forums for regular information-sharing between the City and agencies, such as on human resources, and
- legal supports.

Aside from these important collaborations, some City agencies did report they were not engaged consistently by the City in the early stages of the pandemic response, and that the City didn't provide adequate and timely information and guidance about facility closures and service suspensions. The City has emergency response provisions in the Toronto Municipal Code, but similar provisions are not required of agencies and corporations. Some larger agencies set up their own emergency operations centres, which facilitated communications and responses between the agency and the City (agencies such as Toronto Public Library and TTC). Given the unprecedented duration and nature of this emergency, the City may consider a review of emergency processes and procedures between the City and its agencies and corporations to prepare for future occurrences, applying lessons learned from the COVID-19 pandemic.

Staff consulted with, received emails and calls from, and participated in discussions with City agencies and corporations resulting in the following suggestions for greater alignment with the City. Agencies and corporations would like to see:

- The City build on communication and coordination networks with agencies and corporations developed through the response and restart on an ongoing basis for recovery and rebuild;
- The City better inform and support agencies and corporations in their efforts to return to safe operations in a timely fashion;
- Senior City leadership communicate the City's emergency response, critical and essential business continuity, and recovery and rebuild priorities for each agency and corporation as applicable;
- The City conduct a structural review of community centre models to help determine best alternative service models; and
- The City work directly with agencies to advance initiatives and influence policy related to climate change, protection of vulnerable populations, and other objectives.

Financial Impact of COVID-19 on City Agencies and Corporations

COVID-19's impact on, and response from, the City's agencies and corporations differed depending on their mandate and service area, legislative framework and revenue sources. One of the primary impacts on several City agencies has been a loss of revenue resulting from COVID-19 closures. These agencies and corporations depend on revenue from fares, market sources and non-City funding (provincial, federal or charitable) such as the recreational, arts, social services and tourism focused organizations. Small community-based organizations such as the board-run community centres derive revenues mainly from memberships and donations, while larger boards such as the Toronto Parking Authority and Exhibition Place tend to engage in commercial ventures to manage City assets. In most cases, City agencies and corporations are partially subsidized by the City government.

As municipal entities, City agencies are ineligible (with some exceptions) for direct assistance through many federal and provincial emergency programs that were available to other similar commercial or not-for-profit enterprises. City agencies reached out to the City for financial support and advice including regarding staff layoffs during the closures. They remain anxious about the financial options available to them for operational sustainability.

The City of Toronto supported its agencies and corporations with financial assistance during the COVID-19 pandemic, with a priority on requests for emergency relief funding. Agencies and corporations are provided funding (i.e. scheduled subsidies or emergency funds) once other sources of cash are depleted. The City anticipates that this cash flow process will continue for the foreseeable future, as agencies and corporations are experiencing financial pressures that will likely endure beyond 2020.

Restarting Agency and Corporations Services following COVID-19 Closures

Public-facing agencies began plans for reopening in-person services through spring/summer 2020. They expressed concern that their client base may not return, and by operating at the required lower capacity levels to sustain physical distancing, anticipate there will be little opportunity to recover their revenue potential. To mitigate these challenges, many agencies and corporations are reviewing their business models and how they deliver services, as well as engaging in novel marketing efforts, containing costs through measures such as staff reductions, and expanding fundraising efforts.

Some of the suggestions City agencies and corporations have provided the City to facilitate greater support in the short term include:

- Providing certainty regarding continued short-term and long-term funding for agencies and corporations to support operations through a potential second wave and to recover and rebuild;
- Assisting with pandemic-related costs and supplies (e.g. PPE, cleaning, engineering solutions, technology support);
- Providing assistance to enable the use of critical or essential agency and corporation services;
- In the longer term, allowing for year-end surpluses to flow to a reserve account for agencies or corporations to use to address emergencies in future years; and
- Eventually returning to funding strategic capital projects to support and transform their operations.

Modified Service Delivery

In addition to the financial pressures, agencies and corporations will have to continue to modify services and delivery approaches and implement public health measures, much like the City. Several agencies host large events and attractions as part of their key revenue sources (e.g. Exhibition Place hosts trade shows and conventions, TO Live operates performing arts venues, Toronto Public Library and community centres rent out space for meetings and events). While revenue will be limited as the market for large events will likely be depressed for the foreseeable future, they are pivoting to explore smaller events and alternative use of space. As well, drop-ins, community meetings and general public access to facilities such as community centres are likely to remain curtailed or modified, limiting their program offerings. While arenas are gradually opening with Stage 3 for Toronto, their operations will be modified in compliance with public health measures and legislative restrictions.

Agencies and corporations are using or exploring the use of technology to shift their services to a safer virtual platform, aware that this shift may not adequately meet the needs of their clients, who include low-income families, seniors, newcomers and people with disabilities.

To address some of these impacts, agencies and corporations recommend that the City:

- Continue communication with agencies and corporations to discuss common impacts to social agencies and opportunities to protect vulnerable clients;
- Prioritize longer term solutions (e.g. permanent housing, community social and mental health, community recreation) over crisis-oriented responses (shelters, policing);
- Continue advocacy efforts with the province to provide Toronto with the tools and resources it needs to effectively address challenges; and
- Offer support for virtual platforms to engage community members and provide online services.

Opportunities for the City to Leverage Agency and Corporation Assets

In addition to delivering a range of services to meet the City's strategic, financial and public policy objectives, City agencies and corporations generate and manage a significant portion of the City's physical assets, revenues and other resources. Agencies and corporations manage 48 per cent of the City's gross operating budget and have 27,870 total positions, representing 54 per cent of the City's workforce. These assets, a significant resource, need to be considered against risks for the City when considering planning for Toronto's recovery and rebuild as well as responses to future waves of COVID-19.

Shared Services and Strategic Alignment

The City provides the capital and operating budgets and a range of administrative supports to community-based agencies. The City launched the Shared Services Project in 2013 to identify opportunities for the City to further consolidate key administrative functions across agencies and corporations, including an exploration of how strengthening internal agency supports may achieve potential cost savings.

Given the significance of City agencies and corporations relative to the City's budget, a whole-of-government approach may be required to achieve strategic alignment with Council objectives, mitigate financial risks and ensure agency and corporation resilience over the long term. To that end, recognizing each entity's unique needs, circumstances and scope of responsibility, the City could undertake a review of the impacts of COVID-19 on agencies and corporations, including opportunities to accelerate service digitization and cost savings through shared services.