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G-36

Standing Committee on General Government

Strengthening Quality and Accountability for Patients Act, 2017

2nd Session
41st Parliament

Thursday 16 November 2017

Chair: Grant Crack
Clerk: Sylwia Przezdziecki

Journal des débats (Hansard)

G-36

Comité permanent des affaires gouvernementales

Loi de 2017 renforçant la qualité et la responsabilité pour les patients

2e session
41e législature

Jeudi 16 novembre 2017

Président : Grant Crack
Greffière : Sylwia Przezdziecki

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON GENERAL GOVERNMENT

COMITÉ PERMANENT DES AFFAIRES GOUVERNEMENTALES

Thursday 16 November 2017

Jeudi 16 novembre 2017

The committee met at 0830 in committee room 2.

STRENGTHENING QUALITY AND ACCOUNTABILITY FOR PATIENTS ACT, 2017

LOI DE 2017 RENFORÇANT LA QUALITÉ ET LA RESPONSABILITÉ POUR LES PATIENTS

Consideration of the following bill:

Bill 160, An Act to amend, repeal and enact various Acts in the interest of strengthening quality and accountability for patients / Projet de loi 160, Loi visant à modifier, à abroger et à édicter diverses lois dans le souci de renforcer la qualité et la responsabilité pour les patients.

The Chair (Mr. Grant Crack): Good morning, everyone. I'd like to call the Standing Committee on General Government to order.

We are here again this morning to go through the public hearings on Bill 160, An Act to amend, repeal and enact various Acts in the interest of strengthening quality and accountability for patients.

We have a full agenda. I would like to remind everyone presenting this morning that the presenters have up to five minutes for their presentation, followed by nine minutes of questioning. I am going to have to keep the schedule tight, so if I interrupt you at some point, I apologize, but I have to do my job.

REGISTERED NURSES' ASSOCIATION OF ONTARIO

The Chair (Mr. Grant Crack): First on the agenda is the Registered Nurses' Association of Ontario. I believe we have Doris Grinspun, the chief executive officer, and Mr. Jarvi, senior economist. We welcome you both. You have up to five minutes.

Dr. Doris Grinspun: Thank you very much and good morning, everyone. As you heard first from France Gélinas—thank you—my name is Doris Grinspun and I am the CEO of the Registered Nurses' Association of Ontario, RNAO. With me today, as you mentioned, is Kim Jarvi, RNAO's senior economist.

First, we wish to thank you for the opportunity to present the views of Ontario's RNs, NPs and nursing students to the Standing Committee on General Government.

RNAO supports Bill 160's objectives of strengthening transparency, accountability and quality of care in a person-centred health system. However, we caution against the unintended consequences of a number of the measures in the bill, such as expanding the practice of paramedics to primary care, accelerating potential privatization of health services, and further compromising safety of residents in long-term care.

Our key recommendations are as follows.

With respect to schedule 1, we support allowing ambulances to go to destinations other than hospitals when appropriate so long as clients are given the choice of where to go. We oppose paramedics' role going beyond first aid to deliver primary care, as they do not possess the necessary knowledge and competencies to do so. Added to this is the fact that allowing paramedics to deliver primary care will disrupt continuity of patient care at a time when we are working to anchor the system in primary care.

With respect to schedule 4, we urge a total ban on the practice by the medical industry of making payments to health care professionals and to their organizations. Until that happens, we welcome full public disclosure of the payments and urge a very low reporting threshold and very few exceptions.

With respect to schedule 5, we support strong compliance measures in long-term care but urge the fines only to be imposed as a last resort. While homes generally have high rates of compliance, few escape with no citations. The legislation could result in widespread imposition of fines, which would reduce the necessary resources to actually comply with expectations. As a first measure, inspectors should work with the homes to help them achieve compliance through the application of best practices such as RNAO's Ministry of Health and Long-Term Care Best Practices Program.

We also support measures to minimize the use of restraints and confinement in long-term care. In its action plan for seniors, the province announced an average of four hours of direct nursing, personal support and therapeutic care per resident per day. We urge the ministry to go further and legislate minimum staffing in long-term care as follows: one attending NP per 120 residents, and a staff mix of 20% RNs, 25% RPNs and no more than 55% personal support workers. This exists already in other jurisdictions both in Canada and abroad.

With respect to schedule 7, we welcome the amendment of the Ontario Drug Benefit Act to expand the list of acceptable prescribers beyond physicians. Nurse practitioners and RNs with appropriate training in prescribing will help reduce the bottleneck in the primary care system—NPs already do; RNs are coming—and we urge that they be added to the list of acceptable prescribers in the regulation.

We are very concerned with schedule 9, which will effectively lift the ban on the creation of private hospitals in Ontario. Thus, we oppose the repeal of the Private Hospitals Act and the Independent Health Facilities Act and ask for the complete withdrawal of schedule 9. We understand and support extending regulations over health facilities that are not adequately covered under existing legislation; however, that should be done under separate legislation.

With respect to schedule 10, we support proceeding with strengthening oversight of retirement homes and with regular audits of the Retirement Home Regulatory Authority by the Auditor General and reviews of the RHRA by the ministry. We are concerned that self-regulation continues in a for-profit sector that provides service to vulnerable people. Direct oversight by government would be much more appropriate.

We are also concerned that restraints and confinement are acceptable under the current and proposed legislation and urge that the practices be banned except under temporary and extraordinary circumstances until those residents can be placed in more appropriate settings.

With that, we're complete. Thank you very much.

The Chair (Mr. Grant Crack): That's great. Mr. Yurek, from the official opposition.

Mr. Jeff Yurek: Thanks for coming in today and for the information. With regard to paramedics—there are a couple of projects going on in trials in Huron county, I believe—with paramedics providing paramedicine. You don't support the paramedics having that expanded—

Dr. Doris Grinspun: We do not support paramedics specifically providing primary care. An effective and efficient health system and a high-performing one is anchored in primary care, and that should be comprehensive primary care. This will disrupt both the continuity of primary care—as well, they do not have that expertise.

Mr. Jeff Yurek: You didn't make any mention of fire-medics. Do you have any problem with the creation of a fire-medic role?

Dr. Doris Grinspun: We would not support other people than those who work in primary care. Unless we want to put them in primary care, by all means—but primary care should be provided by primary care providers.

Mr. Jeff Yurek: With regard to the Ontario Drug Benefit Act, you're asking to add in RNs as prescribers?

Dr. Doris Grinspun: That is correct, because, as you know, the minister already sent the directive to the college to move ahead with RN prescribing, so it will make sense to do that.

Mr. Jeff Yurek: We might as well do it while we're having the act open?

Dr. Doris Grinspun: That's right.

Mr. Jeff Yurek: Thank you.

The Chair (Mr. Grant Crack): Madame Gélinas.

M^me^ France Gélinas: Thank you so much for your analysis of the bill. I would say that I agree with 99% of what you say. I am curious, though, when you said that we already have jurisdictions that do—this is in the four hours of hands-on care—the ratio of 20%, 25%, 55%: where in Canada?

Dr. Doris Grinspun: It was two things that I was referring to in that. They're, first of all, way better than 20% or 25% in New Brunswick—way, way better than ours. By legislation, they have a much richer ratio. With the complexity of people we have today. It goes without saying that we put the minimum that we believe is safe.

Outside of Canada, in states like California and others, there are actually legislated ratios, not only in long-term care but also in hospital care.

As you know, we're also speaking in other forums about hospital care—acute care, specifically. That is related to the research that shows the impact of staffing—not necessarily policing but staffing—on the outcome of people.

M^me^ France Gélinas: Agreed.

You have concern with the lift on the creation of private hospitals. You've also seen in the bill that now independent health facilities are going to be called "community health facilities." To me, "community" means something really different than an independent health facility. Do you have any problem with renaming independent health facilities "community health facilities"?

Dr. Doris Grinspun: We are suggesting that they shouldn't be renamed, that they're not renamed.

M^me^ France Gélinas: That it stays the same?

Dr. Doris Grinspun: Yes.

Mr. Kim Jarvi: The Association of Ontario Health Centres is opposed to this as well because of the confusion with community health centres.

M^me^ France Gélinas: Agreed.

When it comes to the use of restraints and confinement in retirement homes, you said, "be banned except under temporary and extraordinary circumstances." Where would you see those extraordinary circumstances defined—in the bill, or in regulation? I'm so afraid to open up that door.

0840

Dr. Doris Grinspun: We are afraid as well. We are quite concerned about what's happening in general in retirement homes in the scope of clients that they are still maintaining, because it creates confusion about who is in retirement homes.

There could be extraordinary circumstances, and you don't want to put the person or the providers in danger. One suggestion would be when we know that in a very short time the person is going to be transferred.

Mr. Kim Jarvi: Sometimes it takes time to place people, and their condition may deteriorate.

M^me^ France Gélinas: If I was to put in the bill something like "temporary or extraordinary circumstances, where a transfer is imminent, within the next four to five days," is this what you had in mind? Or is "within the next month" more what you had in mind?

Dr. Doris Grinspun: No, not in the next month, because that will actually encourage them to maintain clients inappropriately. I would say "within the next 48 hours."

M^me^ France Gélinas: The next 48 hours. Okay, thank you.

The Chair (Mr. Grant Crack): We'll move to the government side: Mr. Fraser.

Mr. John Fraser: Thanks very much for your very thorough presentation and getting it all done in a very short period of time.

Two things I want to talk to you about: the transparency part of the bill—and I appreciate your support for that. You said "very few exceptions." What would you consider to be an exception?

Dr. Doris Grinspun: To the transparency bill?

Mr. John Fraser: Yes.

Dr. Doris Grinspun: None. That was in relation to restraints in retirement homes.

In relation to the transparency bill, in fact, we want no such transactions. We want very low thresholds.

Mr. John Fraser: Very low thresholds. You're saying all care centres, all providers. Is that what you're suggesting?

Dr. Doris Grinspun: Yes, all health care providers, including nurses, doctors, pharmacists and also organizations.

Mr. John Fraser: Okay. I agree with you. I think that that's important, from a point of view of people knowing who is connected to who, in terms of their care plans and their health. It's an important thing for people to know.

Dr. Doris Grinspun: Absolutely.

Mr. John Fraser: I want to talk to you about paramedics. I'm going to challenge you a little bit.

Dr. Doris Grinspun: Please do.

Mr. John Fraser: As you know, paramedics are not self-regulated. They work under the direction of a base hospital, which employs, I think, mostly physicians, I'm not sure if there are other primary health care providers provided there. There are some jurisdictions where they're providing community paramedicine. In Nova Scotia they do a lot of palliative work. Also, in Renfrew county, which is very close to me, they have a paramedicine program that is very effective.

So, I understand what you're saying about the expansion of that scope, but what we're seeing is good outcomes.

Dr. Doris Grinspun: Good outcomes compared to whom, Mr. Fraser?

Mr. John Fraser: Good outcomes with the resources that we have that are available to help people in something like a rural or remote area—

Dr. Doris Grinspun: I would suggest to you that in rural and remote areas, there are RNs, NPs and RPNs who ought to be providing palliative care—they have the education and the training, and they're self-regulated—and also primary care, which is where we are putting the focus. It's important that it be comprehensive in primary care.

Mr. John Fraser: The paramedics are working to their scope, as defined by their directives.

Dr. Doris Grinspun: Paramedics do not have a scope; they're not self-regulated.

Mr. John Fraser: I know, but they have a scope that's given through the directive. That's the hospital and the base hospital—

Dr. Doris Grinspun: If the government wants to regulate paramedics, let's talk about that. The paramedics have not regulated. If that request happened, it was not approved.

I suggest to you that what Nova Scotia is doing is not necessarily what we need to do. We do many things that are different than Nova Scotia. This is one of them that should be different.

Mr. John Fraser: I appreciate your point of view. We'll probably have another debate about this at another time. I want to thank you very much for being here.

Dr. Doris Grinspun: Thank you.

The Chair (Mr. Grant Crack): Thank you to the both of you for coming before committee this morning. It's much appreciated.

EMERGENCY SERVICES STEERING COMMITTEE

The Chair (Mr. Grant Crack): Next on the agenda we have the Emergency Services Steering Committee. We have Kelly McDermott. She is senior solicitor, labour relations and employment, corporate services, legal services division, for the regional municipality of Durham.

We welcome you to committee this morning.

Ms. Kelly McDermott: Wow. That was a mouthful. Thanks.

The Chair (Mr. Grant Crack): I hope it's you.

Ms. Kelly McDermott: Yes, it is me.

The Chair (Mr. Grant Crack): Okay, good.

Ms. Kelly McDermott: I am Kelly McDermott. I am a senior solicitor for labour relations at the region of Durham. I'm here on behalf of Norm Gale, who is the president of the Emergency Services Steering Committee, who unfortunately could not be here today.

Just to give you a bit of background: The ESSC is a working group of senior staff from municipalities. Our membership includes multiple employer stakeholders who directly provide emergency services to the province.

I want to start by saying that we support many of the amendments to the Ambulance Act under Bill 160. In particular, we support a legislative framework that will give paramedic services alternative options for on-scene medical treatment, such as treat and release, as well as more flexibility in determining where a patient is able to receive care. We understand that our friends at the

Association of Municipalities of Ontario, or AMO, will be appearing before the committee later this morning and will be providing some proposed amendments to the Ambulance Act that will augment this operational directive. We certainly support that.

What concerns us is the fact that Bill 160 will enable firefighters who are certified as paramedics to provide paramedic care to treat low-acuity conditions. We foresee several adverse consequences arising from this. We stand firmly beside our partners at AMO, MARCO, LUMCO and the Ontario Association of Paramedic Chiefs in opposition to it.

First, there simply has been no objective data to demonstrate that this model will improve patient outcomes or response times. Further, this parallel service is not going to free up ambulance resources; rather, it's going to tie up fire resources.

Second, this model is bound to create disputes, litigation and increased costs for all of the stakeholders involved.

It's important to note that the legislative and labour relations structures for the fire and ambulance services sectors are very different. Unless these two complicated legislative regimes are clearly untangled and seamlessly blended together, the duplication of services in both sectors is going to lead to labour disputes and litigation.

Further, in order to blend these two regimes, we foresee a number of additional cost consequences to municipalities, to the base hospitals and to the province in order to provide, basically, the standard of paramedic care we have today.

Finally and, I think, importantly for us, this model really cannot be a voluntary model in the interest arbitration world that we live in right now. I can think of no better example than the 24-hour shift in the fire sector, which also started as a voluntary model but was subsequently imposed through a number of interest arbitration awards. For this reason, we think that safeguards need to be built into Bill 160 to preserve the rights of municipalities to determine the scope of work of paramedics and firefighters.

AMO will be speaking to proposed amendments to the Ambulance Services Collective Bargaining Act and the Fire Protection and Prevention Act which will essentially preclude interest arbitrators from being able to expand the scope of work of paramedics and firefighters respectively. We worked with AMO to develop this language, which notably mirrors existing language within the Police Services Act under section 126.

While we understand that the committee is challenged today with looking at the legislation that is before it, we ask that you consider these revisions that my friends will put forward when you're looking at this legislation clause by clause.

In conclusion, we support many of the amendments to the Ambulance Act under Bill 160. But we ask the government to either abandon its proposal regarding the use of firefighter-paramedics or, alternatively, adopt the revisions put forward by AMO that will prevent a voluntary model from becoming involuntarily imposed on municipalities, as we saw with the 24-hour shift.

Thank you for giving us the opportunity to provide some comments. I'm open to questions.

The Chair (Mr. Grant Crack): Thank you very much. We appreciate that.

We will start with the third party: Madame Gélinas.

M^me^ France Gélinas: Thank you so much for coming and for very clearly articulating some of your worries about the bill. I'll take them one by one.

Disputes: Where would you see the labour dispute happening? Give me an example of what you see could happen.

Ms. Kelly McDermott: In my life as a labour lawyer, any time I've seen the potential for what I will call a tri-party relationship, it's bound to lend itself to litigation. Why I say a "tri-party relationship" is because you have ambulance services who certify paramedics, and right now, they're charged with the oversight of those paramedics.

Like I said, unless you carefully untangle these very complicated legislative regimes, what you can end up having is questions about litigation and disputes about who bears the responsibility for these paramedics. You can see that happening in civil claims for malpractice, potentially workplace safety insurance claims, and occupational health and safety claims.

0850

Additionally, there is a potential for work jurisdiction disputes, which is under section 99 of the Ontario Labour Relations Act. We can already see that there is a tension between the fire association and the composite and consortium of paramedic unions about deciding what is the scope of work that is appropriate here. The bill hasn't even been implemented yet and I'm already seeing that dispute arise. So in my experience as a labour lawyer, I suspect that we will see litigation and disputes unless the legislation is very clearly untangled and blended together.

M^me^ France Gélinas: Okay. You went on to say, "increased costs for all stakeholders." How do you see this playing out?

Ms. Kelly McDermott: First of all, like I said, the issue is that this is not going to free up ambulance resources; rather, it's going to increase the call volume for fire service. It's not going to free up ambulance resources because ambulances will still need to attend to the scene, to assess patients and to do the transport. So we'll see the increase in call volumes for fire service without the corollary decrease in call volumes for ambulance services.

Also, again, if you set up a separate regime to govern and oversee these firefighter paramedics, we're bound to see costs associated with the training, with the certification, with the oversight, and also the cost just to outfit the fire trucks with the proper equipment for paramedics to engage. A defibrillator alone is $30,000.

Of course, there's also the issue of costs around legislative compliance. For example, the ambulance sector is

subject to the Personal Health Information Protection Act; the fire sector is not. They're not health information custodians pursuant to that act. So if they now are becoming health information custodians, they have to set up quite a big amount of infrastructure to create that privacy network to ensure that we are protecting the privacy of patients in Ontario.

The Chair (Mr. Grant Crack): We'll move to the government: Mr. Anderson.

Mr. Granville Anderson: Hi, Ms. McDermott. Thank you for being here this morning. So you work at the regional headquarters in Durham?

Ms. Kelly McDermott: I do, yes.

Mr. Granville Anderson: All right. Say hi to Roger for me when you get back.

Ms. Kelly McDermott: I will.

Mr. Granville Anderson: By and large, you do support this bill. I'm going to deal, especially, with the portion that deals with paramedics making a determination as to where a patient should be transported.

You know how at times our emergency rooms are overcrowded as it is. A prime example would be a mental health patient. I think the patient would be better served being transported to a mental health centre than an emergency room. So that's one example, and there are numerous examples in which that would free up the paramedic, instead of, say, waiting around three or four hours in a hospital needlessly. It would also deal with the overcrowding in emergency rooms.

Would you want to elaborate some more on that and say how you think that would save money and also enhance patient care at the same time?

Ms. Kelly McDermott: I agree with your comments wholeheartedly. I think that, just from my anecdotal experience working at the region, we do know that we have a lot of time off-loading at hospitals, that a lot of ambulances are tied up at the hospitals and doing that type of transport. So any alternative options that will allow options to provide care on the scene or to take them to a different off-load site, I think, are going to clearly free up resources and improve response times. So we wholeheartedly support those initiatives. Certainly, if we have any more proposals on that, we'd be happy to provide written submissions on that as well.

Mr. Granville Anderson: Do you think the bill should be more specific as to what sites these patients are transported to?

Ms. Kelly McDermott: I'm not sure at this juncture. I could get back to you on that. I'm not sure if it should go further in that. Again, I said I think it's a very positive step to address the issue of allowing ambulances to look at alternative structures because I do know those base hospitals are facing long delays.

Mr. Granville Anderson: Thank you. I don't know if my colleagues have any further—

The Chair (Mr. Grant Crack): You've got 20 seconds.

Mr. Granville Anderson: Twenty seconds?

Ms. Kelly McDermott: Twenty seconds?

Mr. Granville Anderson: Okay. Thank you for being here, and thank you for your support of the bill.

The Chair (Mr. Grant Crack): We'll move to the official opposition: Mr. Yurek.

Mr. Jeff Yurek: Thanks for coming in today. I'm just going to follow up from the third party's questions you didn't get a chance to talk about, your last point about the interest arbitration system.

Ms. Kelly McDermott: Right.

Mr. Jeff Yurek: It's my understanding it's a pilot project trial they're going to try in a few jurisdictions, but you're saying that that could be expanded through an arbitration system.

Ms. Kelly McDermott: That's right. Like I said, we've seen it through the 24-hour shift that was introduced in the fire sector. I need to look no further than my own region, where it was imposed by Arbitrator Etherington on the town of Ajax when they put forward very distinct expert evidence on the health and safety risks, the costs associated with it and the operational impact.

I think there is a slippery slope, particularly with some of the failures of the current interest arbitration system, which are based on a lot of replication and comparability really without regard for the size of the service, the size of the population and a consideration for how management rights are to determine how and when to deploy its workforce.

While we appreciate the voluntary-type model, we're concerned that it will end up being exactly like the 24-hour shift, which is that it's going to be involuntarily imposed on municipalities. That's why my friends at AMO and ourselves have put together some language to provide that safeguard.

I think it's important to note that it is contained within the Police Services Act. Under section 126, it says that an interest arbitrator is basically precluded from expanding or issuing an award that deals with the core duties of a police officer. If this is going forward as a voluntary model, we'd like to see those safeguards be put in place.

Mr. Jeff Yurek: Okay. Thank you.

The Chair (Mr. Grant Crack): Thank you very much. We appreciate you coming before committee this morning and sharing your thoughts.

Ms. Kelly McDermott: Thanks.

EYE PHYSICIANS AND SURGEONS OF ONTARIO

The Chair (Mr. Grant Crack): Next on the agenda we have the Eye Physicians and Surgeons of Ontario with us. We have the chair and past chair with us. I will invite the two of you forward, and if you could do the introductions, that would be greatly appreciated. You have up to five minutes for your presentation. Welcome.

Dr. Jordan Cheskes: Good morning and thank you to the members of the Standing Committee on General Government for giving us the opportunity to speak on behalf of the Eye Physicians and Surgeons of Ontario.

I'm Dr. Jordan Cheskes, and I'm an ophthalmologist and a retinal surgeon at the Scarborough and Rouge Hospital. Beside me is my good friend Dr. Kylen McReelis, who is an ophthalmologist and the chief of surgery at Peterborough Regional Health Centre.

We come today to educate this committee about the dangerous practice of eye tattoos that is occurring in Canada. We also hope the committee will endorse future health care policy to help regulate the act of tattooing an eye by the insertion of this topic into Bill 160.

The Eye Physicians and Surgeons of Ontario is a section of the Ontario Medical Association. We represent over 450 of Ontario's active and retired ophthalmologists who preserve and restore the vision of Ontario's residents. We are doctors with more than nine years of medical training. We specialize in the diagnosis and treatment of eye diseases by providing comprehensive eye exams, prescribing corrective lenses and administering medications. Ophthalmologists are the only professionals who should perform eye surgery or perform injections in or around the eye to help improve vision in patients.

Dr. Kylen McReelis: We're going to speak to some of the clinical photos we've included in the handout for you.

In September 2017, a 24-year-old Ottawa woman went to a tattoo artist to get her sclera, the white of her eye, tattooed. The process performed on the woman involved using a needle to inject an unregulated purple dye under the conjunctiva or outer skin of her eye. The tattoo procedure did not go as planned. She immediately experienced intense pain and she is at risk of suffering long-term ocular complications. The Ottawa case went viral on the Internet around the world, and our colleague Dr. Setareh Ziai, our ophthalmologist in Ottawa, has been treating this young woman and dealing with her serious eye tattoo injury. Her condition remains vision-threatening.

0900

Ophthalmologists around the world are experiencing increasing numbers of patients with blindness and eye loss because of the increasing popularity of eye tattooing. The risky act of tattooing is being performed by untrained individuals who have no knowledge of the eye's delicate anatomy. We are looking to the Ontario government to ban the practice of eye tattooing in Ontario, and we would like to see Ontario be the leader in the creation of legislation in Canada to protect the public's vision and to prevent unnecessary cases of blindness. We also suggest including in this potential legislation banning of the practice of implanting eye jewelry under the conjunctiva, which has become a growing trend in the USA.

Corneal tattooing, in contrast, however, is a surgery that is performed by an ophthalmologist in a sterile operating room with tested and regulated dyes that have been studied in our literature for many eye conditions. In stark contrast, eye tattooing by tattoo parlours has resulted in numerous severe ocular complications by the needle stick penetration of the eye wall. This has been known to cause cataracts, retinal detachment and hemorrhages in the eye. In Alberta recently, a tattoo artist injected black ink into a patient's eye, which led to immediate blindness, merciless pain and required urgent surgical removal of the person's eye.

Dr. Jordan Cheskes: In the state of Georgia, tattoos are forbidden within an inch of the eye socket except when performed by a physician. We've communicated with the Royal Australian and New Zealand College of Ophthalmologists, and they are working with their governments to amend legislation that will make it an offence for a person other than a medical practitioner to perform eyeball tattooing. The Eye Physicians and Surgeons of Ontario wishes to partner with Ontario government to ban the practice of unregulated eye tattoos to prevent blindness and increase eye safety in our communities. We also wish to decrease the burden on the health care system by banning this unsafe practice.

These young patients will require services from ophthalmologists, ocular prosthesis services and mental health supports to deal with their blindness. We also wish to prevent future cases of individuals that may need ODSP due to permanent disability associated with long-term vision loss and chronic eye pain.

As a doctor, we can never forget to listen to our patients. The woman from Ottawa has performed a very courageous act by telling her eye tattoo experience in the media and warning others about it. As ophthalmologists, we are bound to make sure that her wishes are honoured, and we respectfully request that the act of tattooing an eye be left in the hands of a medical physician and only for therapeutic purposes in a sterile environment. We feel that Bill 160 is the best vehicle to protect the public from unregulated eye tattoos and prevent future cases of unnecessary blindness.

Thank you for allowing the Eye Physicians and Surgeons of Ontario to convey our message of eye safety to your committee today.

The Chair (Mr. Grant Crack): We'll start the questioning from the government side. Mr. Fraser?

Mr. John Fraser: Thank you very much for being here today. I want to start by thanking you for all of the work that has been done by the eye health council and the collaborative efforts that are there. One of the issues that is important to me is children's vision. The work that Agnes Wong and Daphne Maurer is doing is really important; your support of that and other issues related to children's vision is really important. It's a big part of learning and a big part of future success. I want to thank you for that.

I see Dr. Lee in Ottawa. I have a bit of age-related macular degeneration, although my eyes are 10 years older than my body—probably too much sun. Part of that is that you could end up with an injection in the eye, which I have never thought could be a pleasant experience.

When you hear and see this, it's actually shocking that this could happen and that it does. I'm glad that you brought it up. I'm not sure how it fits within the scope of the bill and the acts that we're opening up. That's not to

say that it's not important. I think the challenge is that it has to fit inside the scope. It certainly is something that needs to be addressed—no question. It's very appropriate that you brought it here today. As legislators, this is the right venue to do it in. It's important. Unregulated, non-health professionals should not be doing this. Daiene?

The Chair (Mr. Grant Crack): Ms. Vernile.

Ms. Daiene Vernile: These pictures are really hard to look at, but I want to thank you for bringing this in and bringing it to our attention. This is just horrifying. I agree with you that we need to stop this in some capacity, whether it's this legislation or something else.

Dr. Jordan Cheskes: We've been in discussions with the Ministry of Health. Soo Wong was a nurse, as you know. She worked in ophthalmology at Toronto East General or Michael Garron Hospital. We've met with the Ministry of Health, and they are coming up with some policies. They have expressed an interest in this. We've met with health critics Gélinas and Yurek. As well, we actually even had a meeting with Eric Hoskins, and I bumped into Premier Wynne in the hallway and told her about this. I think everyone is supportive of it.

We'd like to see it in Bill 160 because there is an expediency to this. This is a really debilitating process that someone has to endure. These dyes that are being injected around or into the eye are not safe, frankly, short-term or long-term, and the act of the needle going near the eye is damaging in itself. That's why we were looking towards Bill 160: to get expediency with this issue because it's such a dangerous thing.

In Australia, there are tattoo festivals or fringe festivals where this is occurring all the time. Again, I'm not here to discuss the subculture of people who wish to modify their bodies, but we feel that it has to be done in a safe manner. In the present state, it is not done in a safe manner. It's very dangerous. That's why we look for expediency.

The Chair (Mr. Grant Crack): We'll move to the official opposition: Mr. Yurek.

Mr. Jeff Yurek: Good morning. Thanks for coming in. I was thinking of getting breakfast after this meeting, but maybe lunch.

Dr. Jordan Cheskes: Hansard can't capture those pictures.

Mr. Jeff Yurek: No. I thank you for bringing this issue to committee and discussing the importance of it. Hopefully we're able to fit this into Bill 160, considering that this is the one chance before the new year that we can fix this situation and have regulations in place early in the new year. Otherwise, it might fall until after the election before we have to deal with this. I'm hoping and I'm supportive of trying to fit this into this legislation, understanding the importance of eye health. The fact that people are doing this to their eyes is quite shocking. Thank you very much for coming in.

Dr. Jordan Cheskes: Thank you.

The Chair (Mr. Grant Crack): Madame Gélinas.

M^me^ France Gélinas: Again, thank you for coming to Queen's Park. I think you were really brave in bringing this forward to us in the context of Bill 160. Bill 160 has 10 schedules. It opens up 30 different health care bills. If there's ever an omnibus health care bill, this is it.

You are right that although the banning of eye tattooing and eye jewellery is not in the bill as it is, we have the opportunity—30 different pieces of legislation are open. Through unanimous consent, we can do this.

I will be putting this forward as an amendment to Bill 160 because I want this done. I've already talked to the lawyer who helps us draft amendments. It will require unanimous consent from all parties. I hope that all parties realize that we have an opportunity to do good. We have an opportunity to protect people before Christmas. We already know when this bill is going to go through clause-by-clause. We already have this thing time-allocated. We know that it has an end point. It will happen. It will happen before Christmas. It will help save eyes and health and everything else, like those specialists have just explained to us.

I urge my colleagues to really pay attention to what they've shared with us. We have an opportunity to do good. It will require a unanimous statement. You can already go to your caucus and tell them that I will be putting forward those amendments. Please be ready to support them and put it forward, or even work with your own lawyers so that you have the amendments the way you want them to be. I will be more than willing to give unanimous consent if you ask so that we get this done. We have this opportunity to get this done in a very timely manner. We've all agreed that this needs to be done. Let's be proactive. I'm hopeful.

0910

Dr. Jordan Cheskes: We're very appreciative of everyone's efforts. If there's a will, there certainly is a way. Dr. McReelis and I are not lawyers, and we'll leave that up to your teams to get it in there. But we appreciate that.

Dr. Kylen McReelis: Thank you, Madame Gélinas. We have a strong role for advocacy for our group as a profession. Please, all groups consider us, hopefully, as a resource for questions, concerns or how this may be implemented. We're here to protect the interests of our patients. Ontario has an opportunity to be a leader in this, to help promote this nationally.

Dr. Jordan Cheskes: We would much rather see ourselves leaders in legislation against unregulated eye tattooing than becoming leaders in how to deal with this complication. Again, we'll be willing to work with whatever lawyer you send to us to create policy to get this banned in Ontario.

M^me^ France Gélinas: Thank you.

The Chair (Mr. Grant Crack): Thank you both for coming before committee this morning.

ONTARIO HEALTH COALITION

The Chair (Mr. Grant Crack): Next we have the Ontario Health Coalition. We have Natalie Mehra, who is the executive director. We welcome you to committee

this morning. You have up to five minutes for your presentation. The floor is yours.

Ms. Natalie Mehra: Thank you for this opportunity to speak to this bill. I understand that we have five minutes to speak to a bill that repeals four existing acts, enacts three new acts and amends more than 30 acts. I have to say that we are extremely concerned about the process that has led to this bill: the lack of public consultation on it and the lack of time for public hearings. The fact that they are only in Toronto for a few hours over four days is extremely problematic, especially given the wide-ranging implications of this bill. But I only have five minutes so I'm going to speak quickly and I'm going to try to speak to four of the schedules of the act.

Schedule 1, the ambulance schedule: While we support the provision in this schedule that enables only paramedics to hold themselves out as paramedics, we are concerned about several of the other sections. The ability for the minister to order all the ambulances in Ontario to redirect patients away from public hospitals to other facilities without naming what those facilities are, and the new powers for the minister to order all ambulances in Ontario to treat patients within ambulances rather than taking them to public hospitals: These two provisions are extremely dangerous. They facilitate the privatization of our public hospitals. They support more cuts to hospitals that cannot withstand additional cuts. They bring up a significant range of new liability issues for municipalities and ambulance operators and they entail new costs for patients, since the Health Insurance Act covers patient transport only to public hospitals. If patients are transported to non-hospital facilities, they will be left holding the bag for $200 to $300 or more costs for ambulance transport. We believe that those sections must be amended significantly to limit the places that the minister could refer ambulances to, to make much more specific what policy directives may be considered regarding treatment in ambulances, and to limit those. The minister must hold liability if he's going to begin to make such orders.

The provision that cabinet can make regulations exempting just about anyone from just about any provision of the act should be withdrawn. There is no point in writing legislation if cabinet can, by the stroke of a pen, just exempt anyone from any part of it.

We support schedule 4.

On schedule 5, the Long-Term Care Homes Act: We support the spirit and the intent of this schedule. The goal is to minimize the confining of residents. However, the notion of confining is not defined in the legislation; it's left to regulation. Since all of the amendments of this legislation hang from that definition, we think it's important that it actually be in the legislation.

But there is a proviso: This act speaks only to the resident protection side of the issue. There is another side, which is that long-term-care homes have been required to take more and more acute patients or residents for decades now. Today, only the patients or residents with the highest MAPLe scores can even get admission into long-term-care homes.

The coroner's jury in the Casa Verde inquest into the homicides of two residents by another resident in a long-term-care home recognized that long-term-care homes have become, to some extent, mental health institutions today. The coroner's geriatric committee asked the coroner to bring concerns about the high rate of resident-on-resident homicides in long-term-care homes to the attention of the Attorney General and the minister.

The level of violence in the homes is unacceptable. There's a far higher rate of homicide in Ontario's long-term-care homes than in any city in the province. The issue here is that there are not enough resources to provide for the level of care needs of the residents, so this legislation needs to be amended further to bring in protections to provide for adequate staffing levels to provide for a regime of minimizing constraints safely.

I'm going to skip forward to schedule 9. This schedule repeals the Private Hospitals Act. It repeals the Independent Health Facilities Act and the health radiation protection act and replaces them with a new act that euphemistically calls private clinics "community health facilities." We find this an odious and manipulative cover for the fact that 98% of these facilities are private for-profit clinics, many of which violate the Canada Health Act, many of which practise in unsafe ways and have been problematic since the inception of the Independent Health Facilities Act. Repealing—

The Chair (Mr. Grant Crack): Thank you very much. We'll have to move to questioning now.

We'll start with the third party: Madame Gélinas.

M^me^ France Gélinas: Did you want to finish? Go ahead.

Ms. Natalie Mehra: If you don't mind.

M^me^ France Gélinas: No, no.

Ms. Natalie Mehra: The most important point, I think, is that the repealing of the Private Hospitals Act lifts the ban on private hospitals in Ontario. That ban has been in place since October 1973. Lifting the ban on private hospitals and rolling private hospitals and private clinics in together so that any new definition has to include the ability to admit patients overnight opens the doors to a very permissive—because the way that this legislation is written is extremely permissive—regime to the introduction of a whole array of new private hospitals and clinics. This we consider to be the utmost, serious breach of the government's obligation to uphold single-tier public medicare in our public hospital system. We take it extremely seriously.

M^me^ France Gélinas: Would you like this section of the bill completely repealed?

Ms. Natalie Mehra: It needs to be completely withdrawn. There was no public consultation on it. It's poorly written. The definition of "community health facility" is so broad that it doesn't even mention health care. It could include a massage parlour or a racetrack. It allows for new fees for patients. It's a dangerous, poorly written, poorly-consulted-on piece of legislation, and it should be entirely withdrawn, as well as schedule 10.

M^me^ France Gélinas: And for schedule 10, it's because of restraints in retirement homes?

Ms. Natalie Mehra: That's right. Retirement homes are governed under the Tenant Protection Act. They're not governed under any health care legislation. They are not health care facilities. The majority of them are private and for-profit. Nowhere in our society do we allow private for-profit companies to lock people up—sometimes for the rest of their lives. I don't know why any government would countenance doing it in retirement homes. It is unlawful. That whole section should be withdrawn as well.

M^me^ France Gélinas: Agreed.

When you talk about how we should define adequate staffing levels in our long-term-care homes, do you have a definition of what an adequate staffing level would look like?

Ms. Natalie Mehra: For the average acuity in Ontario's long-term-care homes, the evidence supports a four-hour minimum care standard contoured to acuity. However, if one can have specialized units with higher levels of care needs—essentially, psychogeriatric patients now in long-term-care homes—then you need to have specialized units with specially trained staff and special levels of care. In general, we would be looking at a four-hour minimum care standard. If one is looking at specialized units—locked units—then they need an evidence-based level of staffing as well.

0920

The Chair (Mr. Grant Crack): We'll move over to the government side: Mr. Fraser.

Mr. John Fraser: Thank you very much. I want to ensure that the transparency part of the act—I think I heard you say that you support that piece.

Ms. Natalie Mehra: Yes, we do.

Mr. John Fraser: How broad do you think that should be?

Ms. Natalie Mehra: We haven't had a whole ton of time to look at it, frankly. It's going through very quickly. We've been consulting with some of our partner organizations. They'd like to see an outright ban on certain types of financial transfers, but we haven't really had time to consider it.

As it's written, it certainly is progress. It's better than what exists, and it allows the minister to get information and publicly report that information. We think that's important.

Mr. John Fraser: I had a chance with another witness to talk about paramedicine and the role that it plays in Ontario. A lot of the work that I did in my first two years as PA was around scope of practice, and I'm still connected into that. Paramedics are increasingly having higher levels of skills. They have direct, hands-on care with people and work under the direction of a base hospital—usually a physician, a primary health care provider. I really believe that they play a critical role in outcomes, not just in emergency situations but in situations where there's ability to have a community paramedicine program like they have in Renfrew or a number of—you were mentioning other community paramedicine programs.

Mr. Jeff Yurek: Huron.

Mr. John Fraser: In Huron. I'm just interested in your thoughts on that.

Ms. Natalie Mehra: Yes, we absolutely support that, and recognize that the scope of paramedics' practice has expanded and changed dramatically over the last decade or decade and a half. But they have a huge array of regulation. They have a scope of practice. They have the bases from which they operate. They have physician oversight.

What is new in this schedule is that the minister would be able to order all ambulance services in the province—and you would know that there is a range of paramedics with different levels of skills, and different communities have different levels, so that's problematic in the first place. But to widen the scope of treatment within ambulances rather than transporting them to public hospitals—we think that that raises a slew of serious liability issues.

Paramedics are able to practise within their scope already. There's no need to provide additional powers for the minister to order ambulance services to treat more patients outside of hospitals, despite the best judgment of paramedics.

Mr. John Fraser: But in the reverse, it provides a throttle on how that scope can be expanded, right? It can only be expanded through that direction, as you just said. The reverse of that is true as well. I just wanted to make that point.

The Chair (Mr. Grant Crack): We'll move to the official opposition: Mr. Yurek.

Mr. Jeff Yurek: Thank you for coming in today. You made mention of the size of this piece of legislation that's being rushed through. I find that there are a lot of holes in it. We don't understand what the consequences or the actions are. Everything is left to regulation. It seems to be a theme recently in the bills coming forward in the Legislature. Your thoughts on the fact that we don't really see the end result of this bill and how it's going to affect health care?

Ms. Natalie Mehra: You know, that's really important. In the schedule on long-term care, the vital definition from which everything else hangs is not in the legislation; it's left to regulation. That's really ducking the key element, the key decision of that section.

In schedule 9, which is essentially the "bringing-in of private hospitals and clinics" schedule of the bill, everything is left to regulation: the definitions, the entire regime for safety and the entire regime for enforcement. One wonders why you would even write legislation at all if you're just going to empower cabinet or empower the minister to make vital decisions without ever going to the Legislature, without ever having any proper public consultation.

When you look at the unforeseen consequences of these schedules on patients—there is a reason for proper public consultation. More heads make better policy, and there are very, very serious problems in this policy.

Mr. Jeff Yurek: Yes, and also cost is another concern with regard to the transparency part of it. We look for-

ward to having transparency with payments in the medical system. However, there's no real detail of how that's going to operate and the cost. In the States, it's a couple of hundred million dollars to run their system. I find that if you knew what the costs were up front, you could budget accordingly, but we're having another open-ended possibility of another PSW registry or eHealth concern where the costs are unending, and that takes away from patient care.

Ms. Natalie Mehra: As I said, we didn't really have a lot of time to consider all of the implications of that section. It does seem that certain financial transactions should just be outright banned rather than tracked in this way. Some of them really are corrupt and they lead to a perversion of the provision of health care and a contortion of the public interest in health care. Another way to look at some of those transactions at least would be to ban them outright.

Mr. Jeff Yurek: Thank you.

The Chair (Mr. Grant Crack): Thank you for coming before committee this morning. Appreciate it.

ADVOCACY CENTRE FOR THE ELDERLY

The Chair (Mr. Grant Crack): Next we have the Advocacy Centre for the Elderly. We have Jane Meadus, inter-institutional advocate. As well, we have Christine Morano, a research and policy lawyer, and I believe we have another individual who—

Mr. Graham Webb: I'm Graham Webb. I'm a lawyer and the executive director.

The Chair (Mr. Grant Crack): Welcome. You have up to five minutes for your presentation. We look forward to hearing from you.

Ms. Jane Meadus: Thank you. I'd like to thank the committee for hearing from us today on this very important piece of legislation. I'm accompanied by Christine Morano, who has been working on this, as well as Graham Webb, our director. We provided a small submission. We are going to be doing a main submission at a later date, but we provided you with something with some general issues.

The Advocacy Centre for the Elderly is a legal clinic which provides legal representation and upholds the rights of seniors in Ontario. My specific role is with respect to the issues in health care.

We'd like to speak first to schedule 1, the Ambulance Act. While we support the work done by paramedics, we cannot support many of the proposed amendments. Paramedics are going to be allowed to take patients to other sites. We believe this is outside the scope of their practice as they're not regulated health professionals who can determine and assess place of treatment. The act also doesn't deal with the issue of consent to such transfers. What happens when the ambulance comes now is, you know you're going to go to a hospital, unless you refuse. What will happen under the new legislation? It doesn't include any requirement for consent.

There are also monetary issues with respect to the $45 copay. That's only to hospitals right now, but this will change with respect to private hospitals, and we can see a lot of people having the $200 fees.

We're concerned that there's going to be a push to keep seniors out of hospitals by redirecting them, and we're already seeing that in other ways. We think this is going to affect seniors' care.

We're also concerned about the treatment in place by paramedics. Again, they're not regulated health professionals. They cannot get informed consent, and they cannot do that even on behalf of their base hospital because it is not allowed under the Health Care Consent Act. Treatment in the community requires informed consent, which could not be obtained in this situation.

I turn now to schedule 5, which is on the Long-Term Care Homes Act and its related amendments under the Health Care Consent Act. Presently, we know that many residents are illegally prevented from leaving homes based on paternalistic home policies. The secure unit sections which were under the previous legislation but never enacted were not sufficient, and we're pleased to see the confinement sections, with some caveats and some concerns.

First of all, there's the issue of what the definition is. That's definitely an issue. Secondly, we would like to ensure that it's only incapable residents, so those who have been found incapable to make decisions around confinement who are confined. You cannot confine a competent person.

The issue of confinement and the definition have to also include what the restrictions are. Exactly what could a substitute decision-maker decide? Is it only that they're allowed to come and go with a third party? Can they restrict who they go with and how long, etc.? This is not simply just locking someone up and keeping them inside.

We also have very different requirements between what the physicians in the homes are going to be looking at regarding the test, which is a serious-bodily-harm test, versus the substitute decision-making authority, which is based on the competent wishes or best-interest test. Those two may be irreconcilable when it comes to hearings.

0930

We also would like this act to be amended to include a requirement of notice and rights advice access every six months. We cannot have just simply one time. This is contrary to the requirements under certain kinds of detention authority. The case of P.S. v. Ontario in 2014 of the Ontario Court of Appeal said that in the mental health sector, and it applies here.

We will need to have a process for confinement. We'll have to have a lot of training. The legislation is very complicated, between the two acts, and a lot of training will be required.

We're also concerned about people who are going to be requested to be confined, that they will be refused admission to homes because they're going to have confinement suggested. The ministry really is going to have to ensure that they are inspecting homes on this.

Finally, schedule 10: We vehemently disagree with the recommendation that confinement be allowed in these facilities. They are tenancies, not health facilities, and your landlord should never be able to confine you. There is still the common-law ability to confine in an emergency situation, which would allow some severe cases where confinement could occur, but, frankly, confinement is the most serious limitation on our personal rights in our society, and expanding that to a landlord, we believe, would be inappropriate.

We are concerned about the trend in the legislation regarding the downloading and privatization of health care away from hospitals and long-term-care homes and believe it will have a disproportionately negative effect on seniors' health and finances. We urge the government to amend their legislation accordingly.

The Chair (Mr. Grant Crack): We'll start with the government side: Mr. Fraser.

Mr. John Fraser: Thank you very much for your presentation. On the weekend, I was at St. Aidan's and I met your parents.

Ms. Jane Meadus: Yes, I heard.

Mr. John Fraser: There you go. I figured that I'd better be here Thursday morning.

If you could, I want you to just go into a little bit more detail about informed consent, in terms of your concerns around the changes to paramedics, because informed consent is actually a broad thing.

Ms. Jane Meadus: Yes, so the Health Care Consent Act requires that any treatment requires informed consent. That requires a person being advised what the treatment is, pros and cons, answering questions and then making a decision, and, if they're not capable, determining who the substitute decision-maker is and getting consent from them.

In a normal emergency-type of transaction, that is not necessarily going to occur, and that's an exception under the legislation. That would be done in an emergency situation. But this act is talking about doing other, lower-acuity treatments. Only regulated health professionals are allowed to get informed consent. You cannot get it on behalf of a regulated health professional if you're not a regulated health professional yourself, so this would not allow it. Unless paramedics are regulated health professionals, they cannot treat in the community. I don't think it's possible.

Mr. John Fraser: The other piece I wanted to raise was that confinement is already happening in retirement homes. I see that and you know that as well, too. I understand what you're saying about this piece of legislation, but also it recognizes that it's already happening and we can have a discussion about the appropriateness of that.

I've had some family that are living in retirement homes and you can see, visibly, the choices that people make to live in a home. There are challenges that are of great concern to families because of their loved ones' safety and their ability to care for them. I see it from a different way: that it provides a framework that makes sure that people's rights are respected. I understand the principle of what you're saying, but it's how you get that balance of safety—that's the concern that I have.

Ms. Jane Meadus: Sure. We certainly see that as well, and it is a concern. I think that what we're saying is that retirement homes are contracts. They are not health facilities. They are not held to the same kinds of standards. When you're dealing with confinement, these are people who are not being allowed to go out. We get calls all the time. The detention can be quite serious. This is not the sector that should be confining people. If you require that, you should be going into long-term care—and I know there's a problem there.

Mr. John Fraser: That's also a choice as well, too, right? So there are different living accommodations when you are in a retirement home as opposed to long-term care. I've just seen that in long-term care you're in a 400-square-foot or a 500-square-foot room. In another setting, you may be in a room that's got a bedroom and another room, and you have more access. There's also a choice that's involved there, too, in people's lifestyles.

The Chair (Mr. Grant Crack): We'll have to move to the official opposition: Mr. Yurek.

Mr. Jeff Yurek: Thank you for coming in and for your report. I was wondering if you could touch on section 4. You've hit an issue that has bothered me for years and years and years. If you could speak more to that issue, please.

Ms. Jane Meadus: In schedule 4?

Mr. Jeff Yurek: Yes.

Ms. Jane Meadus: Okay, so you're talking about payments from pharmacies. Pharmacies in Ontario: Some of them are paying large amounts. They're paying bed fees to long-term-care homes in order to get contracts in that home. I've seen numbers of up to $100,000 or $150,000 per home per year. I think that we are overpaying our pharmacies that are providing services in long-term care. They have a captive audience of very high users, and clearly they have lots of money to spend.

I think that the government should be reviewing how we pay these specific pharmacies in this situation. We should be getting rid of the $2 copayment, which is a burden on many people. We should also be looking at what a fair price is in a situation where people are required to get monthly prescriptions and multiple prescriptions from a dedicated pharmacy, and ensure that that money that we save is equitably distributed through the system for care or other services.

Mr. Jeff Yurek: Yes, it seems interesting that the pharmacies are paying large amounts of money for the contract but at the same time they're still charging the $2 copayment. We're unsure where that money goes or if it's even applied to patient care.

Ms. Jane Meadus: We don't know where the money goes. They claim that they use it for things like helping the residents, but we really don't know that at all. I think that we really need to look at that because we're clearly overpaying.

Mr. Jeff Yurek: Okay, thank you.

The Chair (Mr. Grant Crack): Madame Gélinas.

M^me^ France Gélinas: I will start at the end. In retirement homes, you don't see any circumstances where it would be appropriate for a retirement home to confine someone, but you said "except under the common-law duty," when confinement can occur. What does that mean?

Ms. Jane Meadus: Under the common law—and that's allowed under other legislation as well—an example of this is, I cannot come over and grab you and hold you. But if you were starting to walk across the street and I saw a streetcar that's going to hit you, I could grab you and pull you back. That would be the common-law duty in an emergency to keep you safe.

So if there was an emergency situation for a short period of time, you can be confined for a short period of time. So if someone becomes very upset and is hitting out, you can stop that, but you cannot continue that for long periods of time.

M^me^ France Gélinas: Could you define "a short period of time"? Are we talking hours, days, weeks or—

Ms. Jane Meadus: It would be probably hours.

M^me^ France Gélinas: Okay thank you. The other one: In long-term care, if you could explain to me the difference between "consent to confinement under the HCCA is based upon the principles of capable wishes in the best interest," as opposed to the long-term care, which is a "significant risk" that the patient—I don't fully understand what that means.

Ms. Jane Meadus: Under the Long-term Care Homes Act, when a physician is going to recommend that a person be confined, that recommendation is based on the potential of serious bodily harm to self or others. So that is the test; they say, "This person is going to have serious bodily harm." But when the substitute is actually going to make the decision, they have to look at: Does the person have a competent wish? Then the best interest has to set out in the Health Care Consent Act, and it doesn't talk about things like serious bodily harm. So you may have the physician saying, "This is the reason we need to do it," but the substitute decision-maker has a very different set of criteria to make the decision, and those two things are not necessarily compatible.

M^me^ France Gélinas: So you could see where a physician would say, "There's no reason to confine," but the family says, "Oh no, we have to restrain her because I'm afraid she's going to fall," but the physician has already done the assessment and determined that there is no risk.

Ms. Jane Meadus: Or, more likely, for example, you could have the physician say, "They're going to fall," and the person says, "Well, my mother had a competent wish that she never wished to be restrained so I cannot consent."

0940

M^me^ France Gélinas: Oh, I see.

Ms. Jane Meadus: So when you get to hearings and boards you're going to have a problem because those two things aren't compatible.

M^me^ France Gélinas: How do we solve that?

Ms. Jane Meadus: Well, I think that's something we're going to be working on: trying to make some recommendations in our larger piece. To be continued, I think, because, again, this is something that we're going to have to look at in our larger submission.

M^me^ France Gélinas: Okay. And you define a difference between confining of incapable residents and capable residents. Explain that to me again; the difference between the two.

Ms. Jane Meadus: Sure. So if I come to you and I say, "Can I confine you?" and you say, "Okay, I'll stay in this room;" if you turn around five minutes later and say, "I want to leave," you have all the control. I can't really confine you because as soon as you say, "I don't want to be confined," it's the end. You're staying in the room of your own volition and you're leaving of your own volition so it's really not confinement.

The Chair (Mr. Grant Crack): We thank the three of you for coming before committee this morning. It's much appreciated.

Ms. Jane Meadus: Thank you.

YORK UNIVERSITY SCHOOL OF HEALTH POLICY AND MANAGEMENT

The Chair (Mr. Grant Crack): We have York University School of Health Policy and Management with us this morning. We have Joel Lexchin, professor emeritus. We welcome you, sir.

Dr. Joel Lexchin: Thank you.

The Chair (Mr. Grant Crack): You have up to five minutes for your presentation.

Dr. Joel Lexchin: All right. Thank you for hearing me. I'm going to confine my remarks to the Health Sector Payment Transparency Act.

I taught health policy at York for 15 years, until 2016. I'm a practising emergency physician at University Health Network—any of you who want to break a leg, come see me. I've been researching and writing about the relationship between the medical profession and the pharmaceutical industry for about 35 years.

There is a lot of evidence out there that shows that when doctors and the industry interact it either means that there is no change in prescribing behaviour or that prescribing behaviour gets worse. In other words, doctors prescribe more frequently, they prescribe more expensively and the quality of their prescribing deteriorates.

Right now, on just sales representatives and journal advertising alone, the industry is spending close to $500 million every year reaching Canadian physicians and that doesn't include things like payments for speakers, meals, gifts, etc.

I'm going to talk about six things very quickly. First of all, the threshold for reporting transfer of value should be set very low. There's evidence from the United States that a $20 meal will affect prescribing behaviour in favour of the company that's paying for the meal. We need to have it at a low level if we want to pick up influence.

Second are samples. These are the medications that are left behind by the companies for doctors. Sampling

leads to poor prescribing. Doctors reach for the samples—these are the newer drugs; the more expensive ones—and while it may give patients some short-term financial relief, in the long term it's typically more expensive, and newer drugs are ones that we know less about in terms of safety. We need to make sure that this is also reported.

Clinical practice guidelines are documents that doctors use to help diagnose and treat various medical conditions. These are often sponsored by the drug companies that make products in the relevant area. They pay for people to attend meetings, they pay for the production of guidelines, and the costs involved in producing these should also be included.

One of the strengths of the legislation in the United States is that they can link the payments to doctors with prescribing to patients under their version of medicare, which means that we can see whether or not doctors who get money have their prescribing affected, because we can look at the drugs that they've been prescribing. The same sort of thing should be done here. We have the Ontario drug benefits database, and we can open that up so that we can allow linkage between the names of people who get payments and the way that they prescribe.

In a paper that I did a few years ago, we looked at policies for conflicts of interest in Canadian medical schools. They are, with one or two exceptions, typically weak, and therefore any payments made to people in medical schools, or to medical schools themselves, should also be included.

Finally, while I support this act, there is a lot of evidence that transparency is necessary but not sufficient. Transparency can lead to people letting down their guard. You think that somebody is being honest, and therefore you are less critical of what he or she has to say. Transparency is a first step, but it shouldn't be seen as answering the problems of the relationships between doctors and industry leading to negative outcomes for patients.

The Chair (Mr. Grant Crack): We will start the questioning with the official opposition: Ms. Thompson.

Ms. Lisa M. Thompson: I appreciated your six points very much. Thank you for coming in today. If I may, I would appreciate your perspective on something that we spoke about with the previous speaker. You have reflected upon prescribing. How do you feel about pharmacies paying to prescribe, in terms of having access to different homes? What is your opinion on that?

Dr. Joel Lexchin: That's not a subject that I've looked at, so I don't think that I should be talking about that.

Ms. Lisa M. Thompson: Okay. I respect that. That's fine.

In terms of transparency, you reflected upon different models from the United States etc. In terms of accessing your points, is your work accessible online so that we can go and drill down more?

Dr. Joel Lexchin: I've cited a bunch of papers that you can see. I don't want to self-promote, but I have a book about the relationship between the Canadian medical profession and the pharmaceutical industry, so if you want to buy that—

Ms. Lisa M. Thompson: Okay. I had heard that, actually.

I'm good. Thank you.

The Chair (Mr. Grant Crack): We'll move to the third party: Madame Gélinas.

M^me^ France Gélinas: The threshold for reporting being set very low—is 10 bucks low enough for you?

Dr. Joel Lexchin: That's probably okay. Doctors still carry around pens with names of drugs or drug companies on them. Drug companies wouldn't be giving away $1 pens if they didn't think they had some influence. But $10 sounds reasonable.

M^me^ France Gélinas: Okay. Value of samples: The first time I made the connection between "Yes, you go into the sample cupboard, but after this, you will continue to prescribe"—you want this disclosed as well?

Dr. Joel Lexchin: Yes. I think that the retail value of samples that company sales representatives leave behind should be reported.

M^me^ France Gélinas: Can you give me an example where a company made a payment that had an influence on the creation of a clinical best-practice guideline?

Dr. Joel Lexchin: In a study that I did a couple of years ago with one of my former graduate students, we looked at guidelines that were published on the Canadian Medical Association website. We looked at 28 of the most recent ones, and about a quarter of the authors of those guidelines had financial relationships with the companies that were making drugs that were being recommended.

M^me^ France Gélinas: A quarter?

Dr. Joel Lexchin: A quarter.

M^me^ France Gélinas: Wow. So it's not a one-off; it happens regularly.

Dr. Joel Lexchin: It happens regularly. I just looked the other day, actually, at a guideline from the Canadian Pain Society about treatment of pain. They had 18 members on their committee, and 13 of the 18 had a financial relationship with one or more drug companies.

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M^me^ France Gélinas: Okay. I like reading, but you've given us a long list of references. So, if I was to read two, which of those two would I read?

Dr. Joel Lexchin: Which of the two would you read?

M^me^ France Gélinas: That you list as reference.

Dr. Joel Lexchin: I would probably read number 2 and the last one.

M^me^ France Gélinas: Number 13?

Dr. Joel Lexchin: Yes.

M^me^ France Gélinas: Thank you.

You finished by saying that transparency is not sufficient and that future measures must concentrate on actually eliminating conflict of interest. So no more payments to anybody? The payment comes to the government; the government makes the best practice—how does that work?

Dr. Joel Lexchin: So I don't know if we'll ever eliminate doctors and their relationships with the drug companies, but we can certainly try and minimize the influence on people who have relationships on things that affect prescribing. For instance, with clinical practice guidelines, in the United States, the Institute of Medicine recommended that the chair of any such committee not have any conflicts and that a maximum of a minority of people on a committee have a relationship. We can do medical schools: Faculty on medical schools shouldn't be on speakers' bureaus for drug companies.

The Chair (Mr. Grant Crack): We'll move to the government side: Ms. Vernile.

Ms. Daiene Vernile: Good morning. Thank you very much for being here. I really like the title of your book: Doctors in Denial—too close for comfort. To continue the shameless plug, it was published in 2017 by Lorimer. It is the only book that examines the relationship between the Canadian medical profession and the pharmaceutical industry.

One challenge that we had when we were drafting this legislation was trying to get a handle on how widespread this practice is, of big pharma offering gifts and other things to Ontario doctors. Through your research, how widespread is this practice?

Dr. Joel Lexchin: The latest data that I came across was a survey of 1,000 doctors in 2015. It showed that at some point in their career, 46%—so almost half of them—had had some kind of a financial relationship with a drug company: they had been speakers; they had been invited to drug company-sponsored meals; they had been consultants for drug companies—a variety of different things. Almost half had taken money from the drug companies, or things in lieu of money, at some point.

Ms. Daiene Vernile: You mentioned in your presentation that even getting a dinner for under $20—like, they buy me a hamburger—and that's going to influence them?

Dr. Joel Lexchin: According to this study in the US, which was able to link payments for meals by companies to the prescribing of the doctors, they could see a change in the prescribing.

Ms. Daiene Vernile: My colleague wants to ask a question.

The Chair (Mr. Grant Crack): Mr. Fraser.

Mr. John Fraser: Thank you very much for your presentation and for all work in this regard. I fully understand that it's not only a need for transparency, but it's also to make sure that it directs to action or surveillance, as opposed to just reporting.

I do want to mention—and I know you sort of answered the question of my colleague—we're a publicly funded health care system. I think that it's important that we look at organizations and how other private interests interact with those organizations, not only for the influence that's there, but to see how the money flows and what it's spent on, because they are public dollars. So I'm not really looking for an answer, but I'm just suggesting maybe some interesting work that might be in the future.

Dr. Joel Lexchin: There are lots of examples of hospitals taking money from industry to set up chairs, to fund research projects. There is a concern that those may sometimes have adverse outcomes. For instance, at Queen's, there was a company that set up a chair in obesity research, and that company was also trying to get a drug on the market to treat obesity. The concern is that if the company is paying for the chair, who is going to be tapped to fill that chair and what is the message of that person going to be?

The Chair (Mr. Grant Crack): Thank you very much, sir. We welcome your remarks today and we wish you all the best.

Dr. Joel Lexchin: Thank you.

ASSOCIATION OF MUNICIPALITIES OF ONTARIO

The Chair (Mr. Grant Crack): Last on the agenda for this morning, ladies and gentlemen, is the Association of Municipalities of Ontario. We have Lynn Dollin, the president, and Monika Turner, director of policy.

We welcome both of you to committee this morning. If you just want to introduce yourself, whoever is speaking first, it would be greatly appreciated. The floor is yours.

Ms. Lynn Dollin: Thank you and good morning. My name is Lynn Dollin, I'm president of the Association of Municipalities of Ontario and with me is Monika Turner and she is director of policy. I have to say, sadly, neither of us has written a book.

So AMO is here today to speak to amendments to Bill 160. Municipal governments are employers—not stakeholders—delivering the ambulance, public health and long-term-care services. We care and we're co-funders as well. Our concerns emerge from this role and responsibility. Our key concern is that this bill opens the door to the fire-medic model despite our strong objections. We, along with those in the medical community, have strongly opposed this. There remains no demonstrable evidence that says patient care substantively improves given the additional training, care oversight and labour law impacts that this bill invites.

The ministry is ignoring the position of the ambulance service employers. The legislation will allow firefighters certified as paramedics to treat low-acuity patients through pilot projects. These pilots are to be hosted by only willing municipalities. It is the "willing" aspect that is also of concern. Why? Because we saw that 24-hour shift pilots for firefighters were imposed by arbitrators across Ontario despite the employers' non-supportive position. Based on that experience alone, AMO demands absolute, clear legislative protection that makes this out of scope for arbitrators. Our submission contains our proposed language for the amendments. We've been told that all-party support is required to make this change, as it involves different acts than the Bill 160 opens.

If this committee accepts that fire-med service is a decision of municipal governments, then you must agree

with us to make it clear and ensure that unelected arbitrators do not have the authority. Municipal governments are looking to this committee to make this fix.

If we saw the same effort on improving dispatch as we have seen on this fire-med matter, we would have improved patient outcomes today across Ontario.

Concerning the changes to the Long-Term Care Homes Act, we can all agree on the importance of the compliance inspection program and enforcement tools. Yet there are systemic issues and factors outside of the control of municipal home operators which can impact the ability to be in compliance. There are shortages of nurses and personal support workers to meet staffing and legislative requirements, often more acute in the rural and northern areas of Ontario. Success in meeting the needs of residents means that there must be corresponding investments by the government in the long-term-care sector.

AdvantAge, which represents both non-profit and municipal homes in Ontario, is proposing amendments. Given my limited time, I'll highlight that offence provisions on officers of long-term-care homes will be higher than those serving on hospital boards, and I think we need to revisit this.

The HPPA amendments to permit the regulation of recreational water facilities and personal services settings is reasonable, however the amendment is setting up another unfunded mandate for compliance work by municipal public health inspectors. There is already tension in the public health system in that the funding is just not adequate for public health units to meet their current obligated requirements. Municipal governments, on average, are providing about 38% of the financial support for public health on mandatory programs, even though we're only required to provide 25% of the funding. We're filling the gap, and that is not sustainable, especially in the light of the cumulative impacts of other pieces of legislation before the Legislature.

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Thank you for your attention. I would be happy to answer any questions you might have.

The Chair (Mr. Grant Crack): We'll start with the government: Mr. Rinaldi.

Mr. Lou Rinaldi: Good morning.

Ms. Lynn Dollin: Good morning.

Mr. Lou Rinaldi: It's good to see you again. This is getting to be quite a normal occurrence, whether it's through AMO MOUs or—anyway, it's good that you're here today to express your issues. I understand how important that is to you. I just wanted to make sure that we said that. We take your concerns seriously. Although it's a voluntary exercise with the paramedics, you stressed the fact that it might be taken out of context through arbitration and create issues, and we get that. I think we need to look at how we address that. I think your point is well taken.

I'm not sure if you went down this road, but I have a question for you. In the past few years, not just paramedics but firefighters, nurse practitioners, nurses and pharmacists have all been handed more responsibility in what they can do, because of their expertise. I guess the question I would have is: Do you have any sense outside of that fire-medic piece—because you're right; you pay a good portion of the ambulance folks. How can we best use their qualifications to serve the public? When somebody is sick and needs that assistance—I'm going to say, on a personal level, I really don't care who comes, as long as it brings the right level of service that could help me or anybody else. Do you have any thoughts on that piece? How can we best utilize their services?

Ms. Lynn Dollin: I think that there are things in the Ambulance Act that are reasonable as far as not requiring transfer to hospital for paramedics. What we would be calling for in that instance is that we have to make sure that we have proper training for the paramedics. Also, we'll be looking at the liability issue for allowing paramedics to maybe treat and release.

As far as emergency first responders, when it is something like vital signs absent, firefighters are able to attend until the paramedic gets there to stabilize.

Mr. Lou Rinaldi: Okay. In your presentation, you've got some specific recommendations. Can you maybe expand on that a little bit, on those specific recommendations?

Ms. Lynn Dollin: For the Ambulance Act?

Mr. Lou Rinaldi: Yes.

Ms. Lynn Dollin: Okay. First of all, we looked at the definition of a paramedic and we found that that was missing from the bill. It would be good if we could have the definition updated. The current definition is based on a system structure back in 2000 that no longer exists. It references legislation and education requirements that are no longer relevant. The ministry should provide an updated definition.

Also, the conveyance of patients other than by ambulance: We think that it would be reasonable to optimize the use of the new model of care. It should be amended to allow forms of transportation other than ambulance to provide conveyance to hospital or non-hospital—for example, taxis.

The Chair (Mr. Grant Crack): Thank you very much.

Mr. Lou Rinaldi: Oh, really?

The Chair (Mr. Grant Crack): I apologize. I'm going to move to the official opposition.

Mr. Lou Rinaldi: Thank you.

Ms. Lisa M. Thompson: Do you want to finish? Go ahead.

Ms. Lynn Dollin: Thank you so much. This would be a better use of ambulance resources and would keep them on the road to respond to emergency calls.

Another issue that we think needs to be addressed is inter-facility transfers. It's a pressing issue, and it's raising the costs of transporting patients between different health facilities. It's really not effective or efficient. It takes ambulances offline from responding to emergency calls, and it's a costly means of transport.

These transfers would be better done by third-party operators contracted by the ministry. The act should be amended to mandate this. There may be circumstances when an ambulance is required. In this case, it could be accommodated. However, the LHIN should provide payment for the full cost recovery of the cost of service.

We've heard particularly from the northern Ontario municipalities that these transfers can take ambulances out of service for several hours.

Ms. Lisa M. Thompson: Very good.

Mr. Lou Rinaldi: Thank you.

Ms. Lisa M. Thompson: You're welcome.

Thank you for being here today. I was particularly interested in your stressing of willing municipalities, because we all know what has happened in other instances of legislation and initiatives being imposed on municipalities who are unwilling hosts. That wasn't lost on me; I appreciate that very much.

I'm just wondering: Are you familiar with what's happening in Huron county and do you have any comments as to how we're facilitating first responding and whatnot, in the riding of Huron–Bruce?

Ms. Lynn Dollin: I am embarrassed to say: No, I don't. I'll pass it on to Monika if she has any—

Ms. Monika Turner: I believe it's in community paramedicine, but that's as much as I will say that we know.

Ms. Lisa M. Thompson: Okay. I can get that for you if you're interested in reviewing it, Monika.

Ms. Monika Turner: Absolutely.

Ms. Lisa M. Thompson: Okay, thank you.

The Chair (Mr. Grant Crack): We'll move to the NDP: Madame Gélinas.

M^me^ France Gélinas: You brought something forward that hadn't been mentioned before. You said that it "will result in higher offence provisions on directors and officers of long-term-care homes than those serving on boards of public hospitals." What does that mean and where is this in the bill? It's in the long-term-care-home section that you've mentioned that.

Ms. Lynn Dollin: Yes, and it talks about the offences and the enforcement on the boards. It's more restrictive on long-term-care-home boards than it is on a hospital board. We think that those should be the same.

M^me^ France Gélinas: Okay, so the provisions that we now have against directors of hospitals should be the same for long-term-care homes, is what you're asking for.

Ms. Lynn Dollin: That's our position. They should be aligned.

M^me^ France Gélinas: Okay. The higher-offence provision: I can go read, but can you give me an example of what you saw in there?

Ms. Lynn Dollin: If I may, this is actually the work of AdvantAge, which is the association which represents non-profit homes and municipal homes. We work with them and they raised it with us. We wanted to put it on your radar. We haven't seen that they're scheduled to speak in front of you. But we wanted to raise this because often the board of directors for long-term-care homes that are municipal are actually municipal councils, and so the irony of having offences for boards of public hospitals being of a lower level than for long-term-care homes just struck us as very strange. AdvantAge had brought that to our attention.

M^me^ France Gélinas: Yesterday, we had North Bay. A member of North Bay city council came forward for Casselholme to talk about the borrowing authority of territorial district homes. This is something that you support?

Ms. Lynn Dollin: If I may, we don't have the AMO board position, but what we wanted to do was put it on your radar. It is an issue. It goes to the issue of debt for municipal governments. Again, we wanted to raise it because a solution needs to be found. That is needed. Again, we need as many long-term-care homes and beds as possible, and it would be terrible if we lose it because of debt financing issues.

M^me^ France Gélinas: Did you see the recommendation that the city of North Bay made yesterday? The recommendation is basically to allow Casselholme to take a mortgage on its own, secured by their own assets. Is this something that you agree with?

Ms. Lynn Dollin: We would be supporting North Bay on that. We haven't taken that to the board yet, so that would be my one caution. But certainly, debt capacity: Municipalities have a big gap there, and debt capacity should be for municipal issues. If it's all taken out by securing a mortgage for a long-term-care home, then that could leave not enough debt capacity to fix the infrastructure problems that they have.

The Chair (Mr. Grant Crack): I'd like to thank the both of you for coming before committee this morning and sharing your thoughts; much appreciated. Have a great day.

Ms. Lynn Dollin: Thank you, Mr. Chair.

The Chair (Mr. Grant Crack): Okay, members of the committee: I just want to remind everyone before we adjourn that we will be meeting on Monday, November 20 at 2 p.m. to continue public hearings. I would remind that for written submissions, the deadline is 12 noon on Thursday, November 23.

Madame Gélinas?

M^me^ France Gélinas: Can I ask research to please send us the copy of reference number 2 and reference number 13 from Dr. Joel Lexchin—the two that he recommended that I read, number 2 and number 13?

The Chair (Mr. Grant Crack): Okay, we will be able to provide all members of the committee with those two.

Thank you very much. This meeting is adjourned.

The committee adjourned at 1010.

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