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Official Report of Debates (Hansard)

G-38

Standing Committee on General Government

Strengthening Quality and Accountability for Patients Act, 2017

2nd Session
41st Parliament

Wednesday 22 November 2017

Chair: Grant Crack
Clerk: Sylwia Przezdziecki

Journal des débats (Hansard)

G-38

Comité permanent des affaires gouvernementales

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

2e session
41e législature

Mercredi 22 novembre 2017

Président : Grant Crack
Greffière : Sylwia Przezdziecki

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON GENERAL GOVERNMENT

Wednesday 22 November 2017

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DES AFFAIRES GOUVERNEMENTALES

Mercredi 22 novembre 2017

The committee met at 1600 in room 151.

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 afternoon, ladies and gentlemen. I'd like to welcome all members of the committee and support staff. I'd like to call the Standing Committee on General Government to order. Today, we are here to continue the public hearings with regard to Bill 160, An Act to amend, repeal and enact various Acts in the interest of strengthening quality and accountability for patients.

Mr. Yurek.

Mr. Jeff Yurek: I just wanted to raise an issue with the committee. Legislative counsel has informed me that they're unlikely to be able to print out all my amendments. Considering that today has a full agenda and amendments are due tomorrow, I'm quite concerned that we won't be able to get the amendments in on time because legislative counsel is unable to get them to us. I'm hoping that it's a soft deadline and you'll be open to getting them on Friday, if possible. There are a lot of amendments in this bill, and the fact that it's being rushed through—I think it's only fair, in a democracy, that we actually get an opportunity to put amendments in.

The Chair (Mr. Grant Crack): The deadline was set by the committee, so we'll have to go by that, unless there's further action taken.

Ms. Wong.

Ms. Soo Wong: Mr. Chair, through you to the member opposite: We had two weeks of public hearings. Everybody knew that deadline. We're starting clause-by-clause on Monday, if I recall.

Interjections.

Ms. Soo Wong: I'm just saying it would be appreciated if we knew about it a little earlier.

The Chair (Mr. Grant Crack): Just for clarification: I've been speaking with the Clerk, and apparently we will accept amendments after the deadline.

Anything else to add further, Clerk? Feel free. That's fair? Okay.

Ms. Gélinas, on the same point of order?

M^me^ France Gélinas: No, it's not a point of order.

I had asked for information on the six private hospitals. Thank you very much for the work. One thing I had asked is, do they receive accreditation? That part was not answered.

The Chair (Mr. Grant Crack): After the last meeting on Monday, Madame Gélinas made a specific request to legislative research, as she has just mentioned. As a result, if this is for the entire committee, the entire committee should ask for it. If you want to ask, that would be the appropriate way at this point.

M^me^ France Gélinas: During deputations on Monday, there was quite a bit of talk about the six private hospitals that exist in Ontario. Most of us don't know a whole lot about those six hospitals, and none of them have come forward. So I would like to ask legislative research to give us the names of those six private hospitals and the oversight that already exists. Do they have accreditation? Are they covered by the Patient Ombudsman? Are they covered by freedom of access of information? Are they covered by the pharmacy thing? They've already sent us a piece of paper that answers all of those questions except one. They did not answer the question about if they participate in accreditation. That's all I'm asking.

The Chair (Mr. Grant Crack): Is there any objection?

Interjection.

The Chair (Mr. Grant Crack): That's great, because I approved it following the meeting on Monday anyway.

Let's get back to business.

SCHIZOPHRENIA SOCIETY OF ONTARIO

The Chair (Mr. Grant Crack): First on the agenda, from the Schizophrenia Society of Ontario, we have chief executive officer Mary Alberti and policy analyst Antonella Scali.

We welcome the two of you before committee this afternoon. You have up to five minutes for your presentation, followed by nine minutes of questioning.

We'll try to get back on schedule. We're five minutes behind, so I want all members just to know that already when they're asking questions.

The floor is yours. We welcome you. Please state your names for the record.

Ms. Mary Alberti: Yes, thank you very much. My name is Mary Alberti. I'm the CEO of the Schizophrenia Society of Ontario.

Ms. Antonella Scali: I'm Antonella Scali. I'm the policy analyst with the Schizophrenia Society of Ontario.

Ms. Mary Alberti: Thank you very much for the opportunity today to present on Bill 160, the Strengthening Quality and Accountability for Patients Act, 2017. Today, we will be speaking specifically to schedule 8, the repeal of the Ontario Mental Health Foundation Act.

I would like to begin by providing you some brief information on our organization. The Schizophrenia Society of Ontario, known as SSO, is Ontario's only not-for-profit charitable health organization dedicated to supporting individuals, families, caregivers and communities impacted by schizophrenia and psychosis province-wide for the past 38 years. Our mandate is to educate, support, advocate, research and innovate in the mental health spectrum. We are one of the very few organizations in Ontario that provides schizophrenia- and psychosis-specific supports, filling a critical gap when individuals, families and communities have nowhere else to turn.

Schizophrenia, as some of you may know, affects about 1% of the Canadian population, and roughly 3% of the population will experience a psychotic episode, often between 15 to 24 years of age. Although experiences of this illness vary, schizophrenia is often characterized by psychosis, such as hallucinations, negative symptoms, such as social withdrawal, thought disorder and disorganized speech. People living with schizophrenia can get better and do get better with the right timely supports, often realized through research initiatives.

Mental health research for our organization has been a long-standing priority. As an organization, we have a budget of about $2.5 million, and 23% of our funds come from the Ontario provincial government. The rest of those funds we raise through fundraising efforts, and a substantial amount of that money does get allocated to research initiatives in the areas of biomedical research and psychosocial research. Some of the funding we have done has included research projects by new and established scientists in the areas of biomedical and psychosocial research. As well, we conduct our own research in the area of policy and quality of life. We are committed to developing a research program that examines real-world issues and finding solutions for individuals, families and communities.

We've had many achievements in research, often partnered with other organizations and other funding providers. These have included everything from psychosocial research on cognitive remediation, funding to Dr. Heather Stuart on perspectives on stigma and discrimination in schizophrenia, funding to Dr. Eva Chow to study predictors of schizophrenia with people with a genetic high risk for developing the illness, and our own research on the Ontario mental health and addictions strategy. We have recently engaged in some very interesting and new research initiatives under cognitive behavioural therapy, which aligns with the ministry's mental health strategy; and as well in our new innovation portal, which really looks at applying research in an innovative spectrum to develop new products and solutions for people in mental health.

The Ontario Mental Health Foundation has made significant contributions to the advancement of mental health research through its program. It has been a big supporter to us at the Schizophrenia Society of Ontario by providing us with peer reviews on research applications.

Traditionally, mental health research has predominantly included funding of biomedical research, which is essential to advancing our understanding of mental illness. In fact, the Institutes of Neurosciences, Mental Health and Addiction of the Canadian Institutes of Health Research, through their funding database, have shown that about $800 million goes to biomedical research compared to about $253 million spent on non-biomedical research in the mental health spectrum.

Psychosocial research is very important in that it involves the interaction of psychological and social aspects of mental health and typically receives fewer dollars than biomedical research. We know through our own work and through advancements in this field that this kind of research is critical and equally valuable to biomedical research to improve people's lives.

There is a need for continued investment in research that supports community-based interventions to build community capacity to respond, reduce wait times and reduce an overreliance on emergency service use, all of which is in the Ontario mental health strategy.

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The Chair (Mr. Grant Crack): Thank you very much. I appreciate it. I'm always going to apologize for cutting you off, but we have to stay on schedule.

We'll start with the official opposition. Mr. Yurek.

Mr. Jeff Yurek: You can finish.

Ms. Mary Alberti: Yes, we have four very concrete and brief recommendations:

(1) With the repeal of the Ontario Mental Health Foundation Act, now more than ever, we need to ensure that mental health research, including schizophrenia and psychosis, remain a priority.

(2) We are hopeful that by housing the foundation's funding allocation of $1.8 million under the Ministry of Health and Long-Term Care Health System Research Fund transfer payment line, these funds will continue to be earmarked for mental health research.

(3) The funding allocation of $1.8 million for mental health research needs to be adjusted for inflation to continue sustainability of this funding.

(4) Continued funding needs to sustain quality-of-life research—we know that this includes biomedical and

psychosocial research—and also to include community-based research.

In closing, transparency and accountability are also very critical to ensuring that funding continues to be targeted for mental health.

Mr. Jeff Yurek: Okay, that's good.

The Chair (Mr. Grant Crack): We shall move to Madame Gélinas.

M^me^ France Gélinas: The bill right now takes that money and puts it into the Health System Research Fund, with no more guarantee—it's not written in the bill that there will be some money allocated to mental health. Do you feel comfortable with this, or are you asking that we transfer the money into the Health System Research Fund with the caveat that a portion of it will always be reserved for mental health research?

Ms. Mary Alberti: Absolutely, I would say: with the caveat that the $1.8 million always be reserved for mental health research, and that there is inflation to those funds as we go forward, because research is critical.

M^me^ France Gélinas: I agree. If we leave the bill as is—so if an amendment is not put through—are you fearful that the big players in health care will take all of the research money and that mental health will continue to—

Ms. Mary Alberti: Yes. I think we would want more specifics as to exactly how those funds will be allocated, and if they will be allocated directly to the research that we are proposing, which is biomedical, psychosocial and community-based research. We feel strongly that we cannot lose the research capacity when it comes to mental health.

M^me^ France Gélinas: Except for yourself, who else funds psychosocial and community-based mental health research specifically for people with psychosis?

Ms. Mary Alberti: Oftentimes in this spectrum, we will see that a lot of this research is funded by private donors or philanthropists who are contributing to this area because they feel that it is incredibly important. CIHR would be one of the funders, as well. Having worked with the Ontario Mental Health Foundation through matched resources that they have provided—they have also been funding this type of research.

M^me^ France Gélinas: Within the Ministry of Health, do you have another stream of funding for research once this mental health fund is gone?

Ms. Mary Alberti: Not that we are currently aware of, no.

M^me^ France Gélinas: No. Me neither. Okay, thank you.

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

Ms. Soo Wong: Thank you very much for your presentation.

I just want to be on record from the government side that the government and the minister continue to commit to mental health research funding. You'll be hearing consistently that the minister has put more money into mental health, and it has to be evidence-based. In order to have evidence-based, you must do research. So let's be on the table about that piece.

You also know that the Ontario Mental Health Foundation has not carried out seven of their 10 objectives. That is a concern.

The other piece here is—I know you alluded to it in your presentation—that the objectives of the Ontario Mental Health Foundation Act are either being taken over by the Ontario mental health and addictions strategy or by the Health System Research Fund. That fund will continue to do research because we will be continuing to fund graduate studies, whether it's a master's program or a PhD program, which is an important piece of the postgraduate work and the research piece.

I heard your concerns, but I think that the key piece here is, in order for the government to continue to fund the many mental health initiatives where we have expanded those scopes, we've got to have evidence, and the evidence is in the research. I agree with your comments, but with regard to your concern about eliminating mental health research, I don't think that's what the intent of the government is.

Ms. Mary Alberti: Just for clarity on that, we're not questioning in any way your decision with the Ontario Mental Health Foundation. What we are asking, as a community-based organization that very much values evidence-based research—we ourselves do evidence-based research in the community—is that these funds continue to be allocated for research and not allocated for Ministry of Health system transformation initiatives; that they actually do stay in research funds, and also be expanded to community-based research—because a lot of good research that informs the quality of life for people is done at the community level—so that there could be consideration for accessibility of these funds through the mental health strategy.

Ms. Soo Wong: With regard to these changes, do you think this type of change that we are proposing will improve the efficiency as well as the support of mental health in the community?

Ms. Mary Alberti: We would hope that it would. I don't think we have enough detailed information of exactly how that will happen and how it will be translated to the community. We would request that.

Ms. Soo Wong: The concern is on the implementation.

Ms. Mary Alberti: Absolutely—both that it stay for research and how it will be implemented and to include community.

The Chair (Mr. Grant Crack): Thank you very much for taking the time to come before committee this afternoon. It's much appreciated.

CONCERNED ONTARIO DOCTORS

The Chair (Mr. Grant Crack): Next on the agenda we have Concerned Ontario Doctors. We have the president, Kulvinder Gill, with us. We welcome you this afternoon to committee. You have up to five minutes for your presentation. The floor is yours.

Dr. Kulvinder Gill: Good afternoon. My name is Dr. Kulvinder Gill. Thank you for the opportunity to address the standing committee about Bill 160 today, on behalf of Concerned Ontario Doctors, a grassroots, not-for-profit organization representing thousands of community and academic family physicians and specialists in every corner of this province. We advocate for a patient-centred, sustainable, accessible and quality health care system. I am a front-line physician practising in Brampton and Milton, a medical educator and the co-founder and president of Concerned Ontario Doctors.

Ontario's doctors have serious concerns about several aspects of this omnibus Bill 160; in particular, the sections pertaining to health sector payment transparency, community health facilities, and also the billing extrapolation. We support transparency, but not one that is without context and that utilizes a process that will have a direct and negative impact on patient care.

Pharmaceutical companies provide drug samples and compassionate funding for patients who would otherwise not be able to afford often very expensive treatments. Many physicians participate in these programs on behalf of their patients, and the pharmaceutical companies write off these costs as "payments" to the doctors. Since Bill 160 was introduced, many front-line physicians have stopped accepting these samples, fearing that this could be publicly reported as being a direct payment to them.

Similarly, many pharmaceutical companies have compassionate funding programs through doctors whereby patients have partial or full costs of their essential medications covered; specifically, many anti-depressants, anti-psychotics and many of the immunological medications. Many patients who are on such compassionate funding programs have been immensely stressed since Bill 160 was introduced. In an already grossly underfunded health care system, is the government now prepared to provide additional funding for all of these patients who previously had access to their medications through private sector compassionate programs?

Ontario doctors are required to undergo continuing medical education, CME. In 2015, this government unilaterally eliminated funding for doctors to take CMEs. Since 2015, the government has also unilaterally cut more than $3.5 billion from the patient services that Ontario's doctors provide. This, in addition to the recently announced federal taxation changes, has left many physicians struggling to keep their clinics afloat.

The private sector has been instrumental in stepping in where this government has failed to do so. Industry provides essential funding for CMEs that are accredited by either the College of Family Physicians of Canada or the Royal College of Physicians and Surgeons of Canada. It is important to acknowledge the role the private sector has in funding research which includes fellowships and providing funding and support for expensive medical equipment. These are all important aspects of health care delivery for which there is no or inadequate public funding available. Bill 160 will create significant barriers in all of these aspects. Again, at a time of billions in cuts to front-line care, the government certainly has not proposed stepping in to fund any of these programs.

The Oversight of Health Facilities and Devices Act contains many concerning aspects and lacks detail. The definition of "facility" is so vast that the executive officer could designate any place providing medical care as a community health facility, including physicians' private community clinics and thereby then define the conditions for that medical practice.

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The overarching authority granted to the executive officer is also immensely concerning. It enables them to enter and search premises deemed to be a "facility" without a warrant and without notice, including access to patients' private medical records without their consent.

Bill 160 goes further in giving the Minister of Health power to unilaterally suspend, reduce, recover or demand repayment for a patient service arbitrarily at any time from a physicians' practice in a medical "facility." There is no independent appeal process.

What is most concerning is that Bill 160 allows the minister to use extrapolation to recover overbillings. This is identical to the disgraced Medical Review Committee, MRC, that was created by the Ontario government under the College of Physicians and Surgeons of Ontario in the 1990s.

On April 10, 2003, Dr. Anthony Hsu's body was pulled from the cold waters of Lake Ontario. Anthony, a gentle pediatrician from Welland, had died by suicide following his experiences with the MRC. The government suspended the MRC in September 2004. In 2005, former Supreme Court of Canada Justice Peter Cory was appointed by the government to study the MRC process. Justice Cory delivered a scathing verdict on Ontario's punitive system of auditing Ontario's doctors—guilty as charged. He stated that the punitive system "has had a debilitating—and, in some cases, devastating—effect on the physicians of Ontario and their families."

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

Madame Gélinas.

M^me^ France Gélinas: You want us to fully understand that the transparency parts of the bill, as they are written now, if they were to go forward, you feel that either physicians would stop taking samples, would stop using the compassionate support—because of the way it's going to be reported having a direct impact. This is the message you want us to understand?

Dr. Kulvinder Gill: Absolutely. I can tell you that many front-line physicians, since the bill was tabled in September, have already stopped accepting patient samples. What I find very concerning, and I think it's very important for this committee to realize, is that with some of these compassionate programs—I have a psychiatrist in my community who sees some of the patients in the communities for an injectable long-term anti-psychotic, which is very expensive. The injection is every three months, and it costs roughly around $1,500. This is covered entirely through the compassionate

funding program. If he has 10 of these patients, that's $60,000, approximately, that under this law would be considered payment to him and reported on the website as payment directly to him even though it's funding necessary treatment for that patient, which is ensuring that patient's quality of life and also ensuring that that patient is actually able to function in the community and stay out of the hospital.

M^me^ France Gélinas: If there were information attached to the payment that showed that that was for compassionate support for the patient or that was for a sample, would that be enough to reassure you?

Dr. Kulvinder Gill: I think physicians would only be reassured if things that are directly going to patients are actually left out completely: patient samples, compassionate funding, anything that doctors sign off on directly on behalf of their patients, should not be reported as a payment to that physician.

M^me^ France Gélinas: Okay. I had never seen this word "extrapolating" for billing recovery. I don't know what that means.

Dr. Kulvinder Gill: With the MRC, what had happened was that auditors would go into a physician's practice, they would often audit approximately 10 to 20 charts, and then they would extrapolate what they found in those 10 to 20 charts for two years back, and then force the physician at the start of their investigation to pay all of that amount, with interest, back to the government.

M^me^ France Gélinas: Oh, wow.

Dr. Kulvinder Gill: I should mention that we strongly caution the standing committee in bringing forth legislation without significant amendments to ensure that the critical recommendations in Justice Cory's 326-page report are actually adhered to. The government must ensure that physicians are treated with respect and granted due process. One more death by suicide is far too many.

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

Mr. John Fraser: Thank you very much for being here, Dr. Gill.

I want to talk to you about the transparency pieces of the bill. As you are aware, the reporting mechanism on the transparency piece is on the side of the payer, the company that's giving that compassionate drug or that other payment, or what some people might deem as an incentive. They're the ones who are required to report that. There's no onus on the physician, inside this bill, to report—

Dr. Kulvinder Gill: That is incorrect. What happens is that any time these samples are given to the physician, or there's compassionate funding given to the patient, a physician is actually required to sign off on that payment. The doctor's name is signed to that payment or that sample, and that pharmaceutical company then expenses that as a cost to their company.

Mr. John Fraser: Whenever you receive something, like any invoice, like anything we do in life—when Purolator comes to the door—we sign for it.

What I'm getting to is that that reporting, for a variety of things, is done by the companies. I think there needs to be transparency in this area. It's not just with physicians; it's across the health care system. There is money that moves between partners in the health care system that's not transparent. If we're going to have a publicly funded health care system, which I think you believe in—I don't think you believe differently than that—then we have to ensure that we know where that money is moving. As we found in other circumstances, and you'd know this, as well, in your practice, with certain organizations, GPOs, for instance, group purchasing organizations—how did that money flow through there? It's public money.

The challenge with government is, how do you ensure accountability? There are no sanctions in this bill with regard to transparency. What it simply is is, "Let's see what's going where." Quite honestly—and I'm not a practising physician—I don't think the measures in this bill will in any way inhibit people from providing the kind of compassionate care that they're giving, that companies are offering. I think what it's driving at is, "Let's just take a look and see what's going on." I would argue that—

Dr. Kulvinder Gill: As a front-line physician, I completely disagree. I can tell you that my colleagues and myself—I've already stopped accepting samples for epinephrine auto-injectors, for essential puffers, for medications that my patients with lower socio-economic needs would need, because we are fearful of being further vilified by this government, which has done a tremendous job of already attacking front-line doctors. I think it's important to realize this from the perspective of the front-line health care provider, not from a government bureaucrat's perspective.

Mr. John Fraser: It's not a bureaucrat—it's accountability. It's making sure that—and that's what our role is, all of it.

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

Mr. Jeff Yurek: I just have one question, and then Mrs. Munro would like to ask a question.

Thanks for being here.

Perhaps if an amendment was made that there are descriptors given to the transparency, say, for samples; that people understand it's a sample, or some form of education—if there's a descriptor attached so we could prevent data being misconstrued and used against a profession, which you've seen.

Dr. Kulvinder Gill: I think if you have it up on a website and patients see a number of—like the example that I had just given about the anti-psychotic that's essential for those patients. If a psychiatrist is simply seeing 10 patients a year, that's $60,000. That number extrapolated with all of the other medications that are being given through other compassionate programs to that physician, and other samples—that number could easily go greater than six figures.

In terms of transparency, something that is directly going to patients and not the physician should not be

reported under the physician's name. I think there are other means in terms of getting transparency there, and that's where the government can actually work with having the pharmaceutical companies give that information to them privately so that they know how much funding is actually going through compassionate programming. That might be a very useful measure for the government to know so that they can then possibly have that under their Ontario drug formulary.

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Mr. Jeff Yurek: I'm concerned about the sample issue because I know how many patients can't afford the medications that aren't on the formulary at all and are getting them through—

Dr. Kulvinder Gill: Absolutely. I can tell you that I have many patients in my practice that have anaphylactic food allergies who don't qualify under the Ontario drug formulary, who don't have insurance plans and actually rely on me to be able to give them samples of these EpiPens for them to be able to have that life-saving treatment with them.

Mr. Jeff Yurek: Ms. Munro.

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

Mrs. Julia Munro: I come to this conversation with a letter from a specialist practising in the province who sees this kind of situation that we're discussing as detrimental to their future ability. Obviously, there are always people who are more aggressive in their comments and so forth, but I wondered if you have the same sense. When he wrote this letter to me, he used his time in the hospital as a surgeon, but is on call as an anaesthetist. I don't think that anyone does that unless they see the pressing need.

Dr. Kulvinder Gill: Absolutely.

Mrs. Julia Munro: So I just wonder if you would use this issue that we're discussing as a demonstration. Is it that serious for the practising physician in Ontario?

Dr. Kulvinder Gill: It is, absolutely.

The Chair (Mr. Grant Crack): Very quickly, please

Dr. Kulvinder Gill: Sorry?

The Chair (Mr. Grant Crack): Very quickly, please. We're out of time. I'll allow just one comment.

Dr. Kulvinder Gill: Sure. A lot of aspects of this bill are very concerning to front-line physicians, in that before this bill has even officially passed, they've already made changes to the way that they practise. That will have a detrimental impact on patient care.

The Chair (Mr. Grant Crack): Thank you for coming before committee this afternoon. It's much appreciated.

INDEPENDENT DIAGNOSTIC CLINICS ASSOCIATION

The Chair (Mr. Grant Crack): Next on the agenda, we have the Independent Diagnostic Clinics Association. We have the president, Mr. Gerald Hartman, and executive director Stephanie Bolton with us this afternoon. We welcome you both to committee. You have up to five minutes for your presentation, and I hope I don't have to cut you off. It's not a fun part of the job. The floor is yours.

Mr. Gerald Hartman: Good afternoon, ladies and gentlemen. My name is Gerald Hartman, president of the Independent Diagnostic Clinics Association and president of True North Imaging, a community-based diagnostic imaging organization.

The IDCA was pleased to participate in the consultations that resulted in the development of Bill 160. The IDCA has represented the interests of community-based health care providers since the introduction of the Independent Health Facilities Act in 1989.

We understand the need for a single, uniform compliance regime in order to simplify and consolidate standards. We also acknowledge the desire for enhanced monitoring of complaints and incident reporting to ensure accountability to taxpayers. We have concerns, however, regarding a number of matters contemplated in the legislation: the adequacy of funding to the sector, the need for permanent inclusion of provider representation in change development, and the lack of transitional provisions to allow providers time to implement operational changes.

The IDCA understands the need for the imposition of uniform standards in hospital institutions and community-based environments. We would point out that hospitals are specifically funded for such compliance and general administrative protocols, and these institutions are furthermore able to generate additional revenue through their fundraising foundations. In contrast, community-based providers—those represented by the IDCA—often operate on a shoestring budget, with grossly inadequate government funding, which has remained virtually unchanged since the 1980s. The significant implementation costs required to adhere to the enhanced compliance requirements which this legislation contemplates are going to exacerbate an already desperate situation. Accordingly, we would like to see fair and equitable funding provided to meet the changes required of community health facilities. The proposed legislation contains no commitment to reasonably fund this important sector or provide the type of 21st-century reimbursement that such provinces as British Columbia or Alberta afford the sector.

We appreciate that the draft legislation is a high-level structural framework. As a result, much of the implementation detail is going to be left to be developed under regulation. We're concerned, however, that the proposed legislation may leave too much discretion to the ministry and the executive officer for community health facilities. We believe that additional policy guidance is necessary to ensure that actions taken do not prejudice the rights of existing health care providers. For example, section 56 of the Oversight of Health Facilities and Devices Act would give the executive officer the right to suspend, revoke or refuse to renew a licence where there has been "reasonable grounds to believe that there has been a change in any factors related to the management of the health care system." Under these provisions, the mere perception of any political, financial or demographic change could

justify a licence revocation. Given such arbitrary actions—well, they simply lack either fairness or natural justice. As there is an unfortunate state of funding to this sector that does exist, you can perhaps understand why the prospect of enhanced and unrestricted government authority is something that many community-based providers fear.

We believe, however, that a number of the concerns of community-based providers could be addressed quite easily. The most affected stakeholders should have direct and timely input into appropriate policy and implementation considerations. In order to ensure that this occurs, community health facilities should have permanent, formal and irrevocable representation on any and all future committees and task groups that are created affecting the sector.

According to ministry stats, the almost 1,000 community facilities deliver roughly 50% of all diagnostic procedures performed in the province, which translates into some 10 million diagnostic services per year. Given the significant role played by community health facilities in the public health care system, inclusion of sector representation in the development phase of initiatives is imperative. To ignore providers is to risk creating programs which will almost certainly have unintended consequences and implementation hurdles that could easily have been highlighted, if not addressed.

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

We'll start with the government. Mr. Fraser.

Mr. John Fraser: Thank you very much for your presentation. Can you be more specific with—you made a point with regard to representation on committees. Is there any specific committee that you're talking about?

Mr. Gerald Hartman: We believe that there is a significant amount of discretion that is being left to the executive officer to develop a consultation regime. We are concerned that, without representation from those who are going to be delivering service, much of the decision-making will result in bad decisions being made.

Mr. John Fraser: So, arguably, this is the first piece of legislation to come along in a while that governs your sector. Would that be correct?

Mr. Gerald Hartman: That's true, that's true.

Mr. John Fraser: So there would likely, for these kinds of changes, not have been the need until now to ensure that you had that representation?

Mr. Gerald Hartman: Actually, there has always been the need. It's just that the sector, for a long time, was under the authority of the Ontario Medical Association. They had a very paternal method of looking at the sector.

Mr. John Fraser: How long was that ongoing?

Mr. Gerald Hartman: Until 2009, the OMA had direct funding and responsibility for the sector. Since then, it's sort of been taken away from the OMA but has not really found its own independent place yet.

Mr. John Fraser: I think that's—I hear your concerns very clearly—what the bill is driving at, is to ensure that it gets its place so there's—

Mr. Gerald Hartman: Exactly.

Mr. John Fraser: And I know you're agreeing with accountability, because it is a critical thing. I know we were talking about transparency earlier with a deputant before. It's really important to have that because we know that we want to make our insurance system sustainable and we know that we have a finite set of resources, so those pieces are really critical.

I take your comments to heart in terms of your sector's involvement in that. I want to thank you for your presentation.

Mr. Gerald Hartman: Thank you.

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

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Mr. Jeff Yurek: Thanks for coming in. You mentioned earlier in your presentation that you participated in consultations for this bill. Did you raise the concerns of costs etc. at these consultations?

Mr. Gerald Hartman: Yes, and we were told specifically that the issue of funding was not going to be part of the legislation itself.

Mr. Jeff Yurek: So you red-flagged an issue that's going to affect 50% of diagnostic procedures in this province and were ignored.

Mr. Gerald Hartman: Correct.

Mr. Jeff Yurek: I'm saying "ignored"—you're not saying it. You just have to agree.

Ms. Stephanie Bolton: Shut down.

Mr. Gerald Hartman: Yes. It's interesting, there's actually a provision in the bill that says that a community health facility may not raise the adequacy of funding as a defence to any action brought against it.

Mr. Jeff Yurek: Okay. So if, in fact, it's too dear to make the changes necessary and these community health facilities shut down, what happens? Everything goes to the hospital or—

Mr. Gerald Hartman: No, the hospitals really lack the resources to handle the additional volume. There has been a continual downloading of service into the community.

Mr. Jeff Yurek: So we basically pass this bill and—

Mr. Gerald Hartman: Wait times expand; they increase.

Mr. Jeff Yurek: —we just wait for regulation where we have no idea what's going to happen. So it's very key that you're part of this process afterwards.

Mr. Gerald Hartman: Exactly.

Mr. Jeff Yurek: But there's no guarantee you will be.

Mr. Gerald Hartman: That's really what we want: simply a seat at the table.

Mr. Jeff Yurek: Sounds reasonable to me that you're part of that process. This bill is full of waiting until the regulations come out to see what it's going to be at the end of the day. I'm just astonished that you were part of the original consultations and we still have the same problem, and are waiting for the regulations to see if it gets fixed. Thank you.

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

M^me^ France Gélinas: Thank you, Mr. Hartman, for coming. How many members do you represent?

Mr. Gerald Hartman: We probably represent about a third of all of the independent health facilities that exist currently in Ontario.

M^me^ France Gélinas: About 300.

Mr. Gerald Hartman: Yes.

M^me^ France Gélinas: Okay. You said that the "mere perception" by the authority could suspend, revoke, refuse—would you have language that you will bring forward? Or are you leaving it up to us to put language that would basically bring fairness and a little bit of justice to your membership?

Mr. Gerald Hartman: You know, I would love to. In fact, I was a business lawyer for years—until 25 years ago. But I wouldn't presume to be able to insert one provision, because I think that there are a number of other provisions that would have to be mirrored in other parts of the legislation.

M^me^ France Gélinas: Okay. So if we want to help you and we want to put amendments forward so that you are treated fairly and your members are treated fairly, that a "mere perception" does not allow the government to suspend, revoke or refuse, can you—

Mr. Gerald Hartman: I could, actually, give you one suggested amendment and that relates to a provision—I believe it's further in schedule 9. It indicates that the decision of the executive officer cannot be appealed to the HSARB if the decision has been made based on factors that relate to the management of the system. I would have that one provision deleted, because at least a clinic owner or an affected party had a right to appeal to HSARB in the event that there was a regulatory or licensing decision made on the basis of management of the system.

M^me^ France Gélinas: Okay. Are any of your members not-for-profit or are they all for-profit?

Mr. Gerald Hartman: The fact is, most operate at a loss, so they would argue that they are not-for-profit.

M^me^ France Gélinas: But not incorporated as such.

Mr. Gerald Hartman: Yes. There are many who are, I believe—"not-for-profit" is a difficult term because many of us seek only to really have the sustainability of our organizations. Given the lack of a funding increase in 30 years, most have simply scaled back to the point where they're simply trying to pay their staff. For-profit, not-for-profit—to my mind, it's very much a red herring. Any physician is for-profit. Any technologist is for-profit. Anyone providing a service, I would argue, is.

The Chair (Mr. Grant Crack): Thank you very much. I appreciate the two of you coming before committee this afternoon. Have a good evening.

ONTARIO LONG TERM CARE ASSOCIATION

The Chair (Mr. Grant Crack): Next, we have the Ontario Long Term Care Association. We have the chief executive officer with us, Candace Chartier. We welcome you to committee this afternoon. You have up to five minutes for your presentation. The floor is yours.

Ms. Candace Chartier: Good afternoon. I'm Candace Chartier, and I'm here today representing the Ontario Long Term Care Association. The OLTCA is made up of private, not-for-profit, charitable and municipal long-term-care homes. Our member homes are found in large and small communities across the province. Despite our differences, one thing is in common: We all want to serve seniors to the best of our abilities. Collectively, the OLTCA represents over 70% of Ontario's long-term-care sector, and we thank you for the time to present some of our concerns with the proposed changes to the Long-Term Care Homes Act as outlined through Bill 160.

As committed partners in the pursuit of advancing care to Ontarians with complex health needs, we agree that enhancements are required if we are to continue effectively serving seniors, whether that be improvements in funding, regulations, or new accountability measures as proposed under Bill 160's changes.

The bill contains sweeping changes to enforcement as well as new practices related to how we can better protect residents with dementia and other cognitive health challenges. Our primary concern is that if we introduce new changes and do not provide ample time for the homes to be educated, we will end up creating a chaotic environment that may unintentionally impact the people we are looking to serve: our seniors.

The long-term-care sector is a highly responsive environment, where the majority of homes comply with the act. This has been acknowledged by government and is evidenced through the degree of compliance on the reports posted on the ministry inspection website. In fact, there are very few homes, less than 2%, who have refused to comply with the ministry directives.

The OLTCA and our member homes support measures to increase compliance. We agree that more can and should be done to discourage any person from intentionally harming a senior. Through early ministry consultations with the sector, we indicated our desire to work with the ministry on the introduction of penalties being introduced as a regulatory tool to enforce compliance. Further, we believe that these penalties would likely result in only a very small percentage of homes that fail to take the prompt action on orders issued by the inspectors respecting the safety and security of our residents.

Over the past year, the sector has witnessed an increase in enforcement activities taken under the current provisions of the act. These activities reveal the existing broad scope of powers on inspections and the effectiveness of the current enforcement provisions in the act in addressing the safety and security. As such, we question the necessity to introduce new provisions that increase the already broad powers of inspectors and remove protections for staff willingly collaborating with them, sometimes under very difficult circumstances.

We also question the provisions that override legislated corporate liability protections for directors and

operators acting honestly, diligently and in good faith, in both for-profit and not-for-profit corporations. The sector has done a remarkable job caring for seniors with multiple complex conditions over the past five years. According to Health Quality Ontario's annual report, Ontario is doing comparatively well in terms of quality of care in long-term-care homes, best or second-best among the five provinces with comparable data. Homes have advanced quality care by significantly reducing the use of physical restraints by 50%, safely eliminating the use of psychotropic drugs by more than 35%, and have taken efforts to ensure that 50% fewer residents are experiencing pain.

The efforts undertaken by long-term-care homes to improve quality care, although delivered and executed by our front-line staff, have been directed by the dedication and resolve of our sector's leadership, something that would be gravely missed if impacted.

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The proposed amendments that remove the defence of due diligence in response to correcting an order or incident are disappointing. Oftentimes, homes take their best step forward to respond to the orders that an inspection report may contain but cannot achieve compliance for factors that are outside of their control. Take, for example, the mandated 24/7 nursing coverage regulation contained in the act. There are some small homes in rural and remote communities in our province that have difficulty attracting nurses to their homes, and it's largely due to availability. Homes will take the necessary steps to ensure coverage—for example, hiring an agency—but may not be able to hire a full-time staff member to this position at the time of the follow-up inspection. This is but one example of many where we believe the defence of due diligence applies and should be excluded from the amendment.

I would like to close by commenting on the introduction of protections for incapable residents. Ontario's psychiatric hospital system already has a very robust infrastructure—the Psychiatric Patient Advocate Office—to support rights advice and applications to the Consent and Capacity Board for incapable patients. We believe that when applying to long-term care, incapable Ontarians should benefit from this already established and administratively strong rights protection office, accessible throughout the province. That's why we're recommending that the Legislature delay proclamation of schedule 5 provisions related to confinement. This would allow time for the necessary ministry administrative supports to rights advice and access to the Consent and Capacity Board to be set up across the province. It would also provide time for the administrative and change management activities within the sector and offer the opportunity for a trial—

The Chair (Mr. Grant Crack): Thank you very much. We'll start with Madame Gélinas from the third party.

M^me^ France Gélinas: Could you put into months or years the period of time that we're talking about? You want time to implement the changes. You started your speech with this. Are we talking about a year, two years? If we were to put it in the bill, how long would you like?

Ms. Candace Chartier: It would be great if we could start phasing in this bill over the next year, with effects starting in January 2019. We think that it would be wise for both government and the sector to be able to educate and get our people well informed before these changes come into effect.

M^me^ France Gélinas: If we speak specifically to schedule 5, which deals with confinement, would you be satisfied if the bill said that it would come into effect in January 2019. Or is this a section that needs a bit more time?

Ms. Candace Chartier: I think that we have a very good working relationship and we can be at the table to help with this. It's a really concrete system that's in place already, so I think we'd be able to hit the target of January 2019.

M^me^ France Gélinas: A year's time from the date of proclamation gives you 12 months to do the changes, and you would be able to? Okay.

Long-term-care homes had the opportunity to have secure units before. Very few of your members chose to do that. Do you see this new schedule as being helpful?

Ms. Candace Chartier: I think the reason is that there has been a lot of focus and a lot of education around behaviour supports. Honestly, a lot of programs have been implemented in homes where they have specialized staff to work with these residents, which really decreases the incidence of having to be in a confined unit. But there is that proportion who do need that confined unit.

M^me^ France Gélinas: Do you feel that through schedule 5, we will see more uptake from your members for secure units?

Ms. Candace Chartier: I think you're going to see more, especially with the implementation of new beds coming in to be redeveloped and built. I think you're going to see more specialization in an area around dementia, cognitive impairment, psychiatric disorders. And I think you're going to see a lot of operators willing to design those new homes in order to accommodate these new guidelines.

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

Mr. John Fraser: Thank you very much for being here and for your presentation.

I just wanted to start by saying, as you continue on with what you were saying in terms of the care that's provided in Ontario's long-term-care homes, that there is really great care being provided there, but of course, we're all concerned. There are certain situations and actors that exist inside the sector that require the kind of enforcement and the tools that we've put in place.

Personally, I'm supportive of those tools. I believe that we have to be able to ensure that we can hold people to account when they don't deliver on the things that need to be delivered.

You would agree, I'm sure, that if you look at the leadership models that exist inside any organization, and

in long-term care, it's the leadership that drives how well it functions.

I'm interested as well in your suggestion of a delay in the enactment of schedule 5. With the regulations that will have to be put in place, and the kinds of consultations, and the time that it will take to do those things, I would be concerned about putting a time frame inside a piece of legislation. I think you're probably going to be at 2019 anyway, and maybe beyond, if you take a look just at the environment this year, and going into the spring, there's going to be two or three months there that we'll be busy doing something else. So that kind of delay is going to happen.

Ms. Candace Chartier: I would agree. I would say a year at a minimum.

Mr. John Fraser: Yes. I'm always nervous about putting a date in. You put a date in and then you tie yourself to that date, and then what if you don't have those things in place that you need, and that we need, to make it work?

Ms. Candace Chartier: If we could implement a delay in general, it would be greatly appreciated.

Mr. John Fraser: How much time?

The Chair (Mr. Grant Crack): Fifty-four seconds.

Mr. John Fraser: Fifty-four seconds. In this bill, we also have a piece, which you didn't discuss, with regard to transparency and some of the things we're doing between institutions and practitioners, and between companies and practitioners. Do you have any thoughts on that?

Ms. Candace Chartier: Transparency specifically around the act?

Mr. John Fraser: In terms of payments, if you take a look at pharmacies that provide payments—and that is not just to physicians; that's inside institutions. Does OLTCA have a position on that? Are you supportive of that?

Ms. Candace Chartier: We're fully on board for that transparency. I think what people are unaware of is what those pharmacy payments are geared to. If you look at the pharmacy payments that come into a long-term-care home, they are fees that are putting in med carts and medical e-terminals for drug implementation, as well as education and any supports that the staff require.

The transparency part, for us, is basically telling the government, "Yes, this is what I'm getting from the pharmacy, and this is where I'm directing it to enhance care."

The Chair (Mr. Grant Crack): Thank you very much. We'll move over to the official opposition. Ms. Munro.

Mrs. Julia Munro: Thank you very much for coming. I wanted to ask you—you made reference to consent and capacity. This has always been a very important tool that people have had. I wondered if you had any comments in terms of the changes that are being contemplated here in this proposed act: whether it would put greater pressures, if there is more need for education or if there was anything that was different, a different scenario that these people are faced with now, under this proposed legislation.

Ms. Candace Chartier: Why I say I would like more time is that in our general population, 90% of our residents have some form of cognitive impairment. So when you look at consent and capacity in this area, it's a big, big area.

Part of the fear is the administrative burden around this as well. We need to understand it more. If there's a strong, robust system already in place that we can replicate, I think it's a no-brainer. We need to understand what that process is going to look like in the homes, and that's why we'd like to push it off, so that our homes are going to have the ability to follow through and meet the requirements of this bill.

Mrs. Julia Munro: Which suggests to me that not only do you need to make sure that that is articulated in your response, but it's also understood why you need that kind of leeway and the ability to make those kinds of changes to processes that have been very successful.

Ms. Candace Chartier: Yes.

Mrs. Julia Munro: Thank you.

Ms. Candace Chartier: You're welcome.

The Chair (Mr. Grant Crack): Thank you for coming before committee this afternoon. It's much appreciated.

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Ms. Candace Chartier: Great, thank you.

The Chair (Mr. Grant Crack): Have a good evening.

ONTARIO PHARMACISTS ASSOCIATION
ONCOLOGY DRUG ACCESS NAVIGATORS OF ONTARIO

The Chair (Mr. Grant Crack): Next on the agenda, we have the Ontario Pharmacists Association. We have the chief executive officer, Andrew Gall; the EVP and chief pharmacy officer, Allan Malek; and also the drug access facilitator in the cancer care program at North York General Hospital, Alan Birch. We welcome the three of you to committee this afternoon. You have up to five minutes for your presentation. If whoever will be speaking would be so kind as to state that for the record. Welcome.

Mr. Andrew Gall: Good afternoon, Mr. Chair and committee members. My name is Andrew Gall and I'm the chief executive officer of the Ontario Pharmacists Association. I am joined today by Allan Malek, OPA's executive vice-president and chief pharmacy officer, and Alan Birch, drug access facilitator in the cancer care program at North York General Hospital. Thank you for the opportunity to present today as you discuss and hear from stakeholders regarding Bill 160.

The Ontario Pharmacists Association is Canada's largest pharmacy advocacy organization, representing over 10,000 pharmacy professionals who work in community pharmacies, hospitals, long-term-care homes, family health teams and other settings across Ontario.

Today, we would like to talk about a trend that is emerging in Ontario where employers, insurance companies and, on occasion, pharmaceutical companies establish closed preferred provider networks—or PPNs—that we believe can compromise patient care, access and safety. Through closed PPNs, insurers make deals to purchase medicines from one pharmacy provider in exchange for reduced prices. This eliminates choice for Ontario patients and compromises the principle of trust that underpins the patient-pharmacist relationship. Trust is a critical component of protecting patient safety because only your pharmacist knows the complexities of your medication history.

Perhaps most concerning, this proposed strategy continues the slow creep towards American-style models of health care insurance where patients are forced to go to plan-selected providers because they are mandated to do so by their insurer or employer.

While the OPA is concerned with PPNs, we don't want an outright ban. We recognize their commercial viability in specialized cases such as the Ontario Drug Benefit Program.

"Any Willing Provider" is a new initiative championed by pharmacy professionals that promotes patient choice, supports timely access to care and protects patient safety. It introduces a level playing field for all pharmacy providers—big and small—whereby all have the option of accepting the payer's terms and conditions to provide care for the patient.

There's also a precedent being established in other jurisdictions to address this through legislation. Some US state legislatures have introduced legislation to deal with this trend, in some cases calling for the outright ban of these PPNs. The Quebec National Assembly recently passed Bill 92, which mandates that, "No group insurance contract or employee benefit plan may restrict a beneficiary's freedom to choose a pharmacist."

We understand from the member for Nickel Belt's remarks in the Legislature on October 18 that she intends to put forward an amendment to Bill 160 to address this issue. We would like to thank Madame Gélinas for her initiative, and we hope the amendment will gain unanimous consent at this committee.

I would now like to invite Alan Birch, who also represents the Oncology Drug Access Navigators of Ontario, to share with you some perspectives from Ontario's patients.

Mr. Alan Birch: Thank you, Andrew, for that introduction.

As Andrew noted, I represent the Oncology Drug Access Navigators of Ontario—ODANO—and I am also a drug access facilitator at a Toronto cancer centre.

We've seen an increasing and troubling trend recently: Insurance providers are trying to drive down costs at the expense of patient services. As pharmacy professionals, my colleagues and I have observed this growing "Americanization," one that puts profits ahead of patients and the fiscal health of insurance companies over the health care of Ontarians.

There are a growing number of patients, particularly those with complex illnesses such as cancer, multiple sclerosis and rheumatoid arthritis, who are facing real consequences.

I recently spoke to an elderly patient named Bill, who received a message from his insurance provider that his pharmacy coverage would be cut off if he didn't cooperate by purchasing prescriptions at the designated pharmacy.

A colleague of mine also told me of an incident where, as a result of a PPN, a patient was forced to a pharmacy that didn't know his medication details. He was forced to pay a $1,600-copay up front, adding to an already stressful and troubling situation for someone dealing with cancer.

Lastly, Ida, a patient suffering from cancer, needed an oral oncology drug. As a result of the PPN, she experienced delay after delay, had her billing mismanaged and was forced to ask a friend to drive her 45 minutes to get her medication, all while suffering the devastating effects of her newly diagnosed cancer.

These are just some of the consequences of closed PPNs. If we truly care about Ontario patients, it's not a model we should support. If we are to truly strengthen the quality and accountability for patients, as this bill is titled, we hope you will allow for an "Any Willing Provider" amendment to protect patient safety, access and choice. It is a common sense policy. We hope this committee can support an "Any Willing Provider" amendment as we work continuously to improve our provincial health care system and the outcomes for Ontario patients. Thank you.

The Chair (Mr. Grant Crack): Thank you very much. I appreciate you staying within time. Fantastic.

We'll start with the Liberal government. Mr. Fraser.

Mr. John Fraser: Thank you very much for your presentation. I know we've had an opportunity to talk about this before.

I believe that what you're doing and suggesting is right. The challenge would be speaking to an act that's not in this legislation, because I believe you'd have to do it through finance. All this stuff has to go through FSCO. How do we do it the right way, and how do we do it in a way that ensures that it's done the right way?

So I appreciate that. I think you would agree that it would be important to consult on this too. I think that's one of the challenges in there. I fully support what you're asking for; I just think it will be a challenge because it affects another act and should have some more consultation. I think ultimately that's where we're going to be, but it's to make sure you bring all partners along. I don't know if you have any comments on that.

Mr. Andrew Gall: Just one initial comment. If it is included in Bill 160 as an amendment, regulations would be required, and consultation would be during that process as well. I think there's a great opportunity to deal with this issue now.

Allan, if you want to add anything—

Mr. Allan Malek: If I may. Thank you very much for your comment. To echo what Mr. Gall has said, we

would also think this is directly related to issues around transparency, because these are pre-selected pharmacies that are perhaps entering into agreements, so there could be an actual tie with transparency.

Mr. John Fraser: I agree with the transparency piece, but the transparency piece is not prohibitive. What it is, by virtue of the transparency piece, is to say, "Here's what's there." Then people can pass judgment on that, but it doesn't actually provide for any restrictions. They are the same thing, but there's another piece to what you're asking.

I think it's the right thing to do, no question. I'm just talking about the challenges around making sure we do it the right way. Thank you.

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

Mr. Jeff Yurek: Thanks for being here. Just for the record, I am a member of OPA still. I get my insurance so I can continue to practise as a pharmacist.

I do want to make a comment. I've had numerous calls from the hospital pharmacy sector—which I have nothing to do with whatsoever—and those that are providing specialty cancer medications are finding they are being cut out of these PPNs, which is affecting patient access and safety. Do you have any comment on that?

Mr. Andrew Gall: Alan, you come from that space.

Mr. Alan Birch: That's right.

That is a concern. In our hospital, our pharmacy has very well trained staff who deal with oncology patients on a regular basis, on a daily basis. They know the medications that are prescribed inside and out. They have asked in the past to join some of these provider networks and have been told they can't. So it is a challenge, definitely, for us and anyone else who wants to join these networks if they were so inclined.

Mr. Jeff Yurek: The other concern I've heard is, if we open up PPNs, there's going to be an increased cost to the employers and the insurance industry. Can you touch upon that, please?

Mr. Allan Malek: That has been suggested. Our statement would be that this shouldn't have any impact on costs, simply because we're just telling the insurer or a manufacturer that their terms would still be honoured; we're just expanding the pool of pharmacies that would be able to agree or not agree to accepting those terms. All the terms that are currently in place within these closed networks would still be in existence with an open network, so it shouldn't impact costs.

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Mr. Jeff Yurek: And how do the pharmacies join the closed PPNs?

Mr. Allan Malek: With the closed PPN, it's usually a directed invitation. It's a selected invitation. Pharmacies are pre-selected based on jurisdiction and based on the scope of their own network. The usual situation is that these are perhaps larger pharmacy groups. Independent, smaller pharmacies, in their view, don't have an opportunity to participate, so they are excluded. They're not even invited to the table.

Mr. Jeff Yurek: How does this affect patient care? That is, at the end of the day, what should be the focus of this whole issue.

Mr. Allen Malek: In some cases, it's either a molecule-specific type of network where a specific set of molecules are directed to a particular network of pharmacies, which means that other medications would be filled at the regular pharmacy, but these pre-selected molecules, these pre-selected drugs, would have to go through another pharmacy. What that does is it fragments the care and it fragments the medication profile, and the pharmacy that's filling a specialty product is not getting a full view of a patient's medication history and they're not getting the best care possible.

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

M^me^ France Gélinas: I thank you for coming this afternoon. I can assure you that you have my support. Basically, we have an opportunity here with Bill 160, which opens up very many health care acts, to do the right thing. The possibility to do this again is not obvious till after the election, which means another year.

I can talk for the people I represent in the northeast. The cancer treatment centre handles all of their drugs. All of a sudden, one take-home cancer drug cannot be purchased there. It comes from God knows where. When it's the cold chain, it comes in a box that big. It gets delivered to your house. You have no idea what to do with this. You take the whole package back to your pharmacist, who is there to help you through a really tough time.

The people coming to me are coming to me because in the north, this preferred provider network is creating a lot of hardship on people who should be focusing on getting their cancer under check and should be focusing on getting their health back on track. Instead, we have to fight with a mail delivery that has nothing to do with good patient care when we have a pharmacist and a hospital that are willing to match the terms, that are willing to match the money. It's not going to cost more; it's just going to bring better patient care.

When Mr. Fraser says the transparency doesn't provide for restriction—no. The restriction is being put in by the manufacturer. We have an opportunity to make sure that we remove those restrictions and bring the transparency that the bill wants—that says, anyway, by its title, it wants us to do.

Aside from cancer patients—they seem to be the ones we've talked about the most—are there other areas of care where those preferred provider networks are being more and more active?

Mr. Andrew Gall: Alan, you'll know.

Mr. Alan Birch: The preferred provider networks tend to impact specialty drugs or high-cost drugs. That impacts a wide range of disease areas. There are multiple sclerosis drugs that are expensive; hepatitis C; rheumatoid arthritis. It impacts anything that's quite expensive.

Mr. Allan Malek: If I can add to that, I actually spoke with a pharmacist yesterday who indicated that he was

blocked from filling a prescription for his patient for Humira, which is a biologic often used for gastro-intestinal disease such as Crohn's. This is a long-standing patient. He was not able to fill the prescription for this patient with whom he has had a relationship with perhaps for about 20 or 30 years. It is very unfortunate that that relationship has to be severed because of contractual arrangements.

The Chair (Mr. Grant Crack): Thank you very much. We really appreciate the three of you coming before committee this afternoon. Have a good evening.

UNIFOR ONTARIO

The Chair (Mr. Grant Crack): Next on the agenda we have Unifor. We have the Ontario regional director, Naureen Rizvi; the assistant to the national president, Katha Fortier; and national representative Mike Yam. We welcome the three of you to committee this afternoon. You have up to five minutes for your presentation, followed by up to nine minutes of questioning from the three parties.

The floor is yours. Please identify yourselves when you're speaking. Thank you.

Ms. Naureen Rizvi: Good evening. My name is Naureen Rizvi. I'm the Ontario regional director for Unifor. I have with me Katha Fortier, who is the assistant to the national president for Unifor. She oversees the health care sector of our union. We also have Mike Yam, who is from our national research department, overseeing the health care sector for our union.

Unifor is Canada's largest private sector union, with more than 315,000 members across the country working in every major sector of the Canadian economy. In Ontario, Unifor represents 160,000 active members, including 26,000 health care workers, 9,000 of whom work in long-term care. Unifor also represents thousands of retired workers across Ontario, who are engaged in campaigns to strengthen our health care system, including long-term care.

In general, Unifor is concerned with the far-reaching nature of this omnibus health care bill that has been introduced without proper public consultation, including a lack of proper consultation with the health care workers in the province who will surely be impacted by its changes.

I would like to start by speaking about schedule 1, which introduces several amendments to the Ambulance Act.

Unifor has a number of recommendations and serious concerns. The ability for regulations to exempt "any class of persons, services, conveyances, vehicles or equipment from any provision of this act" is incredibly broad, and enables cabinet to make changes without any consultation. These new powers are poorly defined and undermine the act.

We know the mention of exemptions for the purpose of pilot projects refers to planned pilot projects involving fire-medics in municipalities. Unifor is strongly opposed to establishing these pilot projects and the use of fire-medics on a temporary or permanent basis. We believe that there is no need to duplicate work already being done efficiently, effectively and safely by trained paramedics. We would oppose the move away from using skilled paramedics, as we believe this poses a significant threat to public safety and creates unnecessary redundancy and cost for municipalities in the form of additional training, retrofitting of equipment and more.

The union is concerned with the amendment that would allow the minister to direct ambulances to non-hospital destinations. While we see the intent of this change, there needs to be more clarity when it comes to the instances where this may be acceptable; for example, where there is patient consent, where the patient is deemed low-acuity, or whether or not these transfers are made to public and non-profit facilities.

The expansion of treatment by paramedics outside of hospitals also needs to be further clarified in the legislation. There needs to be further consultation related to expanded treatment.

Next, I would like to speak on schedule 5, which contains several amendments to the Long-Term Care Homes Act. This schedule repeals references to secure units and restraints for residents, while bringing these concepts together with a new definition of "confinement."

I'd like to be clear that Unifor has long raised the issue of violence in long-term-care homes. Over the years, violence in these facilities has escalated, where the most extreme cases have resulted in resident-on-resident homicide. This is a safety issue for both residents and staff. One problem, however, is that the schedule does not define the term "confinement" in the amendments. Instead of being left to be defined in regulation, the term should be defined in legislation.

On a related issue, we need to address the reality that long-term-care homes are now taking in more high-acuity residents. Homes don't have the ability to address the increased need for specialized seniors' mental health support, which magnifies the issue of understaffing in general in long-term-care homes.

Amendments to the Long-Term Care Homes Act should address the issue of staffing. This would entail including the elements contained in Bill 33, An Act to amend the Long-Term Care Homes Act, 2007 to establish a minimum standard of daily care. This would essentially establish a minimum care standard of an average of four hours per resident per day, focusing on the direct, hands-on nursing and personal care for residents. The inclusion of this minimum standard would be consistent with the government's action plan for seniors.

Ms. Katha Fortier: We'd also like to speak about schedule 9, which would establish the Oversight of Health Facilities and Devices Act. Especially concerning with this schedule is the move to repeal the Private Hospitals Act and the Independent Health Facilities Act while including some elements of these acts into the new act.

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Repealing the Private Hospitals Act is problematic because this legislation currently prevents the establishment of private hospitals, while the Independent Health Facilities Act, which is not perfect by any means, governs private clinics. Under the proposed new act, the ability to introduce a whole range of new private clinics is widened. Cabinet can change the definition of "community health facilities," which inevitably are private clinics and hospitals. Based on this act, there would be no limitation on private, for-profit ownership or foreign ownership of private clinics. We strongly urge that schedule 9 be repealed—

The Chair (Mr. Grant Crack): Thank you very much. I'm sorry, but I gave you 25 extra seconds.

We'll start with the official opposition. Mr. Yurek.

Mr. Jeff Yurek: Thank you, Chair.

You can finish your presentation.

Ms. Katha Fortier: Oh, thank you.

Finally, schedule 10 would amend the Retirement Homes Act to allow for the legal confining of residents in retirement homes. As previously mentioned, confining would be left to regulations, which is one issue. But what is more concerning is that this schedule would allow the confinement of residents in private, mostly for-profit retirement homes that are not regulated in the same way as nursing homes.

Retirement homes are not—and should not fulfill the role of—de facto long-term-care homes resulting from the lack of space for residents in those facilities. Retirement homes provide a distinctly different role when it comes to the types of services that they provide for residents. They focus on supportive housing and are not meant to provide health care support that would typically be provided in a long-term-care home. The rationale for legally enabling retirement homes to confine residents is troubling and should be reconsidered. As such, we are calling for schedule 10 to be repealed and not to enable private retirement homes to legally confine residents.

To conclude, Unifor is urging a number of changes to this piece of legislation. More broadly, there needs to be proper consultation with labour and workers in the health care sector before such a large piece of legislation passes.

Thank you for your time.

The Chair (Mr. Grant Crack): Thank you. Mr. Yurek.

Mr. Jeff Yurek: Just one question with regard to schedule 10: You're thinking that they are making these changes so they can off-load the lack of spaces for long-term care into the retirement sector. Is that what you—

Ms. Katha Fortier: Well, it's not a secret right now that a number of residents that reside in retirement homes in Ontario, a large proportion—I think the last I heard, about 25%—are actually waiting for nursing home beds. In some cases, they almost look like a nursing home.

But the reality is that retirement homes today just aren't equipped. They don't have the staffing in place. It's mostly unregulated caregivers. Certainly I appreciate the contribution of unregulated caregivers in our health care system, but the reality is, if you're confining or restraining residents, then that should be really left with nurses. Many of these facilities do not have 24-hour nurses.

Mr. Jeff Yurek: And in regard to schedule 1, the Ambulance Act, if the bill passes as is, would you be favourable to inserting in regulations that the patients have a choice, that they could actually deny the ambulance taking them to the spot they want to go to and take them to the hospital?

Ms. Katha Fortier: Well, we think there should be some patient control in that decision, but we also think that the options should be defined within the act.

Mr. Jeff Yurek: Within the act. Okay. Thanks, Chair.

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

Madame Gélinas.

M^me^ France Gélinas: So I'll take it from there. If the options should be defined within the act, would you agree that the definitions would be, first of all, that you have patient consent; second, that you take them to a not-for-profit facility; and then that you name out what those could be, whether they be an addictions centre or a mental health centre or a community health centre or other facilities that are operated by the not-for-profit sector? Would you agree to the framework of a list?

Ms. Katha Fortier: Absolutely. That would be well within the framework we're looking for. Again, this is a concern about the privatization of our health care system. I know you know that's a concern—and I should say the "further" privatization. We'd like those guidelines clearly outlined.

M^me^ France Gélinas: I fully support this and I will try to help you this way.

Coming back to the retirement homes, do you have any members in retirement homes?

Ms. Katha Fortier: Yes. We have probably a few thousand members that work in retirement homes. It's an interesting evolution: Older retirement homes that have been established for 30 years or so are likely to have 24-hour nursing. Usually at least there's an RPN in the building for 24 hours. The newer ones, it's hard to find a nurse. It's almost impossible on a night shift or an afternoon.

M^me^ France Gélinas: What do you figure could happen if we allowed those homes that have no standards of care to restrain or to confine a resident?

Ms. Katha Fortier: I think that there's a big piece of decision-making that goes along with confining a resident. I'm a nurse myself. I understand that this is required at some point in time, but there is also a lot of judgment that needs to take place. I think that regulated professionals and nurses are really the best judge of when that should take place, and they're just not found in the retirement home sector on a consistent basis.

M^me^ France Gélinas: So a retirement home administrator could decide, "This guy is too loud, he's too annoying, he's causing havoc. We will restrain him in his room because the rest of the residents are all complaining and some of them are ready to move if we don't shut him up"? Sorry for the language.

Ms. Katha Fortier: Absolutely, absolutely. And it's understandable that there are residents that will have issues that may require confinement, but we need to find an appropriate place in the health care system for them, and it's not a retirement home.

M^me^ France Gélinas: Yes. And confinement should not be a punishment because of your bad behaviour. I fully agree.

Ms. Katha Fortier: Exactly.

M^me^ France Gélinas: Thank you.

The Chair (Mr. Grant Crack): We will move to the government. Mr. Fraser.

Mr. John Fraser: I appreciate what you're saying, just in your last comment, about an appropriate place in the health care system. We had the Ontario Long Term Care Association here earlier. They do a great job. That is a really great place for people with cognitive difficulties.

One of the challenges is that people make choices and decisions about where they want to be. Not everybody wants to be in long-term care. There are trade-offs in long-term care, which is—you have a smaller room, so your footprint is about 400 square feet. You might have a larger room; you might have a different living environment.

I've been through all this stuff right now, and through all stages of it. I just think that the provisions in the bill recognize what's happening there and provide some recourse. What is happening in that sector right now in terms of—because I had family that was in a facility; they weren't in memory care, but they had a memory care floor—you've got people who are in those circumstances by choice, and also by choice of their power of attorney. You have to find some way to protect them. There is that example of somebody who is annoying somebody, or is a risk—which is another issue altogether—but there is also this thing where somebody goes out the front door and they don't come back. That's confinement, too, right? It's not just confinement to your room. Confinement is that you can't leave.

I don't need an answer to this because my colleague has a question, but I just wanted to put that out there, as I think it's the thing we try to—

Ms. Katha Fortier: I understand that they build big, beautiful retirement homes that are really lovely, and if you're very rich you can afford to live in one of the best ones in the province, I'm sure. But the reality is that even those beautiful places are not staffed appropriately to deal with the issue of confinement. That would be our argument. They need to have appropriate staff to make the decision.

Ms. Daiene Vernile: Earlier this afternoon I met with some firefighters from my community, as many of our colleagues are doing today; they're having a lobby day here today. Within the force that represents my community of Kitchener-Waterloo, they have certified paramedics who oftentimes go out with them. And, oftentimes, as we know, firefighters are the first ones to arrive in an emergency situation. It might be a life-and-death situation, and they want to get in there and assist where they can. So I just want clarity from you on where you stand on fire-medics. Do you think they should not step in and do this?

Ms. Katha Fortier: First of all, there's a dispatch problem, which I think the government is actually working to overcome that will make it better for ambulance dispatch and where they get dispatched to, so that they're getting the appropriate volume of calls, or the higher-needs calls is where they're going first.

But the second point is, of course, a fire truck carries a defibrillator. If they can get to the scene quicker and defibrillate somebody, that's great. But generally, that's what they're doing, that's the extent. They don't have the equipment to provide the care that a paramedic could. The cost of operating a fire truck is significantly higher than running an ambulance, with the number of staff.

We represent about 500 paramedics across the province, and they've been emphatically clear that they do not believe that this is a good idea, that there are fire-medics. Again, they do play a role; defibrillate, of course, if they can get there quicker. That's a good thing.

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Ms. Daiene Vernile: Thank you.

The Chair (Mr. Grant Crack): Thank you very much for coming before committee this afternoon. It's much appreciated. Have a great evening.

GENERAL ELECTRIC HEALTHCARE CANADA

The Chair (Mr. Grant Crack): Next we have General Electric Healthcare Canada. We have government affairs and public policy leader Nicholas Kadysh with us. We welcome you, sir. You have up to five minutes for your presentation. The floor is yours.

Mr. Nicholas Kadysh: Good morning, committee members. My name is Nick Kadysh. I'm the public policy leader for GE Canada. I've come here today to discuss the future of health care, specifically, the future of diagnostic imaging, which this bill touches.

GE Healthcare has been in the business of diagnostic imaging for over 100 years, since the discovery of X-rays. We're glad to see that the government has chosen to modernize the HARP Act, which is the dominant legislation for diagnostic imaging in the province, with Bill 160.

There are two major points that I wanted to make to you today in the short time that we have available to us. The first is that measurability is one of the best ways to improve our health care system. Bill 160 rightly establishes one legislative framework for diagnostic imaging of all kinds—ultrasound, X-ray, CT and MR. In asking for new radiology legislation, Health Quality Ontario rightly focused on system learning as a key component of this legislation.

We wanted to share with you that from our perspective, radiation tracking is really the starting point. Many countries now have dose management legislation. The Joint Commission in the US has specific requirements around tracking radiation dose and investigating high-

dose cases. The European Union has a new regulation coming into effect in 2018 on this.

In order to do this effectively, we actually need to be able to compare dosing across the entire province. In Ontario, St. Mike's Hospital has already started by creating a dose registry that they have made with a select few Ontario hospitals. Coincidentally, Dr. Dowdell, the chief of radiology at SMH, was part of the expert panel referenced in the Health Quality Ontario documents that led to Bill 160.

GE has been producing our DoseWatch solution for a number of years now. Our engineering road map includes a data warehouse upon which a provincial registry could feasibly be built.

Looking further, I wanted to talk to you about how we stop dosing before it even happens. One of the things that Bill 160 allows for is professional training and analysis of dosing information across the province. In X-ray, there is a concept called repeat/reject. Basically, these are images that have to be thrown out because the subject is improperly placed in front of the scanner. The patient still has to endure the X-ray—they still get the dose—but the image is useless. So GE has developed a repeat/reject analytics tool to help close this gap. This technology records every time an X-ray technologist must repeat or reject a scan; it can help identify devices and tests that have higher repeat rates; and, over time, it will help department heads train their technologists to improve their performance. This is a training tool; it has widespread support in the radiology community. The first instance of this technology being used in Ontario is at Humber River Hospital, just north of here. To get great results across the health care system, this type of analytic should be rolled out system-wide.

RRA and DoseWatch could really transform the industry by continuously collecting, storing and analyzing imaging data to drive dramatic system performance improvements in both dose and repeated images. This is the first step in making our system more efficient, just by making our technology and operators work better together.

My second point is around ultrasound. I know that the popular conception of ultrasound is the big machine wheeled into a clinic—for those who have gone through a pregnancy, that's usually what you think of—but technology has not stood still and, just like the phones in your pocket, ultrasound has gotten smaller. Our own ultra-portable technology called Vscan—I wanted to have one with me here today to show you; unfortunately, I couldn't get it here in time—is just larger than a cellphone. In fact, just last week, the FDA approved a new device called the Butterfly. It literally is an ultrasound that plugs directly into a cellphone and uses the cellphone as a screen.

Bill 160 will require registration of all ultrasounds. For large units, that makes sense, but we would ask the committee and the Ministry of Health and Long-Term Care to consider carving out a special category for these ultra-portable ultrasounds so that the devices can be used without significant regulatory burden. These devices are mostly useful on the move, especially in places like northern Ontario, where they can be brought to new locations maybe even several times a day.

Of course, all of this technology needs to be procured. Just recently, our CEO, Elyse Allan, sat on the government's expert panel on the health care supply chain strategy. It's unconnected to this bill, but we're really looking forward to seeing the government's response.

In closing, on behalf of GE, I want to thank you for your time. We support the modernized framework in diagnostic imaging that Bill 160 represents. We would ask the committee to push even further in establishing training programs that support the goal of a more efficient health care system.

As the government works to establish a new regulatory regime for some subsets of diagnostic imaging—like ultra-portable ultrasound, as I mentioned—we'd ask the government to be mindful of the impacts that new regulations could have on patients.

Thank you very much, and I'd be happy to take questions.

The Chair (Mr. Grant Crack): Thank you very much. We'll start with the government side. Mr. Rinaldi.

Mr. Lou Rinaldi: Thank you so much for being here today and for your insightful presentation. I just want to talk a little bit, to take advantage of your expertise globally—

Mr. Nicholas Kadysh: What little I have.

Mr. Lou Rinaldi: Well, I'm sure you have.

A good part of the bill talks about transparency. I know there are other jurisdictions around the world, or North America, that probably do a better job than we do here in Ontario when it comes to the whole broader transparency piece. Can you give us some examples of where we might go with that, or how it's beneficial, that transparency piece, in other jurisdictions—maybe in some states in the US?

Mr. Nicholas Kadysh: I'm not an expert on transparency legislation. I would say that through MEDEC, which is our industry association here in Canada, we are broadly supportive of the transparency goals set out in Bill 160. That has been the position of MEDEC for a number of years. Frankly, we look forward to seeing it in action.

Mr. Lou Rinaldi: Thank you.

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

Mrs. Julia Munro: Thank you very much for being here to make your presentation. I wondered, as you were speaking about the benefits of moving into some kind of technology, as you describe—have you been able to look at the measures of costing, timing and efficacy, in being able to come today?

Mr. Nicholas Kadysh: Yes, of course. In fact, just about three weeks ago, we got our first report on the rollout of repeat/reject analysis technology at Humber River. We're seeing double-digit improvements over time in terms of a decrease in rejected X-rays.

Everything in this industry must be validated by outside validation. That's a mainstay of the industry. So,

yes, we're seeing very, very good results with digital technology. The key here is that you're not replacing anybody. This isn't a question of people losing jobs. It's just getting our health care workers, and the machinery that they work with every day, functioning more smoothly together. We think that this is a really good way to get improvements out of the health care system.

Mrs. Julia Munro: Thank you.

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

M^me^ France Gélinas: I would like to pick your brain a bit, as our deadline to submit amendments is tomorrow at noon.

I understand what you would like us to do. I'm not too sure how we get this done within Bill 160. You would like us to add a section that has to do specifically with training when it comes to—am I hearing you well?

Mr. Nicholas Kadysh: I actually think that Bill 160 provides the legislative framework. I think this is more of a regulatory piece to Bill 160, because Bill 160 already allows for certain performance metrics to be established.

We think that this legislation does exactly what it's supposed to do. There's a certain amount of work that the Ministry of Health and Long-Term Care still has to do to establish the right kind of regulations, but we very much look forward to working with the government on that.

M^me^ France Gélinas: Okay. So the bill as it is written is fine.

You are a member of MEDEC?

Mr. Nicholas Kadysh: Yes.

M^me^ France Gélinas: They have made a number of recommendations for changes to the bill. Are you in support of those changes as well?

Mr. Nicholas Kadysh: Yes, but I believe that those changes could also be made in the regulation, to be completely honest with you. I understand your point. The two changes that MEDEC asked for were, as I said, the establishment of an ultra-portable ultrasound category that would face exemption from the registration requirement; and the second piece was around demonstration devices, if I'm not mistaken, so basically, an exemption from registration for demonstration devices on behalf of MEDEC members. These would basically be moved from place to place all the time because they would be for demonstration purposes, not for use with patients. I believe that the government has already expressed some willingness to make those changes through regulations.

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M^me^ France Gélinas: Through regulations? Okay. Sounds good. Thank you.

Mr. Nicholas Kadysh: Thank you.

The Chair (Mr. Grant Crack): Good? Well, thank you very much, Mr. Kadysh, for coming before committee this afternoon. You have a great evening. We appreciate it.

Mr. Nicholas Kadysh: Thank you very much.

The Chair (Mr. Grant Crack): You're welcome.

Just a correction, Madame Gélinas: It's a 5 p.m. deadline for amendments tomorrow, not 12 noon, as was indicated. I want to make sure that's clear. I'll be clarifying it at the end of the day.

CANADA'S WONDERLAND
WORLD WATERPARK ASSOCIATION CANADIAN WATERPARK COMMITTEE

The Chair (Mr. Grant Crack): Next, we have on the agenda, from wonderland, wonderland, Canada's Wonderland, Heather Hill, director of operations. We welcome you this afternoon and we look forward to your presentation. You have up to five minutes.

Ms. Heather Hill: Okay. Good afternoon. Thank you, Mr. Chair. My name is Heather Hill. I'm from Canada's Wonderland and I am here representing the World Waterpark Association Canadian Waterpark Committee. This committee includes 11 members—10 from across Ontario—with more than 85 years of experience in building and operating parks in Ontario and throughout Canada.

One of the goals of our committee is to work with officials within Ontario's Ministry of Health and local health units to better inform and participate in the legislative process and policy implementation as it relates to the water leisure industry. We seek to work collaboratively with the Ministry of Health and have liaised with Tony Amalfa from the health protection policy and programs branch to provide feedback regarding updates for the Operating Procedures for Non-Regulated Recreational Water Facilities Guidance Document.

We were notified in September that amendments to the Health Protection and Promotion Act were introduced for first reading in the Legislature. As we engaged and reviewed the information available, we were informed that updates to the training standards were being proposed, such as updating bather supervision certification, allowing the inclusion of lifeguard and assistant lifeguard training courses comparable to the certifications that are currently named, as well as updating requirements for instructor and coach certificates.

We believe that the current prescriptive language in the regulations naming the National Lifeguard service's lifeguard certificate should be replaced with functionally based requirements, such as those listed in section 6.2 of the Model Aquatic Health Code. I had prepared a synopsis of that piece from the Model Aquatic Health Code as well.

The Model Aquatic Health Code, for those of you who may not be aware, is a set of voluntary guidelines based on science and best practices that were developed to help programs that regulate public aquatic facilities reduce the risk of disease, injury and drowning in their communities. The 2016 MAHC underscores the CDC's long-term involvement and commitment to improving aquatic health and safety. Although it is based in the United States, in the waterpark environment it has become the standard of care within our industry. Federal, state and local public health officials and the aquatic sector formed an unprecedented collaboration to create the MAHC.

I have got a number of—to save time, I won't go through them all, but basically pulled in that section—the highlighted section you'll see there, the yellow pertains to lifeguards, the orange pertains to instructors and the

blue pertains to supervisors. For all of those things, we are suggesting the relevant content that would be best served for those certificates.

The lifeguard training and delivery system would need to be standardized and comprehensive with both in-water and out-of-water skills practice, both shallow-water and deep-water training, and a course length sufficient to cover content, skills practice and an evaluation for competency.

Based on Brad Duguid's message regarding the 2017 Burden Reduction Act regarding cutting unnecessary red tape to grow the economy and create jobs, it is imperative that the regulations permit additional lifeguard certifications beyond the Lifesaving Society's National Lifeguard certificate. The current requirement to have lifeguards licensed by a single agency is clearly a burden on the water parks and pools in the province. Simply stated, there are not enough candidates trained with the NL Bronze Cross certification to staff the growing number of lifeguarding positions available in the province.

Our priority of water safety for all of our clientele is of top priority. As employers of large numbers of young people who assume the challenging task of maintaining bather safety, our goal is to ensure that lifeguards focus on similar concepts, regardless of the training agency.

Thank you.

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

We'll start with the opposition. Mr. Yurek.

Mr. Jeff Yurek: Thank you for being here. Does Canada's Wonderland follow these guidelines now?

Ms. Heather Hill: We do, yes.

Mr. Jeff Yurek: Is that above and beyond what is called for right now?

Ms. Heather Hill: I wouldn't say it's above and beyond. There are a lot of details within the Model Aquatic Health Code. We're certainly a leader in our industry. We've operated at the top of our game for a number of different years. I think that when you start to compare certifications, everyone has pride of ownership. It's not about what is the best program; it's about what is the minimum content that's needed. Certainly, if you can go above and beyond, that's great, and we always strive to do that, but I think it's important that we have enough lifeguards available at many different agencies.

We have new water parks in the north of Toronto. It seems to be a dwindling pool of applicants, whether it's that young people want to do different things—it's very cost-prohibitive. It's over $200 to gain your certification, whereas in some programs they can be trained on the job. They have a similar number of hours of training and so forth, but for a candidate, as a young person who is looking for a job, they may not be willing to invest that initial time and money to gain that accreditation, whereas another program where they can be hired and then trained—they may prefer to choose that.

Mr. Jeff Yurek: Would these changes in adopting this code—would that make it easier to become a lifeguard?

Ms. Heather Hill: Right now there's one certificate you can have to be a lifeguard. By using different criteria rather than naming an agency and naming criteria that different programs need to follow, it would allow any program to be measured against that to make sure that they're comparable.

Mr. Jeff Yurek: So Canada's Wonderland can create their own program and develop—

Ms. Heather Hill: We already use a different program that many water parks use across the States: Disney, Great Wolf Lodge—it's called Ellis and Associates, but it's not relevant to that. That would certainly meet those criteria, but other certifications could meet it as well.

Mr. Jeff Yurek: Okay. Thank you.

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

M^me^ France Gélinas: Wow. I was surprised to see Canada's Wonderland coming to talk about the—

Ms. Heather Hill: Very different than the rest of the people today.

M^me^ France Gélinas: Yes, but it all makes sense now.

Right now we have a bill that names a specific training agency. Only if you receive your training from that specific training agency, which charges $200 for people to get that training, will you be allowed to go and get a job as a lifeguard.

Ms. Heather Hill: Correct.

M^me^ France Gélinas: Wow. I missed that, so I thank you for coming.

You say that other jurisdictions have gone with criteria rather than naming a training agency. Are you knowledgeable enough to share with us what their record is—as in, how safe are they compared to the training agency that is defined in the bill?

Ms. Heather Hill: The Lifesaving Society: I'm not an expert on their data. I can speak for Ellis and Associates, whom we use on top of—so we hire lifeguards within our water park who have the Canadian credentials. We go further than that, and we train them on the Ellis and Associates program. That agency, I've been involved with since 1991, and they have had zero drownings within their entire global population. They have water parks all throughout the United States, Dubai, Thailand, China—all over the place, so it's a very high calibre of guarding.

M^me^ France Gélinas: So the criteria that you have highlighted in yellow, in orange, in—whatever—blue, I think: Those are the ones that come from one of the training programs that you already use?

Ms. Heather Hill: The Ellis program meets all of those details, yes.

M^me^ France Gélinas: Okay. Have you mentioned it to the government, have you mentioned it the ministry, to see if they were—

Ms. Heather Hill: Yes.

M^me^ France Gélinas: What did they say?

Ms. Heather Hill: We participated in the modernization of regulation 565 and were at different meetings. That issue was brought up, and the Lifesaving Society was at the meeting and quickly closed the issue for discussion.

M^me^ France Gélinas: Oh, wow. Okay. Thank you for bringing this forward.

The Chair (Mr. Grant Crack): Thank you very much, Ms. Hill, for coming before committee this afternoon. I appreciate your comments.

We had better go—

Mr. Granville Anderson: I know you want to go—

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

Mr. Granville Anderson: Hi, Ms. Hill. How are you today?

Ms. Heather Hill: Hello. Good, thank you.

Mr. Granville Anderson: Thank you for being here. Did you say you belong to an organization that represents—is it 10—

Ms. Heather Hill: Yes. It's a group of mainly Ontario water parks, but we also have one over in Edmonton. We have come together as a group since about 2014 to share best practices but also to work on our challenges with various lifeguarding issues and ministry issues and things like that.

Mr. Granville Anderson: Okay. Were you aware that there are probably over 1,000 unregulated facilities that provide the same in Ontario?

Ms. Heather Hill: Yes.

Mr. Granville Anderson: The standards may be different throughout the other organizations, so we are trying to—

Ms. Heather Hill: Sure. This is water parks, not necessarily aquatic venues—not flat water pools; more like a water park that has different attractions: wave pools, waterslides and things like that.

Mr. Granville Anderson: Okay. How does amending the Health Protection and Promotion Act increase the health and safety of patrons using the water park? In water parks, there are small kids usually.

Ms. Heather Hill: Yes.

Mr. Granville Anderson: How would you go about protecting—

Ms. Heather Hill: Many waterslides are already governed by TSSA. It's really this overlap between the Ministry of Health and TSSA. My reason for providing that backup was just to give criteria, rather than trying to name certificates. I don't think you're in a position where you're going to name a bunch of certificates within the regulation, but I felt that it was more appropriate to look at what the minimum criteria are and measure someone's certification program against that to see if it meets that.

Mr. Granville Anderson: How much time do I have?

The Chair (Mr. Grant Crack): A minute.

Mr. Granville Anderson: Does anybody have any questions? I think we're good. Thank you. I know we all want to go home.

The Chair (Mr. Grant Crack): For my second attempt, thank you, Ms. Hill, for coming before committee this evening.

Ms. Heather Hill: Thank you.

The Chair (Mr. Grant Crack): It's much appreciated. Have a good evening.

Members of the committee, there are no further delegations this afternoon. I just wanted to give you a few reminders. Written submissions are due tomorrow, Thursday, November 23, at noon. Amendments are due tomorrow, Thursday, November 23, at 5 p.m.

M^me^ France Gélinas: Sorry. What's due at noon?

The Chair (Mr. Grant Crack): At noon, it's the written submissions. Amendments are due tomorrow, Thursday, November 23, at 5 p.m.

There's no further business. We will adjourn until 2 p.m.—

Interjection.

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

M^me^ France Gélinas: When can I expect the Hansard from today, even like a draft one, to be out? Because some of what they've said—when he went through the changes he wanted to schedule 9, it's way over my head.

Interjection.

The Chair (Mr. Grant Crack): The information that I have, after consultation, is that it's going to be a few more days—hopefully by Monday.

M^me^ France Gélinas: By Monday?

The Chair (Mr. Grant Crack): We're working on last week's hearings.

M^me^ France Gélinas: I'm fully aware of that.

Is there any way to get the recorded broadcast of it?

The Chair (Mr. Grant Crack): Of which? Yesterday's?

M^me^ France Gélinas: No, of today.

The Chair (Mr. Grant Crack): Today's? How quickly could the broadcast be available through Hansard?

Interjection.

The Chair (Mr. Grant Crack): The Clerk has informed me that, in order to try to facilitate your request, she could provide a link to the recordings of what happened today, not perhaps through Hansard.

M^me^ France Gélinas: Okay, good enough. I'll take whatever you can give me.

The Chair (Mr. Grant Crack): It would be through the stream.

M^me^ France Gélinas: It will be distributed—

The Chair (Mr. Grant Crack): Through the stream—the cameras.

M^me^ France Gélinas: Good enough.

The Chair (Mr. Grant Crack): But Hansard has to verify everything before they officially send out their final—

M^me^ France Gélinas: I tried to take notes as he was going through. I gave up.

The Chair (Mr. Grant Crack): Fair enough.

Again, amendments are due tomorrow, Thursday, November 23, at 5 p.m.

There being no further business, we will adjourn until 2 p.m. on Monday, November 27, 2017, for clause-by-clause consideration. I remind all members that we're back in room 2.

This meeting is adjourned. Thank you very much to everyone for all your hard work on Bill 160.

The committee adjourned at 1754.

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