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Standing Committee on Social Policy

The People's Health Care Act, 2019

1st Session
42nd Parliament

Tuesday 2 April 2019

Chair: Nina Tangri
Clerk: Eric Rennie

Journal des débats (Hansard)

SP-12

Comité permanent de la politique sociale

Loi de 2019 sur les soins de santé pour la population

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42e législature

Mardi 2 avril 2019

Présidente : Nina Tangri
Greffier : Eric Rennie

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Tuesday 2 April 2019

Mardi 2 avril 2019

The committee met at 0900 in room 151.

THE PEOPLE'S HEALTH CARE ACT, 2019

LOI DE 2019 SUR LES SOINS DE SANTÉ POUR LA POPULATION

Consideration of the following bill:

Bill 74, An Act concerning the provision of health care, continuing Ontario Health and making consequential and related amendments and repeals / Projet de loi 74, Loi concernant la prestation de soins de santé, la prorogation de Santé Ontario, l'ajout de modifications corrélatives et connexes et des abrogations.

The Chair (Mrs. Nina Tangri): Good morning. We are meeting today for public hearings on Bill 74, An Act concerning the provision of health care, continuing Ontario Health and making consequential and related amendments and repeals.

Pursuant to the order of the House dated March 27, 2019, each witness will receive up to eight minutes for their presentation, followed by up to 12 minutes of questioning from the committee, divided equally amongst the recognized parties.

Are there any questions before we begin? Madame Gélinas.

M^me^ France Gélinas: Thank you, Chair. I gave notice yesterday that I would like to receive a written summary of the deputations, but, more importantly, I'd like to receive a written summary of the copious amount of written submissions that we are receiving. I was wondering if the committee wants to support this, or if I'm just asking for myself.

The Chair (Mrs. Nina Tangri): Are we in agreeance of the committee of the request by Madame Gélinas to have a summary of the presentations as well as a written summary of those that have come in in writing?

One moment.

Interjection.

The Chair (Mrs. Nina Tangri): First, I'd just like to notify the committee that, due to the deadline that we have of 6 p.m. today, we are unable to provide a deadline of when they can be received.

So I'm asking the committee: Are we in agreeance of providing—

Mr. Deepak Anand: Can we start the process, and we'll give you when we come back at 2 o'clock, so that we don't stop the process? We can discuss and decide. This way, we don't stop the process. Anyway, the decision is not going to be binding until we get everything in.

The Chair (Mrs. Nina Tangri): Madame Gélinas.

M^me^ France Gélinas: We got quite a few yesterday, so we know that we have those. I take it that you have received more written submissions. The deadline to submit amendments is Thursday, so the idea of having the summary is to help us prepare for the amendments.

This is why people connect with us: They want to be heard. If they can't be heard, they send things in writing. We have to be able to have a summary of what they've said, so that we can use this to meet the deadlines for making amendments.

I am very respectful of the people who work here. If they need more time to do their work, then I would say let us know, so that we will consider pushing the deadlines for amendments to accommodate the workload of the people who work for us. I'm very respectful that you can only do so much in a day. But if that's the case, then let us know, and we will look at changing the deadlines for amendments to accommodate their workload.

The Chair (Mrs. Nina Tangri): As I understand it—

Interjection.

The Chair (Mrs. Nina Tangri): I'll pose the question: Do we have agreeance from the committee to provide a summary of the oral and written submissions without providing a timeline, due to the significant number? Mrs. Martin.

Mrs. Robin Martin: I think we had a request from MPP Anand that we defer the answer to the question until we have a chance to confer amongst ourselves.

The Chair (Mrs. Nina Tangri): So 2 p.m. this afternoon? So the question has come—

Interjection.

The Chair (Mrs. Nina Tangri): It is my understanding that there is no agreement at this time. We can come back to the question this afternoon.

M^me^ France Gélinas: Just to finish this: Then I would just request, as an individual member, that the summary be done.

The Chair (Mrs. Nina Tangri): That is absolutely requested. Madame Gélinas has requested a summary from the legislative library.

We'll move forward. Can I call upon the Ontario Hospital Association, please?

Mr. Mamakwa, in the meantime.

Mr. Sol Mamakwa: Just before we start—thanks, Madam Chair. Yesterday, we cut the responses from six minutes to five minutes. In fairness, I think we should share and be equitable in some of the responses that we have. Keep the six minutes that were scheduled, rather than five minutes midway through the hearings.

The Chair (Mrs. Nina Tangri): Pursuant to the time allocation, six minutes is allocated for responses. For some of them, they were lesser. But we have a hard deadline of the time we must finish. Now it's 10 a.m. and we've already lost five minutes of that time, so I'd like to get forward. Yes, it is six minutes, but we need to move quickly between.

ONTARIO HOSPITAL ASSOCIATION

The Chair (Mrs. Nina Tangri): If you can please state, for the record, your names, and introduce yourselves. Thank you very much.

Mr. Altaf Stationwala: My name is Altaf Stationwala. I'm president and CEO of Mackenzie Health, and chair of the Ontario Hospital Association.

Good morning. I'm joined today by Anthony Dale, who is the president and CEO of the OHA. We would like to thank you for this opportunity to present on behalf of the province's 141 hospitals.

In January, I spoke before the Standing Committee on Finance and Economic Affairs, outlining the serious capacity challenges jeopardizing access to hospital care. The government's surge investments during the flu season have helped to avoid a crisis; however, hospitals continue to experience worrying capacity levels, and too many patients aren't receiving care in the right place. In February, a record high 5,000 patients waited in hospital beds to be discharged to their homes, to long-term care or into the community to receive more appropriate care.

Hospitals are keenly aware that many of the solutions to hospital overcrowding lie outside of the hospital walls. That's why we welcome Bill 74, The People's Health Care Act, which will help address this challenge.

For many years, hospitals and the OHA have called for increased integration between different parts of our fragmented health system. We know that silos prevent us from making the best use of health system resources and dedicated front-line health care professionals. More importantly, fragmentation leads to negative outcomes and experiences for patients, who are forced to expend energy navigating a confusing system instead of focusing on getting well. It also has negative impacts on caregivers, who are burning out at an alarming rate.

Recently, the OHA has been working closely with our partners to find solutions that would improve transitions and communication between care providers. We know that forward-thinking hospitals and other providers across the province have been working together to create new models of care that wrap services around the needs of the patient.

In a rigid system that discourages innovation, these initiatives are too often the exception to the rule. Providers want to work together to better serve patients, but there is too much red tape standing in their way. Integrated care delivery systems, referred to as Ontario health teams, will do much to remove some of these barriers and improve the care journey for patients across the full continuum of care.

Hospitals are eager to work with the government and with one another to make better-connected care a reality province-wide.

I'll turn things over to Anthony now to discuss the path forward. Anthony?

Mr. Anthony Dale: Thank you, Altaf, and thanks again to the committee for having us here today.

One of the most important aspects of Ontario health teams, as outlined in the legislation and described by the Minister of Health and Long-Term Care, is their ability to be customized to flexibly meet the unique needs of different communities. There is no one-size-fits-all solution to the challenges of our health care system. By asking service providers to voluntarily come together to become Ontario health teams, the government makes room for diverse models of care suited to certain geographies and populations. Our hope is that the result is a made-in-Ontario solution that empowers service providers to focus on delivering care, not navigating unnecessary bureaucracy.

Of course, we know that change, especially of this scale, takes time, and that many specific implementation details are still to come. In some ways, the process will be generative and will evolve over time. We encourage the government to continue to consult with the OHA, hospitals and all stakeholders across the system. There is a wealth of knowledge about the challenges of the current system and ways to avoid pitfalls moving forward. The expertise of providers will help us strengthen what's already working well in Ontario's health system, while making the changes that are needed to correct what's not.

During this work, it will be important to avoid known barriers to integration that risk stalling our progress. These include workforce coordination challenges, limits on communication between members of a patient's circle of care due to privacy concerns, and factors which, unfortunately, limit the adoption of virtual and digital care. Through close collaboration between government and providers, we believe such obstacles are surmountable, and we are ready and willing to help.

Finally, as we work to build a better system, it's crucial that our existing patients never fall through the cracks. That's why we encourage the government to take steps to ensure continuity of care and an orderly transition.

Hospitals currently act as a crucial safety net for patients who aren't able to access care in other settings. Because it will take years for the transformed system to reach maturity and for capacity in other sectors to come online, we expect they will continue to play this role for some time.

Continued investment in hospital services and the surge strategy is required to maintain access to care and address hospital overcrowding and hallway medicine. A smooth

transition also requires keeping health service providers informed about coming changes and providing guidance.

Some hospitals and service providers are already far along their integration journeys, while others may require additional support. Just as Ontario health teams are designed to be flexible to the needs of patients, so must the government be responsive to the concerns and needs of health service providers.

0910

To make the most of this change, providers need opportunities to share knowledge and best practices as they work to better integrate care. The OHA is eager to play an active role in this regard, in building capacity for change.

I'll turn things back over to Altaf to close our presentation.

Mr. Altaf Stationwala: In closing, we'd like to thank the government for taking action. Ontario's health system is made up of exemplary service providers staffed by dedicated and skilled front-line workers. But fragmentation and administrative barriers have encouraged us to compete with one another rather than co-operate. We believe the changes enabled by this legislation will help bring the focus back to a goal we all share: providing the best possible care to patients and families.

Thank you for your time. We'd be happy to answer questions at this point.

The Chair (Mrs. Nina Tangri): Thank you very much. I'll begin with Madame Gélinas.

M^me^ France Gélinas: Good morning. Thank you for coming.

The first question is just a quick one: When did you start to be consulted about the integrated care delivery changes that were to come in Bill 74?

Mr. Anthony Dale: I think formal consultation with the government started several months ago. We've had several intensive briefings with Ministry of Health and Long-Term Care staff, and that has occurred as recently as two weeks ago. We provided some feedback on the draft implementation document that the ministry is producing.

M^me^ France Gélinas: Would you say that last September you started to hear about the new models of integrated care delivery that were going to come?

Mr. Anthony Dale: As the Premier's council came on stream and was created, it was clear through informal conversation that change was probable.

Just backing up the clock a little further, the OHA is a non-partisan organization and has had speakers from all three political parties over the years.

In the late spring of last year, during the general election campaign, Dr. Rueben Devlin did come as our guest to the OHA board of directors and spoke about the fact that, in his opinion, if elected, the new government would likely reverse the merger of LHINs and CCACs. For us at the OHA, that triggered some work and some thinking to prepare for that possibility.

I know, France, you're aware of this: We've chosen to work very closely with the home and community services sector as part of that rethink of that part of the delivery system.

M^me^ France Gélinas: Of the early expression of interest—is there lots of interest within your membership?

Mr. Anthony Dale: There is quite a bit of interest.

Altaf, would you like to comment on that?

Mr. Altaf Stationwala: I think from hospital providers there is this pent-up excitement around the fact that many of the things that we face every day, that have been out of our control—there's finally an opportunity to try to address some of the issues that we're facing. As an example, yesterday morning I arrived at our hospital, Mackenzie Health in Richmond Hill, with 41 patients waiting for a bed in the emergency department.

The things that we can control, we do, the best we can, but many of the challenges we have around access and flow are really linked to some of those system changes.

So the sector is very supportive of these changes, and there's lots of excitement to apply.

M^me^ France Gélinas: Good.

I have a couple of questions.

So, 141 hospital corporations, a maximum of 50 integrated teams—the small hospitals are coming forward saying, "We will be the losers in this."

Second, same thing with staff saying if PSLRTA is not—because you've seen the changes, and I think OHA supports the changes to PSLRTA. What will happen to some of the staff who will be under a hospital corporation integrated care model, but not be paid the same way, or not be treated the same way? How is OHA handling that?

Mr. Anthony Dale: Well, the changes we've recommended to the Public Sector Labour Relations Transition Act are intended to take us back to the pre-2006 state. The reason we think that's important is because this is legislation that was supposed to facilitate bargaining unit consolidation in the case of a full corporate merger between hospitals and other broader public sector entities. The previous government made changes in 2006 so that it applied to partial service integration rather than full corporate mergers. What that did is it accidentally created essentially a freeze on integration activity because of the risk of accidentally transferring collective agreements from a higher-cost setting like a hospital into other kinds of settings.

M^me^ France Gélinas: So you're okay with having people under your corporations that will do the same work but be paid a different amount?

Mr. Anthony Dale: No, but that's I think the practical side to Ontario health teams. The truth is that to contemplate full corporate mergers and integrations would be highly impractical. It's a very expensive proposition. It also creates a very adversarial and confusing labour relations environment.

The Chair (Mrs. Nina Tangri): One minute to go.

Mr. Anthony Dale: The changes that we've recommended are intended to be balanced in nature to protect the bargaining rights of existing bargaining agents who represent those workers outside the hospital setting, while giving them clarity and stability in their own working environment.

M^me^ France Gélinas: The community agencies are also asking for a one-way valve. We've seen where you could take all of the money that is in the community and give it to the hospital, and we'll still have hallway health care. Would you be in favour of a one-way valve to make sure that the hospital doesn't take it all over?

Mr. Anthony Dale: I'm not sure of your question. We certainly believe that independent governance of all of the providers must be protected. Hospitals are one partner among many in the constellation of providers who are looking to create health teams.

M^me^ France Gélinas: But if they're in charge of the team, how do you protect the budgets from the community agencies from being used in the hospital?

Mr. Altaf Stationwala: I would actually—

The Chair (Mrs. Nina Tangri): Thank you very much. I'm actually going to move to the government side. I'll start with Mr. Anand.

Mr. Deepak Anand: Altaf, you wanted to say something?

Mr. Altaf Stationwala: Well, I would say, actually, it would be the reverse. From the hospital perspective and the relationships we have with home and community providers, we would like to move resources out of the hospital if it can facilitate timely discharge and flow of patients. The reality is we are occupying—5,000 patients in very high-cost environments today that could be cared for more appropriately in the community at a more cost-effective level.

The Chair (Mrs. Nina Tangri): Ms. Triantafilopoulos?

Ms. Effie J. Triantafilopoulos: I believe Mr. Anand wanted to—

Mr. Deepak Anand: No, that's okay.

Ms. Effie J. Triantafilopoulos: Thank you very much for joining us today. Your support of Bill 74 is very welcome as we move forward in a new environment where we can actually be very patient-centred in the kind of care that we deliver.

I wanted to talk to you specifically about some of the comments you made in terms of ending hallway health care in your hospital and others, and discuss the issue around how you transition patients out of the hospital and then give local communities more flexibility to innovate and break down some of the walls that currently exist with health care providers. What type of opportunities do you believe this bill gives hospitals to equip them with the necessary resources to increase this patient-centred care and end hallway medicine?

Mr. Anthony Dale: Thank you for the question. It really brings together with what I think France was also getting at and what Altaf I think very articulately said—that hospitals are one partner in the constellation of providers that will come together to create Ontario health teams. They are incredibly motivated to play a role within a team context because the solutions to ending hallway health care lie outside of the hospital setting. Almost 5,100 patients on February 3 in hospitals were alternate-level-of-care. That's one in six hospital beds. And all across the province, you have hospitals that are literally jammed to the rafters without any physical space left to care for patients. While the staff of hospitals work unbelievable efforts to maintain quality of care, it is in remarkable conditions.

Essentially what the legislation does is, it enables the kind of direct provider-to-provider relationships and connections that have been not only frowned upon in the past but have actually been illegal. There is a state of absurdity at certain times that's occurred in recent years when you think about the structural design of the system. It was illegal up until recently through waivers for a hospital to have any direct contact with a home care provider. There are major regulatory barriers to direct connections with long-term-care facilities. Everything has had to be channeled, funneled and heavily regulated through local health integration networks. There are some amazing people working in LHINs and in the old community care access centres, but it's a system that was increasingly unresponsive to the needs of patients, clients and the providers who were working feverishly to deal with it.

0920

The math is relentless. Wait times in emergency departments and alternate level of care, and now the daily bed census for hospitals, are the best we've got at measuring the system's overall performance, and it shows a gross imbalance, with so much congestion. So this gives the basic tools to provide those direct relationships, to build and customize care pathways for patients in a geographic area. At the same time, it is the responsible thing to emphasize that continued investment in hospitals and all services across the continuum is absolutely necessary. Without the surge strategy this past winter, it would have been a calamity, and that's the third winter in a row—and those are strong words, but it's the truth. It provided an incredibly important safety net for the system, and we do hope that in the upcoming budget, both that investment in hospital services and continued support for the surge strategy is maintained.

Would you comment, please, Altaf, on Mackenzie?

Mr. Altaf Stationwala: Absolutely. So some of the solutions are very straightforward, but the reality is, there are structures that get in the way of making decisions. Pretty regularly, for example, we'll have patients who are waiting for certain services in the community, and sometimes they're very simple services like Meals on Wheels, and you'll have a patient occupying a very expensive resource, a hospital bed, for four or five extra days while those services are coordinated. If there was a greater ability to shift resources and sometimes, I would say, even let the hospital pay for that service—it's a very nominal service, but it does improve the flow in a dramatic way. It gets that patient to the appropriate place and gets the patient in emerg that's waiting for a bed in there that much faster.

The Chair (Mrs. Nina Tangri): One minute.

Mr. Altaf Stationwala: So there's a real willingness to work these solutions through, and I think the providers have the answers and the front-line staff have the answers.

You really just need to support us in making those things, and that's what your bill does.

Ms. Effie J. Triantafilopoulos: One more quick question, if we can: Let's talk a little bit about the small hospitals. I understand there are maybe 60-plus small hospitals in the communities. They are also experiencing the same overcrowding, and they also have limited ability to deal with surge spaces. Going forward, how would this bill be able to incent more providers to work together in a smaller hospital setting?

Mr. Anthony Dale: Well, the truth is, a lot of small hospitals have been at the forefront of integrated models of care for many years. I know France is shaking her head; she's well aware of them too, especially in northern Ontario, in places like Dryden, Espanola, Chapleau and others. They've been living this experience for years. They have come together in all sorts of creative ways. It might be through a single form of governance that has been arrived at voluntarily; it might be through shared governance and a common management team or co-location of services on one site. They've really shown the way for a lot of the province.

The Chair (Mrs. Nina Tangri): Thank you very much. I'm going to have to cut you off there. Time is up. Thank you very much for coming out and presenting to us today.

Mr. Anthony Dale: Thank you.

CHILDREN'S MENTAL HEALTH ONTARIO

The Chair (Mrs. Nina Tangri): I'd like to call upon Children's Mental Health Ontario. If you can please introduce yourself for the record. You have eight minutes to present, followed by six minutes each from the recognized parties.

Ms. Kim Moran: Thank you so much for the opportunity to present today on Bill 74. My name is Kim Moran. I'm the CEO of Children's Mental Health Ontario, and I'm honoured to contribute to the Premier's Council on Improving Healthcare and Ending Hallway Medicine. But today, my input is wearing my hat as the CEO of Children's Mental Health Ontario and as a mother who almost lost her daughter at 11 to mental illness. I really want to thank you for the opportunity to bring my perspective to you today.

Children's Mental Health Ontario represents Ontario's publicly funded child and youth mental health centres regarding their perspectives on Bill 74. There are 90 child and youth mental health centres located across Ontario, in every community that you can think of, providing on-the-ground services to kids and families every single day, and mental health treatment services and support to more than 120,000 infants, children, youth and families across the province. You've seen the written submission that we prepared with our colleagues from Addictions and Mental Health Ontario and the Canadian Mental Health Association, Ontario division.

In many ways, Ontario's health care system is first-class. If you're diagnosed with cancer, the care you receive is exemplary. But there are many parts of the health system that really aren't working as well as they should. We know that too many people are seeking help in hospital because they can't get the treatment, services and supports that they need in their community. The Ontario Hospital Association just spoke about that very eloquently.

I think that also often when we are talking about these issues, there's less attention paid to how many patients with mental health and addictions are part of those groups of patients who shouldn't be in the hospitals. We've shown data over the last number of years that over the last 11 years there has been a 79% increase in in-patient admissions for kids with mental health issues and a 72% increase in admissions for kids with mental health issues in the emergency department. I would say that's like a flashing red light to say that a health system is in trouble. That means, in real kids, that 72,000 kids are going to the emergency department every year who don't need to go. That's 14,000 kids who don't need to go to an in-patient hospital bed.

The thing that I think everybody has to recognize is that hospitals play an extremely important role in a system of care, but that's not where treatment happens for mental health issues. You get stabilized and then you're exited for mental health care treatment that you don't get. You have to wait for it. Of course, what that means is that you often go back to hospitals over and over. The rate of kids with mental health issues who are going back to hospitals is also three times the average. So we know, just through logic, that the problem is that you don't have enough community treatment.

The other thing we have to think about is, in adult mental health, that one in four alternate-level-of-care patients—which are those patients who shouldn't be in hospital, and everybody has agreed to that—have a mental health or addictions problem, and they cannot be exited because there isn't a home to return to; there isn't a place where they can go with the appropriate supports.

But the thing you all have to remember is: It's not mysterious as to what those community supports are. We have models all across Ontario, in probably every riding that you guys are in, that I could point to where we know what to do in the community. We have to make sure that that capacity is built so we can do those things.

You know that 70% of mental health issues occur when you're a child. So those patients who are in the adult mental health and addictions system—we saw them when they were children. We have to get to them faster, because we know that mental health treatment works. And if we get to them, we can actually reduce cost to the government over the long term. But cost is one thing. It's the life cost—it's those people who you see struggling as adults with mental health and addictions, and you know you could have gotten to them when they were children and changed the trajectory of their life.

Today, in community mental health treatment for kids, you can wait two years. It's awful. In some communities, care that kids need is not even available at all. Sol, in your community, there is no intensive treatment. There is no intensive treatment north of North Bay—not at all. I can

tell you, from personal experience, that you don't want your kid far away from home without their parents when they're that seriously ill. It makes no sense.

Creating Ontario health teams has the potential to better integrate health care systems. As accountable care networks and organizations are rolling out across the world, we have good evidence that there is some really nice integration that can happen. We have seen evidence of integration in Ontario, and we just want to keep doing that because we know that's the way of the future—getting patients out of the hospital, out of acute-care systems and into community care. That's the future. We know that these models can be very effective when there are inefficient systems. I think that they just mentioned that when you have a delay because Meals on Wheels isn't arranged and people are in hospitals—that is a slam dunk. That's obvious.

But in mental health, one of the things we have to be careful about on implementation is being thoughtful about this, because while these accountable care network organization or integration ideas really solve for inefficient systems, like what we're talking about with Meals on Wheels, they don't solve for capacity problems. We would say that mental health is really a capacity problem. Of course, any system has some efficiency issues that have to be dealt with, but really the problem is insufficient capacity in mental health. So as we implement these models, we need to be careful about that, because if we don't, it could imperil implementation of Ontario health teams in a very profound way.

0930

The good news is that there's money on the table for mental health and addictions because the government has recognized this. There's $1.9 billion in federal funding and $1.9 billion in provincial funding over the next decade to solve this. As we're embarking on huge system transformation in health care, I need each and every one of you to make sure that mental health and addictions are addressed at the same time, that we build the capacity to enable the Ontario health teams.

As Anthony said in the last presentation, it's going to take a little bit of time for Ontario health teams to form and really come to maturity, and that happens when you're moving big systems. But right now, your average kid who's waiting, your average family who's waiting for mental health treatment can't wait.

The Chair (Mrs. Nina Tangri): One minute.

Ms. Kim Moran: They can't wait. So we need to have these important issues dealt with soon. We need to get kids who are in and out of hospital out of hospital.

I want to tell you about Myles. He lived in Toronto here with his mom and dad—a regular family. He was 10 and he had a serious mental illness—very aggressive at school and very aggressive at home He needed intensive day treatment here in Toronto. He was on long wait-times. He was on wait-times of about a year. He died by suicide while he waited, and he was only 13 years old.

There's another Myles now. His name is Martin. His mom works for the OPS. He's only eight. He's waiting for intensive day treatment right now. His mom is a hero. She's off work. We text every morning because I want her to feel supported.

The Chair (Mrs. Nina Tangri): I'm going to have to just stop you right there and continue with questions from the governing side. Mrs. Martin.

Mrs. Robin Martin: Thank you, Ms. Moran, for your submissions. It was very interesting. As you know, we've been working together quite a bit with respect to where we should make those investments in mental health. So from the point of view of this legislation, recognizing that there is still a capacity challenge in the community for mental health, particularly for children's mental health, can you help us with how you foresee or think—the best way for us to build mental health capacity that will best enable these Ontario health teams?

Ms. Kim Moran: Absolutely. I think what we have to do is focus on those kids who are in and out of hospital, those kids who have the highest needs. They're the ones we can get—

Mrs. Robin Martin: Sorry. Can I just interrupt so I understand? Is that like acute ambulatory you would call them, or—

Ms. Kim Moran: No. I would say that these are the kids who are going to emergency rooms who don't need to be there or who are in-patient beds who don't need to be there. I would focus exactly on that. There are models in the community that work. In Ottawa, there's a model where we can take kids to prevent them from going into hospital—kids who might have serious anxiety and depression. What we found is that when we provide them with interprofessional team care in a community setting, they don't need to go to hospital. The results of the tests were amazing: from an over-50% readmission rate to less than 1% Those types of very intensive services work.

In Windsor, we have a similar model where, for a kid like Myles, for the kid like Martin who's now waiting for day treatment, these kinds of day treatment programs are intensive for kids. Remember, kids have to go to school; right? We have to wrap care around school. So what we do in Windsor is, the model is, when a kid is as ill as, say, Martin, who's eight, then a team would go into a home, they would go in to help the parents to get the kids up and ready and on the bus to go to care, because that part, for a family, is often super-tough, particularly when a kid is really struggling.

They would go to care all day, intensive mental health treatment with an interprofessional team, including psychiatry, psychology, social work, child and youth workers, and they would stay there all day, get care from the team but also schooling. Then they would go home in the evenings with their parents and the team would go with them to help the parents so that they understand how to provide that kind of care. What that model does is help train parents and, at the same time, provide treatment to kids.

You have to understand that when you have a kid with a mental health issue, it really is a hard job as a parent. You need to change how you parent, and sometimes it's

because you may not have had the skills. You may not have had the skills when you were growing up; you may not have had parents who were having a stable home for you, so you may not have understood that. But it also could be families like ours, where we had to learn how to manage an anxious kid and what we had to do and how we had to change.

Those kinds of intensive models, Robin, are producing tremendous results, where we're seeing kids like Myles go on to lead better lives. My daughter was the beneficiary of that. My daughter was in intensive day treatment for about 18 months. Now I'm very proud to say that my daughter is in first-year nursing at George Brown. I'm very happy about that. Kids do recover, so when they have that kind of intensive treatment, we can change the trajectory.

I think Lauren is always going to have trouble with anxiety. This morning, we had trouble; last night, we had trouble with anxiety. But she has learned tools, and I feel very comfortable that she's going to have one of those very productive lives. But we lose too many kids like Myles, who died by suicide, because we don't get them that treatment.

What I would say is, that's where I would start. I would start with those kids who are occupying in-patient beds who don't need to, those kids who are in and out of emergency rooms who don't need to. Let's start there, because we can deliver savings to the government of almost $1 billion in hospital costs over the next five years. That's substantial, and that's going to enable the Ontario health teams, so we can get money in the right spots in the system. I would absolutely focus on those high-needs kids.

Mrs. Robin Martin: Do we have—?

The Chair (Mrs. Nina Tangri): One minute. Oh, sorry; you have two minutes.

Mrs. Robin Martin: Can you tell us the names of those programs you referred to, if they have names? For example, you said there's a model in Ottawa. Is that the Bridges model?

Ms. Kim Moran: Yes, it's the Bridges program that's—

Mrs. Robin Martin: I just wanted to make sure I understood.

Ms. Kim Moran: Yes, absolutely. It's a joint venture between CHEO, Youth Services Bureau, the community agency and the Royal psychiatric hospital, a proven model that we want to expand across the province so that every single Ontarian can access them when they need them.

Mrs. Robin Martin: For a riding like Mr. Mamakwa's, where there isn't, for example—I think you said "residential" or "out-of-home services"—I imagine there aren't a lot of these services. What do you think we need to do? Can we put that kind of a model into those areas?

Ms. Kim Moran: Do you know what? I think that we have to be clever when we come to big distances in the north. But what we do know is, right now, when their kids are sent to Toronto—

The Chair (Mrs. Nina Tangri): One minute.

Ms. Kim Moran: —or southern Ontario, that's the wrong thing to do. So I think that we have to be clever, and so you have to have a combination of the in-home treatment to provide that kind of parenting support that's needed and so that these kids get, in their homes, in their communities, the kind of care that they need. I think that many of those kids are First Nations kids and so I would really respect First Nations' right to articulate the kind of services they need, and would say that for other more clinical child and youth mental health settings that we could provide those kinds of supports based on what they need.

But absolutely, we can apply those models in vast geographic areas. We have to tinker with them a little bit. For example, the intensive day treatment model I spoke about in Windsor—there are also kids who live in the county, who live farther outside of Windsor, and so it's not practical to always have them bus in every day. What we do is have them stay for a 24/7 period for a short period of time. Their families come in. We do it in a very holistic way, because it has to be with the family, and then we can make those work.

The Chair (Mrs. Nina Tangri): Thank you very much. I'm going to move to the opposition. Who would like to speak? Madame Gélinas.

M^me^ France Gélinas: Thank you so much for being here this morning.

I know that you are on the Premier's council table. I was just wondering, can you share with us how involved the Premier's council was in drafting Bill 74?

Ms. Kim Moran: No drafting of legislation at all—there was no involvement. But I would say that we have been talking at the Premier's council, and I would say that I've been talking for five years about integrated ideas and how to push integration in the province, and what structures would enable that.

M^me^ France Gélinas: Okay. Did you have to sign a non-disclosure agreement because you were on the council, or are you free to share with us?

Ms. Kim Moran: At certain periods of time, yes, it would be under non-disclosure agreements that I've signed for certain pieces of it.

M^me^ France Gélinas: Okay. You've made it clear in your pre-budget submission that children's mental health in Ontario needs $150 million, and today, you've made it clear again that we need to build capacity. What will happen if that $150 million is not in the budget?

Ms. Kim Moran: What's going to happen is, we're just not going to be able to deliver on the promise of enabling Ontario health teams. The reality is, those 72,000 kids who are in the emergency department this year just aren't going to be able to come out, and they're going to still be clogging up hallways of health care. Those 14,000 kids who are in in-patient beds who don't need to be there are, again, going to be the ones who aren't getting out of the hospital.

We're also going to spend an extra $150 million that we really don't need to spend, which is really unfortunate, because that money could be redirected to other services that are absolutely necessary on the front line. I think that it would be incredibly sad if we didn't see that.

0940

The other thing that would happen is, you're going to have people like my friend who is in the OPS, who has her son, Martin, who is just waiting, who can't work today. We know that the cost to the economy for families not working, every year, is $440 million.

There are costs all the way through. There are hospital costs; there are costs to the economy for parents not working when they're looking after their kids; there are costs to the kids themselves. Martin, today, is not in school. His mom is doing her best. She's not a teacher; she doesn't know how to do that. These kids can get lost, and they can lose years.

I was lucky. Lauren lost, probably, a year, from her mental illness. She was able, through a lot of work, to catch up so that she could go on to college. But I hear from kids across the province that they don't catch up; they don't get the kind of treatment they need. They're not going to colleges and universities. These are the kids that, really, we're not going to see the promise, and we're also going to carry them on our social service rolls for the rest of their lives.

So the impact of not making that investment is, in the very short term, to families who are struggling right now; to hospitals that are having kids in hospital who really shouldn't be there at all; to the kids themselves who are struggling every single day, and to their lifelong ability to be a productive part of our community.

M^me^ France Gélinas: If we want to have equity, because you've talked—north of North Bay, we have no intensive therapy. That includes all of my riding, all of his riding.

Ms. Kim Moran: Absolutely.

M^me^ France Gélinas: Right now, to be an integrated team, you only have to have three of the six: hospital, long-term care, primary care, mental health and addictions, home and community, and palliative. That means that in some of those teams, we won't even have mental health and addictions. How do we make sure that doesn't happen?

Ms. Kim Moran: If the money is there, if the investment is there, then I can tell you that our members will make sure they're making connections with the right people to make that happen. As soon as we get the signal from the government that they want to expand intensive day treatment and expand the Bridges types of programs, we will be on it.

So never mind the structures, France. We will get it done.

M^me^ France Gélinas: I agree. It really boils down to what you talked about: to build capacity. Right now, for this year, you have identified this at $150 million. Do we know, next year and the year after, how much money we're looking at to make this happen?

Ms. Kim Moran: We think this is an annualized amount. We think that when we do that, we can manage the demand that's in the sector right now.

We think that, as we see the Ontario health teams work over the next couple of years, then we can see where there are other opportunities, at that point, to rationalize and make sure that community care is at the right capacity.

But for right now, we think that that's going to be the number, annualized, that is really going to enable these Ontario health teams to work the way the government wants them to.

The Chair (Mrs. Nina Tangri): One minute.

M^me^ France Gélinas: You were here when the OHA was here, just before you. They also want an influx of dollars, because they say it will take time to build capacity in the community sector. It will take time. But what you're saying is that if there's $150 million that starts to flow on April 11, you will be able to manage this capacity.

Ms. Kim Moran: We're a very fast start. We have the bricks and mortar there. I'm a CPA by background. The return on investment is fast. While some sectors are going to take a while to build capacity—obviously, long-term care takes a long time to build—the quick turnaround that we can provide is really quite amazing.

It's about hiring more clinicians. Our ask is 14,000 more clinicians. We don't need bricks and mortar; we've got all that.

It's just about making sure that we have the face-to-face services that kids need. I think it's important to understand, for those kids who are needing intensive services, that it is a face-to-face business. I know that we're going to do a lot of work on enabling digital solutions and virtual care on the back end and in the background, but it's a human business that these kids need. They don't want to tell their story over and over. They need to tell their story to somebody who really cares and who they connect with.

The Chair (Mrs. Nina Tangri): Thank you very much. I really appreciate you coming out today and presenting to us.

Ms. Kim Moran: Thank you.

MR. KENNETH YURCHUK
MS. PATRICIA CHARTIER

The Chair (Mrs. Nina Tangri): I'd like to call upon Patricia Chartier and Kenneth Yurchuk. Thank you. If you can please introduce yourself for the record. You have eight minutes to present, followed by six minutes from each of the recognized parties.

Mr. Kenneth Yurchuk: I'll be splitting my time with Pat Chartier. I'll be speaking for four minutes, and so will she.

Anyway, good morning. Thank you for hearing my submission. I was planning to dress up for this but I tried on my suit and realized I've lost 65 pounds since the last time I wore it. Jenny Craig, eat your heart out. Thank you for hearing my submission on Bill 74 regarding proposed changes to the Ontario health care system.

I'm a stage 4 colon cancer patient. My cancer has spread to my liver and possibly my lymph nodes as well. This isn't my first rodeo with cancer. About six and a half years ago, I was diagnosed with pulmonary lymphoma. I had a tumour on one lung about the size of a tennis ball,

and three smaller ones on the other lung. Thanks to the care I received, I survived that.

Now, I'd like to talk about my experiences with our existing cancer care system and my concerns about proposed changes, including rolling Cancer Care Ontario into the proposed super-agency. Firstly, I'd like to say that I've had excellent treatment to date. From the moment I first went into emergency complaining of severe abdominal pain, through diagnostic imaging, a biopsy which confirmed the presence of colon cancer, surgery to remove a section of my colon, and the subsequent chemotherapy, my experience has been excellent.

The oncology team—doctors, diagnostic imaging techs, blood work techs and the front-line nursing staff who have been administering my chemotherapy, the receptionists and administrators who made all my appointments and communicated with me, the nursing connected to my local LHIN that removes the IV chemo bottle I take home with me—they've all been efficient, compassionate and, above all, kept me informed every step of the way. Wait times have been minimal, and while my prognosis is not great, that is in no way a reflection on the team which is helping me fight for my life. So I have to wonder: Why the rush to fix something that obviously is not broken?

The government has not been particularly communicative to cancer patients. I haven't received a single word on what the future will look like, because apparently nobody really knows for sure. A lot of my concerns about the existential treatment I am receiving are based on anxiety and stress about how this will affect my future treatment.

Will diagnostic imaging services be privatized? Will blood testing be moved off-site from the oncology treatment centre at Trillium Etobicoke where I receive my treatment? If so, will my results reach my oncologist in half an hour like they do now, or will it take a day or two? Will I have to make my own appointments and go to multiple sites instead of the one-stop-shopping that I have now? Right now, my pain is manageable. This may not last. I've heard rumours that pain management is on the privatization chopping block. This worries me, and adds to my stress.

Cancer is stressful at the best of times. Anxiety is always there. Our current system is designed to minimize additional sources of this stress. Cancer Care Ontario is working extremely well right now. Once it is rolled into the super-agency, will it still have the focus it does now? Will it still receive the funding it does now? Or will an ideological decision to privatize certain areas of health care, which has been communicated without details, put tax dollars into private pockets instead of into the care that cancer patients need?

All of these questions require answers that, until now, have not been forthcoming from the government other than in the form of meaningless slogans. Ending hallway health care? The answer to that is to get long-term patients out of acute-care beds and into facilities that will better serve their needs—not to mess with systems that are working well for cancer patients.

In conclusion, I'd like to thank the committee for a chance to be one of only 30 who will have a chance to submit on this bill. And a final question: Does the government really feel that 10 hours of submissions on a bill that is as existential to the health care of millions of people in the province of Ontario is sufficient?

Thank you, and I look forward to your questions.

Ms. Patricia Chartier: Should I go now?

The Chair (Mrs. Nina Tangri): Yes, you have three and a half minutes.

Ms. Patricia Chartier: Okay. Good morning and thank you. I have never spoken much before about having breast cancer and I would really prefer not to start right now, this set-up being intimidating, but Cancer Care Ontario was there for me when I needed it and I must rise above my nerves and be here for Cancer Care Ontario today.

0950

The suggestion that we can improve health care by dismantling Cancer Care Ontario and Trillium Gift of Life takes my breath away with its wrong-headedness and absolute risk for all patients. Just the inevitable chaos alone from the drastic transition is a recipe for unnecessary disaster. This even has national implications as people come from all over to be treated here.

I don't want to live in an Ontario in which the needs of cancer and transplant medicine are lumped in with every other aspect of health care and forced to compete for attention from a small board. That makes no sense. In fact, it feels to me like a crime against the people of this province.

Premier Ford's government has made it very clear that it has zero qualms about pulling the rug out from underneath vulnerable Ontarians. Why should cancer and transplant patients expect a different outcome?

Speaking as a cancer survivor, I can tell you that you are never more vulnerable than when diagnosed. It happened to me on a sunny day in 2011: routine mammogram, call-back, biopsy—and bam. I was a stranger in a strange land, where nothing looked familiar, stable or sure. On the day of my diagnosis, I felt there was nothing for me to grab onto except my husband's hand.

And that's where Cancer Care Ontario—its excellence manifested in the University Health Network—came to my rescue. I quickly learned I could grab on to the wonderful team at the UHN. I could keep calm and chemo on—still scared stiff, yes, but confident of being in the best place possible.

My treatment included mastectomy, chemo and radiation. I got so many supports—and these are the things that really enabled me to get through it with a modicum of grace. I took exercise programs, classes in managing side effects and so on. I had the help of a brilliant psychiatrist.

Shortly after my treatment, I attended a remarkable UHN and, I think, CCO seminar on breast reconstruction. When I said to the surgeons, "You know, I just don't think I'm ready," they replied, "That's okay. We'll be here for you if and when you are ready." Four years later, I underwent reconstruction, which boosted my self-confidence

more than I even care to admit—yay me, and yay Cancer Care Ontario.

In closing, for a long time after my treatment I would wake at 2 a.m. and worry about cancer coming back. Today I wake and I worry that it will come back and Cancer Care Ontario will be gone. Premier Ford and Minister Elliott will have done to cancer patients what they did to the 4,000 people faithfully enrolled in the basic income project and the families of autistic kids: Misrepresent your plans, pull the rug right out from under us, throw us into chaos, and then vilify anyone who protests.

Some said last summer that Minister Elliott would temper the Premier's excesses, but she has given no indication of the courage to speak truth to power. With this harmful plan coming down the pike, it's kind of late for her to start now.

Given all this, can anyone in this room explain to me why my fears are not completely justified?

Thank you.

The Chair (Mrs. Nina Tangri): Thank you very much. We will begin with Mr. Mamakwa.

Mr. Sol Mamakwa: Thank you, Patricia and Ken, for having the courage to come here and for being warriors in fighting cancer and also coming forward with your truth-telling stories of how you encountered and how you faced fighting for your life with this disease.

I come from a northern Ontario riding, the most northerly riding. When we talk about cancer care, provision of cancer care services is very minimal, at best, to non-existent. We have a high rate of cancer in our communities.

First off, my question is: Have you ever tried to contact the government to share your story or feedback on Bill 74.

Ms. Patricia Chartier: That's what I'm doing right now. I've never felt they were that open to hearing from people who were not friends of the Ford family.

Mr. Sol Mamakwa: Do you know of any cancer survivors or cancer advocates who have been consulted in the drafting of Bill 74?

Mr. Kenneth Yurchuk: I don't know about experts. I do know that not very many patients have been consulted. Certainly, as you heard from my presentation, most of my presentation consisted of questions, because I got zero from the government. In fact, if it hadn't been for the opposition leaking certain documents about the super-agency and about the government plans for health care, I wouldn't know anything. So quite frankly, what my concern is is that this has been kept a deep, dark secret. The government's only allowing 10 hours of consultation on what is an existential system of care in this province—10 hours. There are probably thousands of people who want to hear and present on what's going to be happening with their health care system. You're limiting it to 30 people, a few minutes each. That's really disgusting. That's really—I'm almost at a loss for words. I'll just leave it at that.

Mr. Sol Mamakwa: Thank you. In viewing the importance of Cancer Care Ontario to cancer survivors like yourself, do you think that the government has the responsibility to reach out to cancer survivors before making such changes to the health care system?

Ms. Patricia Chartier: I have so little faith. Go back to my original comments. They can reach out as much as possible, but as my mom said, you only get one chance to make a first impression. That first impression was indelible. I think it would be almost a waste of time.

Mr. Sol Mamakwa: One of the things we hear is that government claims that nothing will be changed when Cancer Care Ontario is rolled into the super-agency. What do you think of this claim?

Mr. Kenneth Yurchuk: I'll respond to that, if you don't mind. One of the great promises of the Ford government has been, "Not a single job will be lost." Well, I'll tell you what: Already, nurses are being laid off. Teachers are being laid off. The ABA instructors and dozens and dozens of people working with autistic kids are being laid off. Based on performance, which is the best indicator, can we really depend on that? I'm saying no.

First of all, the super-agency, divided into these smaller teams, will be looking at all sectors of the health care system. There won't be a single group, like Cancer Care Ontario, concentrating on a specific area of care. That's what's made our cancer care system in Ontario, up to date, one of the best in the world. We had the best outcomes in the world, we've got the best treatment in the world, and people from all over the world look at the Ontario model and say, "Hey, this is a system that works for cancer." Maybe not every area of the health care system is as well organized or as well set up as Cancer Care Ontario, but we do know from the results and from what happens that our system, with Cancer Care Ontario as a stand-alone agency, does work—

The Chair (Mrs. Nina Tangri): One minute. You have one minute to conclude.

Mr. Kenneth Yurchuk: Oh, okay. Just very quickly, as I said in my submission, if you've got something that's working that well, why tear it apart? I've got to ask, why tear it apart? That's all.

Mr. Sol Mamakwa: I know the Minister of Health has said that she's engaged thousands of patients in developing plans to overhaul the health care system that exists. I think you're the first two I've met who said that they had been engaged—through this process, I mean—

The Chair (Mrs. Nina Tangri): Thank you, Mr. Mamakwa. We have concluded time.

I'm going to recess now until 2 p.m. this afternoon.

The committee recessed from 1000 to 1400.

CANCER CARE ONTARIO

The Chair (Mrs. Nina Tangri): Good afternoon, everyone. We are meeting here today for public hearings on Bill 74, An Act concerning the provision of health care, continuing Ontario Health and making consequential and related amendments and repeals. Pursuant to the order of the House dated March 27, 2019, each witness will receive up to eight minutes for their presentation, followed by up to 12 minutes of questioning from the committee, divided equally amongst the recognized parties.

Are there any questions before we begin? Seeing none, I would like to call upon Cancer Care Ontario. If you could please introduce yourself for the record.

Mr. Michael Sherar: Good afternoon, and thank you, Ms. Tangri and members of the committee. My name is Michael Sherar, and I am the president and CEO of Cancer Care Ontario.

The Chair (Mrs. Nina Tangri): Go ahead.

Mr. Michael Sherar: The legislation we are here to discuss is very likely the most important health legislation in Ontario for the last 25 years, and for the next 25 years. It is intended to enable a complete overhaul of Ontario's health care system. The legislation includes the intended dissolution of Cancer Care Ontario as a crown agency and the repeal of the Cancer Act, which currently enables Cancer Care Ontario's work. The success of the new agency, Ontario Health, and all the associated changes contemplated in Bill 74 for the people of Ontario will be wholly dependent on how well these sweeping changes are implemented.

The reason I am here today is that I believe we can offer good advice, based on Cancer Care Ontario's experience of health care change implementation, on the things that are important for this committee to consider when arriving at the final version of this legislation. If the recommendations that we propose for the legislation are accepted, the progress that has been made over the last 15 years for Ontario's cancer and renal care systems can be protected, and even strengthened. Based on our experience at Cancer Care Ontario, we are recommending that three key areas of this bill, specific to the objects of Ontario Health as set out in section 6, need strengthening in order for the government's health system transformation plans to be successful.

The first area is planning. One of the objects of Ontario Health must be to lead the development of a plan for health system improvement, an Ontario health system plan. This plan should be renewed about every four to five years. The legislation should require that this plan be developed openly and transparently, and in partnership with clinical leaders, doctors, nurses, patients and families from across the province. The plan should be developed largely independently of the government, and should be presented to the government as advice for implementation and investment.

In the context of this planning, it should be Ontario Health's responsibility to ensure that this plan aligns with the government priorities of the day. The gains we have seen for cancer patients and for patients with chronic kidney disease have been enabled by such plans—the Ontario cancer plan and the Ontario renal plan. In fact, Cancer Care Ontario is about to launch the fifth Ontario cancer plan and the third Ontario renal plan.

We would further recommend that vital components of this Ontario health system plan also be specified in the legislation. That Ontario health system plan should contain an Ontario cancer plan; a renal plan; a vascular plan, including cardiac and stroke; a plan for mental heath and addictions; a plan for diabetes; a plan for organ donation and transplant; and a plan for palliative care. These component plans should be developed through engagement with experts, clinical leaders, patients and families in each of these areas of care, and brought together in coordination in the overall Ontario health system plan.

One other critical area of engagement and planning that should be required to be part of the Ontario health system plan is that it be developed in partnership with Indigenous peoples of Ontario. Over the last 10 years, the gains being made for Indigenous peoples in the areas of cancer care and care for chronic kidney disease have been dependent not just on engagement, but on a commitment to develop and implement a plan in partnership with First Nations, Inuit, Métis and urban Indigenous communities for the delivery of health care services that work for peoples in those communities. It is vital that the commitment made over the past 10 years to Indigenous peoples, a commitment made by Cancer Care Ontario, be assumed by Ontario Health as it begins to take on its work. The best way to protect that commitment is to embed it in the legislation by requiring that Ontario Health continue this partnership work with Indigenous peoples, and to specify how that partnership should work.

The second area is with respect to clinical and scientific leadership. Our recommendation is that Ontario Health be required to engage clinical and scientific leaders in the development of advice, the planning for health system priorities, and the design and evaluation of new programs of health care, and be accountable for the implementation of health system improvement initiatives.

Currently, the draft legislation states that Ontario Health cannot accept funds, other than from the crown, without approval from the Lieutenant Governor in Council. The gains made for cancer patients and for patients with chronic kidney disease have been critically dependent on Cancer Care Ontario's ability to engage, contract and employ scientists and clinical leaders, most of whom apply for grants and funding from other provincial, federal and international agencies for the purposes of scientific study. Ontario Health must be allowed to hold these funds, in order to attract and retain scientists and clinical leaders willing to engage in health system improvement.

Just one example of the importance of science is the work that was recently announced by this government to support a better understanding of disease and illness, including cancer, contracted in the workplace due to hazardous exposures. This research, and the implementation of new tools to track disease clusters, is being led by Cancer Care Ontario's Occupational Cancer Research Centre, led by Dr. Paul Demers. This work could simply not take place under the auspices of Ontario Health, as the draft legislation is currently written.

The third area—

The Chair (Mrs. Nina Tangri): You have one minute to conclude.

Mr. Michael Sherar: One minute, if I may—that we recommend be strengthened in the legislation is that of independent public reporting of progress against the plans for health system improvement.

The legislation should require that Ontario Health establish a quasi-independent council to oversee the reporting of the quality and efficiency of Ontario's health system. For practical purposes, given that the infrastructure for data collection and analysis will be within Ontario Health, the council should leverage this infrastructure. But in order to preserve its independence, the council should report through the board of Ontario Health, not through its management. The council should have the ability to post its reports publicly, after advising the Ontario Health board, the Ministry of Health and the government.

The gains that have been made for cancer patients in this province have been critically dependent on the existence of such a council, the Cancer Quality Council of Ontario. The terms of reference of the new council should include, where possible, the benchmarking of Ontario's health system against the best in the world, wherever that may be found in any area of care.

The Chair (Mrs. Nina Tangri): Thank you very much. I'm going to move to questions. I'll begin with the government side. Mrs. Martin.

Mrs. Robin Martin: Thank you very much, Mr. Sherar, for your presentation. As you know, the minister has indicated several times that it's the model of Cancer Care Ontario that we want to learn from. That comes partly out of the Select Committee on Mental Health and Addictions, which the minister participated in, along with Madame Gélinas. In that, they said that this is the kind of model we want to look to; we want to provide this kind of care across our health care system, to make sure we have that kind of connected care that Cancer Care Ontario can bring.

I thank you for your presentation and for giving us some advice. I would ask if we can get a copy of what you said, because I was trying to take notes but didn't catch everything.

Mr. Michael Sherar: Yes. I will leave my copy with the committee.

Mrs. Robin Martin: Thank you. One of the things you suggested was that we have a four- or five-year plan, renewing. I was just briefly trying to find the Cancer Care Act, under which Cancer Care Ontario is set up, and I didn't see that requirement in the act. Is it in the existing act?

Mr. Michael Sherar: It is not in the existing cancer act.

Mrs. Robin Martin: It's just a practice that you developed?

Mr. Michael Sherar: It's a practice. That's correct.

Mrs. Robin Martin: Okay. And when did they start doing that?

Mr. Michael Sherar: The first cancer plan came after the major change at Cancer Care Ontario which occurred in 2004. The first cancer plan went from 2005 to 2008 in its current form, and we have renewed it every three to four years since then. As I say, we're about to launch our fifth cancer plan.

Mrs. Robin Martin: Okay. But you think that would add something that this legislation could benefit from?

Mr. Michael Sherar: The recommendations that we are making are that embedding it in the legislation, a practice that we believe has been very helpful, will benefit Ontario Health, the Ministry of Health and the government in achieving their plans.

1410

Mrs. Robin Martin: You also listed a number of diseases that should have plans.

Mr. Michael Sherar: Yes.

Mrs. Robin Martin: I listened carefully. I guess I'd be worried—and I want to know what you think about this—that if you list some diseases, you will leave some out. For example, you didn't mention a sickle cell anemia plan—a smaller number of impacted, but obviously for those people it's an important thing. Are you concerned at all that if we have these eight plans or so that you set out, that will actually preclude attention being paid to some of the other areas?

Really, what we're focusing on is making sure that no patients, whatever their disease type, are going to fall through the cracks. We want to make sure there is care for all of them, whatever their needs are.

Mr. Michael Sherar: Yes. I appreciate the desire to make sure that care for all illness is of very high quality, but I also believe that there are major areas of care that require an identified focus. Cancer is one of them; renal care is another. I'm not saying that that particular list of eight is precisely the right list, but it's about that size in terms of the number of major areas of care that would, I believe, benefit from an identified focus within the legislation.

Mrs. Robin Martin: Okay. Thank you. Anybody else?

The Chair (Mrs. Nina Tangri): Mr. Anand.

Mr. Deepak Anand: Thank you so much for coming.

I was just reading—you said that only through working together can we create a sustainable health system for Ontarians. Just a quick question: How do you think a cancer patient would benefit from a system with greater integration? What are your thoughts on that?

Mr. Michael Sherar: The last little bit of my remarks, which I didn't get to but you'll see in the printed remarks, is that of course we're never satisfied with the system of care that we have, even for cancer patients. We want to continually improve it.

I do believe that there is opportunity in what will come, with respect to improvements in home care, improvements in primary care. That will be important for cancer patients and renal care patients. Cancer patients will benefit from better integration, as will all patients within the Ontario Health system.

Mr. Deepak Anand: Thanks so much.

The Chair (Mrs. Nina Tangri): Mr. Sabawy.

Mr. Sheref Sabawy: I have a quick question in regard to that area. You mentioned something—that currently you can't retain donations or external funding for research without the approval of the Attorney General.

Mr. Michael Sherar: That's correct.

Mr. Sheref Sabawy: And that's part of the current legislation?

Mr. Michael Sherar: That's part of the draft legislation.

The Chair (Mrs. Nina Tangri): One minute.

Mr. Sheref Sabawy: The new one, or—

Mr. Michael Sherar: Your draft legislation; that's correct. We're recommending that that be changed so that Ontario Health can receive research grants from federal or international agencies for scientists to carry on their work, and for that to be relatively easy for them to do.

The Chair (Mrs. Nina Tangri): Ms. Kusendova, very quickly.

Ms. Natalia Kusendova: Okay. I have a question regarding the fragmentation in our health care system. We've heard from patients around Ontario that the LHIN system is not working because, depending on the geographical area where they may be located, they don't have the same access to care. This was also mentioned today by MPP Mamakwa—that cancer patients in the north have much lower access to cancer treatment and care than GTA-centric patients. Do you have any thoughts on that?

Mr. Michael Sherar: Part of the work that we undertake in the context of the cancer plan is to provide as much care as we can, as close to home as possible. Some of that care just cannot be provided very close to home because of the complexity of the care that needs to be delivered. We have some services in the province that need to be delivered in our major cancer centres in the province, whether it's stem cell transplant or very complex surgeries. So we try to strike that balance of providing as much care as close to home as possible, but in some cases people have to travel for that care and in some cases that travel is quite a long distance, particularly for people in the north. We want to make that as easy as possible to achieve.

The Chair (Mrs. Nina Tangri): Thank you very much. I'm going to move to the opposition: Madame Gélinas.

M^me^ France Gélinas: Thank you for being here. It requires a bit of courage. I appreciate that.

When were you informed of the government's plan to dissolve Cancer Care Ontario?

Mr. Michael Sherar: I learned when the draft legislation was announced.

M^me^ France Gélinas: When we leaked the documents or when the legislation was tabled?

Mr. Michael Sherar: Both. I saw the leaked documents, as you did, when they were in the press, and then the announcement sometime later.

M^me^ France Gélinas: Were you ever consulted about the drafting of Bill 74?

Mr. Michael Sherar: No, I was not.

M^me^ France Gélinas: The government goes out of its way to lay praise on your agency, that the way that you work is why we have those outstanding results for cancer patients and that they want to expand this to other areas of care—mental health and addiction are often mentioned—but they've never come to you to say, "How do we do that"?

Mr. Michael Sherar: I was not involved or consulted in the drafting of the bill. That's correct.

M^me^ France Gélinas: Thank you. We know that your board is no longer. They received the email saying, "Thanks, but no thanks." Do you know what happened to CCO data assets and the data information that you own right now?

Mr. Michael Sherar: Cancer Care Ontario still exists as a corporation. We have a new board, which is, as you I'm sure are aware, the board that will be the board of Ontario Health and is going to act as the board for all of the existing legacy agencies. There has been no change with respect to the assets that we continue to hold, and we continue to do our work.

M^me^ France Gélinas: You've come in and made three suggestions that you think should be in the bill. The first one is to force, by legislation, a four-to-five-year plan. Why is it important that it be in legislation?

Mr. Michael Sherar: I think—

M^me^ France Gélinas: Sorry—and then you went on to say: specifically for cancer, renal, mental health etc.

Mr. Michael Sherar: Yes. Our experience is that these plans are vital. When we can demonstrate together that something is effective and works very well for our province and for the people of Ontario, I think the best way to ensure that that is carried on in the future is to put it in the legislation. I feel confident that in the experience that we've had with these plans, it meets the bar now of being embedded in legislation for the future, and I believe if it is, it will be incredibly helpful for our province.

M^me^ France Gélinas: Agreed. Recommendation number 3 is on reporting, so the reporting is the same. You put it in legislation that not only do you have to have a plan; you have to transparently report on that plan with benchmarks. Do you have any data that support that this is good practice?

Mr. Michael Sherar: We have had such a council in place, I think, since 2002. It's a very uncomfortable process sometimes each year when that council reports to the Cancer Care Ontario board with me and my team sitting there and the board asks us about the report of the council on the progress we've made—whether it's good progress, whether it's not as good progress as we might have expected—and that that be publicly available. I think it's an incredibly important tool in the accountability of us as public servants for what we are committing to on behalf of the people of Ontario.

It wasn't established at that time, just based on an idea here in Ontario. I believe it works in other jurisdictions and that there is good data that it has a positive effect on improvement in our health systems.

M^me^ France Gélinas: I know that the bill was only introduced three weeks ago. You haven't had much time to look into this, but other jurisdictions had a dedicated cancer care agency; they rolled it up into a super-agency. How did their cancer services fare?

Mr. Michael Sherar: I think Ontario has a very effective cancer care system.

The Chair (Mrs. Nina Tangri): You have one minute to conclude.

Mr. Michael Sherar: The recommendations that I'm making today are to ensure that we sustain that leadership.

I believe it's something that we can be proud of internationally. The intent of my recommendations is to make sure that the quality of our cancer care system and the other areas that I mentioned cannot only be protected, but can be actually strengthened.

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M^me^ France Gélinas: And you would like to see the linkages and partnership with Indigenous people in the bill also?

Mr. Michael Sherar: Again, I think, based on our experience over the past 10 years, we've had terrific leadership from Alethea Kewayosh, an Indigenous leader in Ontario, to help with our partnership with Indigenous peoples. Again, I think her leadership and the things that we have seen meets the bar of understanding the things that work for this province and for the people of Ontario, and that it is time that get embedded in legislation and that it can be incredibly helpful.

The Chair (Mrs. Nina Tangri): Thank you very much for coming out and presenting to us today.

Mr. Michael Sherar: Thank you.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION

The Chair (Mrs. Nina Tangri): I'd like to call upon the Ontario Public Service Employees Union. If you can please introduce yourself for the record, you have eight minutes to present, followed by up to six minutes from each of the recognized parties. Go ahead.

Mr. Smokey Thomas: I'm Smokey Thomas. With me today is Clarke Eaton.

I'm here on behalf of the 155,000 front-line public service workers and the 50,000 health sector workers represented by OPSEU to say this to you: Repeal Bill 74.

This legislation is deeply flawed and highly dangerous. In its current form, Bill 74 does absolutely nothing to improve or expand the delivery of public health care. Our public system has been starved for a quarter century, and Ontario now spends less than any other province on health care. We're dead last, and that's not something to be proud of.

This government should focus on investing in our public system and in front-line public health care services, not taking another kick at the costly restructuring can. Our members know what restructuring really means is huge costs, less services and more privatization. With Bill 74, there are no new services, beds or staff positions being created despite the growing need in our communities. This is a make-work project and an absolute waste of taxpayer dollars.

But before I continue, I'd like to raise serious concerns about this entire legislative process. When Mike Harris wanted to overhaul the health system, at least he formed a commission. This time around, we found out about the government's plan through leaked documents and then this scrambled-together piece of legislation, which is full of gaps and uncertainty. Too many important details are purposely left out of the legislation, to be decided later on through regulation.

But public health care is the public service that matters most to Ontarians, and we, the people, deserve a meaningful voice in the decision-making process. Instead, this government provided less than 24 hours' notice of these committee hearings and less than one week for stakeholders to prepare these presentations and submissions in response to a massive omnibus bill. These hearings will only take place over two days, for a total of eight hours, and only in Toronto.

Does this government not think that health care matters to Ontarians in every other part of the province—in rural and northern Ontario? You've capped the total number of presentations to 30, which means that 98% of the people who wanted to appear weren't allowed. This is shameful. For a government that claims to be for the people, it sure doesn't like listening to them.

Before the legislation has passed and before you've even heard these public presentations, the new health care super-agency's board of directors has already been selected, vetted and hired—and quite the selection of members, I might add: a team of PC Party contributors and elites who stand to make a killing off of private health care services. Who knows how much these board members will make and who knows how much this entire restructuring scheme is set to cost us taxpayers? We haven't been informed.

We only need to look at this week's rollout of cannabis sales in private stores to know this government needs to be kept on a tight leash in messing with our health care. The cannabis file is a mess. Ford has only opened a fraction of the stores he said he would. The criminal element probably isn't losing sleep over competition from the Ford Conservatives and they probably feel this is the gang that can't shoot straight.

Since Ford has botched cannabis so badly, do we really trust him to be playing around with something as critical as health care? I don't think so.

OPSEU members know what's really going on. We know that this legislation isn't an investment in patients; it's an investment in privatization, plain and simple. It's time for the Ford government to abandon this dangerous plan and focus on investing in front-line public health care services. This is an exercise in erasing the Liberal legacy and bringing in a Conservative-made scheme. But health care shouldn't be about politicians' egos; it should be about providing excellent patient care.

The Ford government says Bill 74 is about improving integration and coordination, but that's already the mandate of Ontario's 14 regional LHINs. They aren't perfect and there's definitely room for improvement, but creating more than 50 new bureaucracies or mini-LHINs with shiny new names doesn't save money, it doesn't free up resources for front-line health care and it doesn't improve the delivery of public health care.

Centralizing power into the super-agency doesn't fix the LHINs; it only makes the biggest problem worse. There is still a lack of accountability to the local patients and communities they serve. The board of Ontario Health should be democratically elected, not stacked with Ford's

political appointees whose mandate is to do the bidding of the Minister of Health and not actually plan to meet population need.

Bill 74 will mean more bureaucracy and even less accountability to the public. This top-down, heavy-handed approach, which gives the minister and super-agency far too much power to order integrations and amalgamations, will only serve the purpose of facilitating more cuts and costly privatization schemes. Privatization is already costing us too much. It's the pay more, get less plan.

Ontarians don't agree with it either. We're proud of our public health care system and believe that services should be publicly funded, managed and delivered by public and not-for-profit organizations. Recently, Minister Elliott made the comment that this legislation isn't privatization because patients would still use their OHIP card. That is a very misleading and troubling thing to say.

Public health care isn't just a funding formula, and we shouldn't be handing off public dollars to for-profit providers. Ontarians expect better than that. They expect quality management and delivery of health care services, too. But when private companies deliver health care, quality suffers because they cut corners to increase their profits. Our taxpayers' dollars are paying for duplicate administrations. Each private company has its own tiers of bureaucracy, including high-paid CEOs and senior management, and we're stuck paying for their profit margins. It's a lose-lose: higher costs and lower quality services.

We also know from years of research, including many reports from the Ontario Health Coalition, that private, for-profit health care providers are notorious for charging patients out-of-pocket user fees and illegally double-billing both OHIP and patients. They're making profits off the backs of the sick and often elderly. We don't see that in the public system because the profit motive doesn't exist there.

Saying that Ontarians will still just "use their OHIP card" shows a pretty shallow understanding of public health care and the implications of privatization. Ontarians expect and deserve better than that. OPSEU's submission highlights several key concerns and recommendations so I won't go through all of them here.

For the sake of the short time I've got, I'll say this: Leave our health care system alone and focus on overhauling this legislation. Most importantly, overhaul part IV on integration. This section must be amended to ensure that no integrations result in the closure or reduction of any public or non-profit service, provider or hospital.

No integrations should result in the transfer, merger or amalgamation of a public, non-profit provider or system to a for-profit provider or system—

The Chair (Mrs. Nina Tangri): You have one minute.

Mr. Smokey Thomas: —and all integration decisions must be subject to a meaningful appeals process.

Lastly, quality health care depends on respect for front-line workers, and that means respect for the collective bargaining process.

With that, I'd just say that the future of health care should not be decided on the back of a napkin. Thank you very much.

The Chair (Mrs. Nina Tangri): Thank you. I'll begin with Ms. Armstrong.

Ms. Teresa J. Armstrong: Thank you very much for your presentation. Also, I want to extend the gratitude that we have for front-line health care workers and the work they do in our health care system.

We've been going through the presentations yesterday and today and it's no surprise we've been asking the presenters if they've been consulted on Bill 74. We've seen a consistent pattern, and we're not sure exactly who has and who hasn't been consulted. I'm just wondering whether or not your members were consulted on this draft before the Bill 74 was drafted?

Mr. Smokey Thomas: No, we wouldn't have known about it if we hadn't read the leaks in the press.

Ms. Teresa J. Armstrong: And why do you think that is, that they wouldn't want to consult with members who actually do the front-line care work?

Mr. Smokey Thomas: Well, I think a guy named Dean French just wants to do what he wants to do. They took a lot of attention away from the autism file which they totally screwed up. I think it was a deflection. When you read the bill, the way it's put together, it's pretty clear that somebody cobbled it together on very short notice.

Ms. Teresa J. Armstrong: Warren, can you tell us whether your members are impacted by the 20 crown health agencies that are being dissolved, and if so, if they've been informed about the process and whether their jobs will exist? Have they been impacted by the dissolving of those 20 crown agencies, and are there going to be job losses at that—

Mr. Smokey Thomas: Well, we represent a lot of workers in the LHINs and they don't know what their future holds. There is no labour relations plan. The employers don't even know what to say. So, yes, there are a lot of people in limbo. We want to assert our rights if they transfer the business so that the workers go with their collective agreement, but all that appears to be up in the air. So, no, I don't fault the LHIN management for this. They just don't know what to say or what to do.

1430

Ms. Teresa J. Armstrong: Is anyone asking for those answers from the government, so that the workers can understand what's in store for them with this bill passing?

Mr. Smokey Thomas: I wish they would, but no. We don't get consulted on anything. I read it in the press—or hear from the NDP, actually.

Ms. Teresa J. Armstrong: Based on your expertise, what are the problems with Bill 74? I know you've highlighted some of them and you talked about—that you weren't going into detail. But if you can maybe bring one of those sections out that you feel is a problem, and what you think is going to happen if it isn't fixed.

Mr. Smokey Thomas: I think the biggest—

Ms. Teresa J. Armstrong: You mentioned part IV—sorry.

Mr. Smokey Thomas: I'm not sure, but if I could just say this: The real problem is the unfettered power that's invested in the Minister of Health and the new health

board. It starts there. If somebody has undemocratic, unfettered power, they can order anything they want and people have to comply. I thought the Liberals were bad for going down that road, and I warned them at the time that it was a dangerous road to go down. They went down it anyway, and now these folks over here are going to take it to a whole new level.

Frankly, I think there could be some charter challenges in there and everything else. This fight is just beginning; it's far from over.

Ms. Teresa J. Armstrong: Would it be a fair assessment that we're going from bad to worse?

Mr. Smokey Thomas: We're going from bad to jumping into the deep end of the pool without looking to see if there's any water. And guess what? There ain't no water in the pool. Yes, it's horrible. At least when Mike Harris did it, they went around the province and heard from people.

I know Duncan Sinclair; I know him well. They didn't do what he said. He actually wrote a letter to the editor—only the Whig-Standard ever published it—denouncing everything the Tories at the time were doing, and he got paid $1 for it. Now it's all very high-priced—people are going to be on boards and everything else. Duncan's heart was in the right place, and I think maybe Mike Harris's was too, in a strange kind of way. But these folks are—I just fear more privatization.

We've proven that it's the "pay more, get less" plan. It's misleading for the minister to say, "Well, you'll still use your OHIP card." Yes, but the taxpayers, when you pay your taxes, are going to pay out the profit—private labs cost the taxpayers 40% more, by the government's own admission, than public labs.

It is, I guess—just to say a disaster in the making would be an understatement.

Ms. Teresa J. Armstrong: The fact that front-line workers, your members, weren't consulted—what does that feel like to them? What have they expressed—that they weren't part of this drafting, or at least heard what their challenges are in the workplace, and how they can make things better.

Mr. Smokey Thomas: They feel totally disrespected, and with good cause. But it's the way this government treats all workers who work in the public sector, whether in the Ontario public service transfer payment agencies or anywhere. They treat everybody with total disregard. Doug Ford's claim that he's for the little people is arrogant in the extreme, because they're not little people; we're all equal, right? And those folks on the front lines know how to make the service work. They know how to make it better, but nobody asks them or listens to them.

The Chair (Mrs. Nina Tangri): One minute.

Ms. Teresa J. Armstrong: If you could give me your thoughts on whether you think this is an underfunding problem or a capacity problem or a policy legislation issue, as opposed to underfunding. What do you think on that?

Mr. Smokey Thomas: Ontario spends the least amount of any province on health care, so there needs to be an actual, real infusion of real money, but into front-line services, right? If they would simply take the private sector back into the public sector, think about the savings; they're enormous.

Hospitals should be hubs for care. So in the north, a hospital out of Thunder Bay could operate the clinics elsewhere. They would all be not-for-profit, and you could provide really good service.

Ms. Teresa J. Armstrong: Great. Thank you very much.

Mr. Smokey Thomas: Thank you.

The Chair (Mrs. Nina Tangri): The government side: Who would like to speak first? Ms. Kusendova.

Ms. Natalia Kusendova: Thank you, Mr. Thomas, for your presentation today.

Just for your benefit, I wanted to state that I'm a registered nurse and I worked, day in and day out, alongside members of the organization you represent when I was working as a registered nurse in the emergency room. The members that you represent bring great value to our health care system. Nurses, doctors and other health practitioners couldn't do their work if it wasn't for the contributions of your members. So on behalf of this government, we thank each and every one of them for the hard work that they do each and every day for our patients in Ontario.

I was listening intently to your presentation. You mentioned that Ontario now spends less than any province on health care, but what you failed to mention is that it's per capita spending. With Ontario being the largest province in Canada, it's quite normal that we spend the least amount per capita.

But did you know that health care funding is our number one spending in Ontario, and that 42 cents for every single taxpayer dollar that is spent in Ontario is spent on health care? Yes or no: Did you know that?

Mr. Smokey Thomas: Thank you for your questions. I'm an RPN by trade. I worked in mental health for my whole life, so I understand a little bit about health care too.

Your point that on a per capita basis—but just think about this: What if you took the privatization out of health care, and brought that 40% profit margin that private labs are making back into the system? What if you got rid of all of those private clinics and brought it back into the not-for-profit system? You could actually have—

Ms. Natalia Kusendova: Mr. Thomas, what we're doing with this legislation is, we're investing into our publicly funded health care system. With the 14 LHINs, what we've heard over and over during our campaign—I've knocked on thousands of doors, and health care is something that resonates with each and every person. Everyone has a health care story. I'm sure that you experienced that, as an RPN having to take care of patients in a hallway.

A hallway is not a place of healing, and it definitely is not a place of work. What we've heard over and over from health professionals such as yourself, and from patients and families across Ontario, is that the LHIN system is not working. What we're trying to do with this health care transformation, and with Bill 74, is to centre the care

around the patient and not around the bricks and mortar where the patient actually happens to be.

By having all of these agencies go into one agency—it's not a super-agency; it will only have one CEO and only one board, instead of 20 boards—it's actually to take the money that we find there and invest in front-line care, including in members of your organization. So why are you not in support of investing more money into the front lines?

Mr. Smokey Thomas: Because I don't trust you.

Interjections.

Mr. Smokey Thomas: No, let me answer the question. You asked me a question.

I don't trust you. To me, this is just about undoing anything Liberal. Your government, two days in, killed the—

Ms. Natalia Kusendova: Mr. Thomas, did you know that the Liberals did not invest in one single long-term-care bed in 15 years? This is why, in our current health care system, we have 32,000 patients waiting for a long-term-care bed, creating a very dangerous domino effect where we have patients waiting in our emergency rooms because the beds that they should be occupying are occupied by patients who should be in a long-term-care bed. These are alternate-level-of-care patients.

We have 1,000 patients in Ontario, every single day, being treated in a hallway or in a closet or in a washroom. Do you think that's appropriate?

Mr. Smokey Thomas: Do you lecture everybody who comes here? You must have been a charge nurse. Were you?

Ms. Natalia Kusendova: I'm actually very passionate about health care, and it's the reason why I got involved in politics.

Mr. Smokey Thomas: Do you know what? You're right that the Liberals didn't invest. But there's nothing in there—and you read our submission. There's nothing in there that says you're going to invest in the front lines. So, I'm sorry; I just don't trust you. The people of Ontario don't trust you.

Ms. Natalia Kusendova: Have you heard our announcement that we have already introduced 7,000 long-term-care beds within the last nine months that we've been in power?

Mr. Smokey Thomas: Are they not-for-profit or for-profit?

Ms. Natalia Kusendova: Long-term-care beds are not-for-profit beds.

Mr. Smokey Thomas: They are not-for-profit?

M^me^ France Gélinas: No.

Interjections.

The Chair (Mrs. Nina Tangri): I'm going to interrupt. I'm going to ask for order, please.

Ms. Kusendova, if you ask a question, please allow the presenter to answer the question. Thank you.

Ms. Natalia Kusendova: Thank you, Chair.

Mr. Smokey Thomas: I don't know how to answer a lecture. I thought I was coming here to lecture you.

But I'd just say this: It's a flat piece of legislation, because it's non-inclusive, it's not clear and it's not rational. When the Minister of Health says, "Oh, it's not privatization if you get to use your health care card," that's misleading, because in those private clinics, you still use your health card, but they're for-profit.

The last Minister of Health under the Liberals, Hoskins, actually admitted that private labs cost 40% more than public, like in the hospitals. He actually admitted that all of the clinics that are making a profit cost OHIP more than they would if they were delivered in not-for-profit hospitals or not-for-profit clinics.

I'm a big advocate of public services for people, not profit. If you come out over the next year or two years and it's all in the not-for-profit world, I'll be the first one to stand up and say, "Good job." Ask any Liberal, because on occasion, I did give them credit for doing a good job. But if you're not going to do a good job, we'll be here to criticize you.

1440

The Chair (Mrs. Nina Tangri): Mr. Anand, there are 40 seconds remaining, so please be quick.

Mr. Deepak Anand: Thank you so much, Mr. Thomas. Thanks for coming.

I read that you're saying that Ontarians need quality management and delivery of health care services. You did mention that we should put the priorities of patients first, and that's exactly what the bill is actually talking about. Why do you think the patient will not benefit from integration?

Mr. Smokey Thomas: Because it depends on how you do it. You can gerrymander the management system all you want; you're still going to have way too many bosses and not enough front-line workers. Your government said they're going to get rid of all these managers. Well, guess what? They're not getting rid of all the managers. In fact, in your system, what you're going to have to watch for is that you don't actually end up creating more bureaucratic positions, because each one of those subs—

The Chair (Mrs. Nina Tangri): Mr. Thomas, thank you for coming out to present today. We need to move on to our next presenter.

ALLIANCE FOR HEALTHIER COMMUNITIES

The Chair (Mrs. Nina Tangri): I'd like to call the Alliance for Healthier Communities to please join us. Please introduce yourself for the record. You have eight minutes to present, followed by six minutes from each of the recognized parties. Go ahead.

Dr. Kate Mulligan: Good afternoon, everyone. Thank you for having us here today. I'm here on behalf of the Alliance for Healthier Communities. My name is Kate Mulligan. I'm the director of policy and communications. We are Ontario's leading community health care providers—more than 100 community-governed family health teams, nurse practitioner-led clinics, Aboriginal health access centres and community health centres. Many of you have one of these vital centres in your own backyard. You know the vital role we play in providing seamless,

coordinated, integrated care with our local partners for Ontario's most medically and socially vulnerable people, through a focus on community.

We welcome the promise of person-centred, integrated and local health care. The written submission before you sets out the specific amendments we're proposing to strengthen the ability of The People's Health Care Act to deliver on this promise—things like making sure the bill includes specific and meaningful definitions of health and health promotion, and specific accountabilities for the better health outcomes for diverse communities that are alluded to in the preamble but not borne out in the actual bill.

What we have learned from over 40 years of doing this important work in the community is that if you do not spell out specific accountabilities for health equity, health promotion and primary health care, and a role for community, it will not happen. The system is just not designed to foreground this important work all on its own—at least, not yet.

The evidence shows that a failure to address preventable poor health outcomes is a colossal waste of money, time and human potential. The Auditor General points out that just four modifiable risk factors for chronic diseases—physical inactivity, smoking, unhealthy eating and excessive alcohol consumption—cost Ontario almost $90 billion in health care costs between 2004 and 2013. Failure to address disparities in those poor health outcomes further destabilizes societies and pulls everyone's health and well-being downward.

Fortunately, the fixes are quite simple, and this bill presents one of the best opportunities we've got to make it happen. So I'm going to address three very specific points of accountability that require all partners to come together to address diverse health needs and prevent avoidable social and economic costs.

First, we need specific accountabilities for health promotion and prevention. In other jurisdictions, these are considered core functions of a modern health system. It's way past time for Ontario to catch up. Why? Because you can't fix hallway health care by focusing all your attention on the back door of the hospital. People will keep coming in the front door. This bill is an opportunity to focus on that front door and the hard work of those whose mission it is to keep people healthy, at home and connected to their communities. Without this very specific accountability for the work of health promotion and primary health care in communities for both Ontario health teams and the Ontario Health agency in this bill, it will not happen. We are already seeing this in real time. Most of the attention with the minister's health care tour, for example, after the announcement of this bill, has been focused on partnerships that move those alternate-level-of-care patients out of the hospital, rather than any examples that help prevent patients from going into the hospital.

Second, we need primary care on the team and, in many cases, leading the team. Family doctors, nurse practitioners and community-based teams are not only most people's first point of contact with the health care system; they're also those who are in it for life. Primary care is the long-term relationship between the health system and people in their communities. That's why primary care is the natural home for care coordination for that episodic and sometimes longer-term care that people will need at other points in their lives. That's why primary care is a critical partner for anything that's meant to be truly seamless and person-centred.

The evidence from other jurisdictions shows that Ontario health teams, if they don't include primary care, are much less likely to succeed. So to make this happen, this bill needs two things: (1) an explicit commitment to move the LHIN and former CCAC care coordinators into primary care, with full scopes, where they can best serve this bill's aim of seamless and coordinated care; and (2) an explicit commitment to include primary care, plus at least two other partners, as a mandated and not optional partner on Ontario health teams.

Finally, we need smart collective goals for specific outcomes for diverse communities. We're pleased to see the recognition in the preamble to this bill that Ontario communities are really diverse in geography, in social life and in the health services and providers that are available to people. The evidence is clear: Some people in Ontario are much more likely to face poor access to health care and poor health outcomes. Indigenous people, Francophones, Black communities, rainbow or LGBTQ+ communities, remote and northern communities, newcomers—each needs a specific local strategy to ensure healthy outcomes and access. This bill is a huge opportunity to change that and to ensure that accountability for race-based and socio-demographic data collection is part of routine reporting aimed at quality improvement. We already do this successfully, but not universally, for example, through the We Ask Because We Care initiative happening here in Toronto.

To strengthen this bill we need these very specific accountabilities to be built in. It's not too late to require a focus on the front door through health promotion and prevention. It's not too late to focus on people's whole lives through care coordination and the work of primary care. And it's not too late to focus on smart collective goals for Ontario's diverse people and diverse populations.

The Chair (Mrs. Nina Tangri): Thank you very much. I'll begin with the government side. Mrs. Martin.

Mrs. Robin Martin: Thank you very much for coming today, for your presentation and for all of the good work that you're doing in the community.

As you know, with these Ontario health teams, the idea is to have more local groups that bring together some health providers. They can start with any combination of a list that is mentioned in the legislation, but the team is supposed to reach out and provide all care for the community, and that's sort of the model. They have to start somewhere and build up. So it may not be full to begin with, but the idea is that it will build up to be a full coverage of things like chronic disease, which I think you mentioned, and which are the kinds of conditions that are not well addressed by our current system.

Do you see any—I think you sort of said this as I was trying to listen—potential within this legislation to address those kinds of things that have not been addressed well in the past?

Dr. Kate Mulligan: The potential is there with specific accountabilities built in. I think right now, for example, primary care is just listed as one of many potential partners and reference to health prevention and promotion is negligible in the bill. I think it needs to be foregrounded, otherwise the biggest organization in town has the potential to really try to bring everybody else on board with their current agenda and try to lead things, and that is not going to move the dial for things like promotion, prevention and equity.

Mrs. Robin Martin: Okay. Well, I'm glad you mentioned accountability, because one of the issues in the Ministry of Health—my colleague Effie Triantafilopoulos and myself are both parliamentary assistants to the minister. One of the things that we are advised by a lot of the civil servants working there is that the government never has had, does not have, a very clear line of sight into what it's buying, effectively, with taxpayer dollars. It doesn't have those accountability agreements so that it knows that we got these outcomes. One of the things we're looking at is strengthening that kind of accountability to make sure that we get the services that we're paying with taxpayer dollars for.

Can you make any suggestions in that regard how we could beef up accountability?

Dr. Kate Mulligan: Community health centres, for example, have had very, very detailed accountability agreements with the LHINs for a number of years. That's not true for all primary care organizations, but it is true for community health centres.

We have struggled to have things like health equity, health promotion and prevention included in those accountability agreements partly because that work doesn't happen in every organization. So I agree that it's important. I think that those accountabilities do help to shape the goals that organizations set for themselves and that teams would set for themselves, but, again, if it is not mandated, if it is not explicit, it will not happen. And if it's not led by primary care or a comprehensive organization that knows how to do this, and knows how to do this in conversation with community, it will not happen.

1450

Mrs. Robin Martin: Thank you.

The Chair (Mrs. Nina Tangri): Mrs. Karahalios.

Mrs. Belinda Karahalios: Thank you for coming today.

Health equity and the promotion of equitable health outcomes is a cornerstone of our health care system, and is captured implicitly throughout the proposed legislation. For example, it is implied in Ontario Health's object to manage health service needs across Ontario, and to ensure the quality and sustainability of the Ontario health system.

Ontario Health's objects, as set out in the proposed legislation, include implementing the health system strategies developed by the ministry, and managing health service needs across Ontario consistent with the ministry's health system strategies to ensure the quality and sustainability of the Ontario health system.

Equity is a core dimension of quality in our public health system, and it will be important in achieving sustainability.

My question is if you could provide examples of the types of barriers that individuals and communities that you serve are facing in the current health system, and how more integration would be beneficial for those you serve.

Dr. Kate Mulligan: Yes. Once again, I want to reiterate that having something implicit in the bill is not the same thing as having specific accountabilities. What may appear to be implicit to you will not be evident or apparent to others in the health system, particularly those who want to continue business as usual. I know that that point has been made, but I will continue to reiterate it.

With respect to examples, our work on the collection of sociodemographic data has helped us to create very hyper-local and even personalized approaches to quality improvement. By way of example, the Women's Health in Women's Hands community health centre here in downtown Toronto has a focus on women, and on racialized and marginalized women in particular. By focusing in great detail on parsing the data that they received about who was using their services, they were able to determine that there was a high need for services for women who were HIV-positive.

The Chair (Mrs. Nina Tangri): One minute.

Dr. Kate Mulligan: That would not have happened if we had not done a great deal of work to think through the data. The apparent rate across their service catchment area was very low, but when you start looking at intersectionality, looking at very specific populations where we think there might be vulnerabilities, with that hyper-targeting you are able to identify areas in which you need those very, very targeted programs and services.

Mrs. Belinda Karahalios: Thank you.

The Chair (Mrs. Nina Tangri): Mr. Mamakwa.

Mr. Sol Mamakwa: Kate, thank you for your presentation. Thank you for bringing the voice of community-governed primary health care.

My name is Sol Mamakwa. I'm the MPP for Kiiwetinoong riding, the most northerly riding in Ontario.

Certainly, health has always been my passion in the last few years. I've seen the stories, the truth-telling stories, of our people where they fall into that jurisdictional black hole of services that impact the lives of our people, the health of our people.

When we talk about equity, when we talk about equality, and when we talk about health promotion—as an example, what you talk about—those types of things do not exist, just because of that jurisdictional ambiguity that exists within the system.

I've only been here nine months or so. It's really difficult to get this government to respond to the needs of the people on-reserve. Just because we're on-reserve, because we are First Nations, it seems that the systems that are there—that we do not matter.

You spoke about some of the strategies for Indigenous people, and also specific strategies with respect to northern First Nations as well.

But I'll start out with a question: Did you have an opportunity—was there any consultation with respect to the drafting of Bill 74?

Dr. Kate Mulligan: No.

Mr. Sol Mamakwa: As you know also, Bill 74 doesn't include any information on health promotion and even health equity. I know that your organization has proposed amendments on health promotion and health equity. Can you further explain what the risks would be for Ontarians if these amendments are not incorporated into Bill 74?

Dr. Kate Mulligan: Yes. I want to make it clear that this is a revocation of some existing objects under current legislation. LHSIA, the Local Health System Integration Act, did include specific objects for health integration organizations to foreground health equity and health promotion. So it would be a loss for Ontario to lose those specific targets.

With respect to Indigenous communities, I look to the work of our sister organization, the Indigenous Primary Health Care Council, whose members are also members of the alliance but with whom we work in as allies. Placing Indigenous health in Indigenous hands is the way forward to really address the many long years of colonialism and the legacy that people continue to deal with as individuals, as communities and as regions. It's vital to get this right: not just to put it in the preamble, but to ensure that cultural safety, anti-oppression and related practices are made explicit in this bill.

Mr. Sol Mamakwa: Thank you for bringing up those issues. With respect to the colonial system, I know, working under the system itself, the system is not in fact broken, but it's exactly working the way it's designed to, which is to take away the rights of our people to their land and resources.

I'm wondering: Is there anything in the organizations that you work with respect to cultural safety training? Is there any work that's done with your organizations?

Dr. Kate Mulligan: Yes. The Southwest Ontario Aboriginal Health Access Centre leads the Indigenous cultural safety program for Ontario. They're one of our members. For those of you who are not aware, this is training around the legacy of colonialism and the impacts on current practices in health care for Indigenous people.

Mr. Sol Mamakwa: Can you tell us more about team-based primary health care, such as the different types of health care providers involved in the role of community health centres in rural and northern areas of Ontario?

Dr. Kate Mulligan: In some communities, we are the only health care option available, so for many years we have taken a very holistic approach to what is considered "health" and have taken a team-based approach. Our physicians are on salary, for example, and are regular members of health care teams. We include health promotion and community development work as part of the regular work of the centre.

We have two really important innovations that I think speak to the potential of this bill to help further integrate with the rest of the province and with areas that don't currently have community health centres or similar organizations. One is called TeamCare, and it's a way to connect people to a health care team whose family physician does not have access to a full health care team.

The Chair (Mrs. Nina Tangri): You have one minute.

Dr. Kate Mulligan: It's a way of organizing this very, very big group of physicians who otherwise lack access to those teams. So there's a lot of potential. We have over 30 communities participating right now and hundreds of physicians and, by extension, thousands of patients who are benefiting from this. Then, the related approach is social prescribing, which further connects people to social and community supports in their communities.

M^me^ France Gélinas: Have you been able to connect with the government in having one of your members be a lead in one of those new teams, where we would have a community health centre rather than a hospital or extended care?

Dr. Kate Mulligan: Community health centres are very well positioned to lead these teams. They have a long history of partnership and integration with many other health care organizations as well as social service organizations as well as communities themselves. They're community-governed in the true sense that clients and everyday people are on the boards of these organizations. We continue to work to try to bring these models forward and continue to invite the minister to visit some of these models. We continue to try to keep putting that forward.

The Chair (Mrs. Nina Tangri): Thank you very much for coming out and presenting to us today.

Dr. Kate Mulligan: Thank you.

The Chair (Mrs. Nina Tangri): I'd just like to remind the committee members: When you wish to speak, let me know so that I can recognize you for Hansard.

M^me^ France Gélinas: Okay. Thank you.

SAVE YOUR SKIN FOUNDATION
RETHINK BREAST CANCER

The Chair (Mrs. Nina Tangri): I'd like to call on Save Your Skin Foundation.

If you can please introduce yourself for the record, you have eight minutes to present, followed by six minutes from each of the recognized parties. Go ahead.

Ms. Louise Binder: My name is Louise Binder and I'm the health policy consultant for Save Your Skin Foundation, which is a national patient-driven organization serving people with melanoma and other skin cancers, of which I am one.

On behalf of Save Your Skin Foundation and the other patient organizations that have endorsed our deputation today, we sincerely thank you, Madam Chair and members of the social policy committee, for inviting us to present today regarding Bill 74 in relation to oncology.

I'm honoured to introduce MJ DeCoteau. She's the founder and executive director of Rethink Breast Cancer, a national organization representing young women concerned about and diagnosed with breast cancer. After

her presentation, we're both available to answer your questions and for discussion.

1500

Ms. MJ DeCoteau: Thank you. As Louise said, I'm M.J. This deputation has been endorsed by a number of cancer groups, including Lymphoma Canada, Colorectal Cancer Canada, Save Your Skin Foundation, Lung Cancer Canada, Rethink Breast Cancer, Ovarian Cancer Canada, Canadian Cancer Survivor Network, BioCanRx, the GIST Sarcoma Life Raft Canada Group, and Myeloma Canada.

As you may be aware, there are approximately one million cancer survivors across Canada, close to 40% of whom live in Ontario. Our organizations directly represent the issues of more than 200,000 cancer patients, of whom more than 75,000 live in Ontario, as well as their formal and informal caregivers, and 200 researchers.

We agree with the need to end hallway medicine. We agree that we need seamless patient care across the continuum. We agree that in order to achieve these goals, we need to find efficiencies, and avoid duplication and unnecessary spending within the current health care system in Ontario.

The current management of cancer in Ontario, under Cancer Care Ontario, although not perfect, is one of the best in the world. It has achieved many accomplishments that have improved patient outcomes, including expanding our Ontario Breast Screening Program to approximately 34,000 women in Ontario, aged 30 to 69, who are at high risk for breast cancer because of genetics or a personal or family history.

I am one of those women. Being in the program since its inception in 2011 identified that my risk of breast cancer was increasing significantly, from 30% to 55%, over that seven-year period. As a result, I had the information I needed to make the decision to have risk-reducing prophylactic bilateral mastectomies, which reduced my risk dramatically, to less than 5%.

CCO also facilitated early and accurate diagnosis by expanding the work on cancer staging and pathology. This was a CCO-led, multi-year Ontario project that has substantially improved the quality and completeness of cancer pathology and staging data.

It has also ensured that cancer patients have equitable access to treatment, regardless of where they live in Ontario, through the development or expansion of major cancer treatment facilities in Barrie, Kingston and St. Catharines-Niagara, and the upgrading of radiation equipment at nine regional cancer centres.

It has launched the lung cancer diagnosis pathway, the first in a series of pathway maps for lung, colorectal, breast and prostate cancers. Developed using evidence from local, national and international clinical practice guidelines to improve the quality of care, processes and the patient experience for a given type of cancer, these maps are essentially evidence-based flow charts that provide a high-level overview of the care that a cancer patient in Ontario should receive.

Recently, Cancer Care Ontario's ability to collect patient-reported experience measures improved significantly. Patients are systematically able to report on their experience in real time using an electronic survey tool called Your Voice Matters in regional cancer centres across Ontario. Real-time, linked patient experience data is made available to the regions to inform quality improvement.

Cancer Care Ontario supports patients through their entire cancer journey, and is linked to the best practices in the world. Additionally, the data it collects and manages are used to improve patient experiences and outcomes.

In 2018, 90,483 people living in Ontario were expected to be diagnosed with cancer. It is an increasingly urgent public health issue, with the number of people expected to get a cancer diagnosis rising from one in four to one in two.

We are here today to request that the substance of Cancer Care Ontario's mandate and role as the government's adviser on, and the provincial driver of, prevention, screening and delivery of care for cancer not be diluted by inclusion with a large number of very different health systems organizations under one large umbrella.

Cancer is complex, and the treatment and management of cancer are undergoing major changes because of breakthrough innovations. Cancer requires dedicated expertise, knowledge and skills, and therefore a distinct place in Ontario's health care system. New developments in cancer therapies, such as immuno-oncology, genetic-related therapies and chimeric antigen receptor therapies, or CAR-T, are complicated but exciting.

In addition, the development of algorithms for treatment sequencing are being undertaken by pan-Canadian health technology assessment agencies. This requires current oncology-specific and specialized knowledge, training and skills, and also skills specific to each type, subtype and stage of cancer.

These new treatments will continue to evolve, and further information will create new treatment paradigms that will shift over time as research and real-world evidence becomes available.

This comprehensive approach to cancer care and treatment has made a profound difference in the lives of thousands of Ontarians and their families. Natalie's story is one such example.

Natalie Richardson, 43, from Meaford, Ontario, says, "I was diagnosed in April 2014 with stage 3 nodular melanoma. I was told I would not see my children finish high school, as I had no more than six years to live. I was referred within a week to Sunnybrook cancer centre. I was put into a clinical trial for ipilimumab"—it's very complex—"a novel immunotherapy treatment. This trial was sponsored by Cancer Care Ontario, the only cancer agency across Canada to support this trial. The experts at CCO had the expertise and experience to recognize and understand the potential of using this treatment in an adjuvant setting. CCO was willing to go the extra mile to save my life. The trial lasted 13 months and at the end, I was told my cancer was totally in remission, with no evidence of disease."

The Chair (Mrs. Nina Tangri): One minute to go, please.

Ms. MJ DeCoteau: "I am followed every six months with a CT scan as part of the follow-up to the trial and to this day I remain healthy. It sure looks like I will see my children not only finish high school but also enter the next chapter of their lives."

We respectfully submit that the Ontario government protects and defends the world-class status that CCO has garnered, deservedly, while continuously improving the delivery of services and outcomes from this agency. In our submission, because of the complexity of the issue and the profound importance to the health and lives of the estimated 362,577 people in Ontario living with cancer, and their loved ones, the legislation should provide an exemption from immediate implementation for CCO under the super-health agency, to allow further study.

We offer our ongoing support and advice, in collaboration with other knowledgeable stakeholders, to develop management approaches to optimizing cancer care and outcomes for the people of Ontario, along the continuum of prevention, diagnosis, care, treatment, support, monitoring and evaluation, and meaningful data collection, as well as supporting research. This must be developed within the context of efficiency, lack of duplication and unnecessary cost expenditures.

The Chair (Mrs. Nina Tangri): Thank you very much.

Ms. MJ DeCoteau: Thank you.

The Chair (Mrs. Nina Tangri): I'm going to move on to the opposition. Ms. Armstrong.

Ms. Teresa J. Armstrong: If you'd like to finish your presentation, please take that time.

Ms. MJ DeCoteau: Okay. It was just the thank you.

Thank you for giving this network of oncology groups the opportunity to present today. Please be assured that you can count on our support to ensure that cancer systems meet the needs of patients, caregivers, researchers and clinicians, allied health professionals, public health systems administrators, and all of you who have accountability to taxpayers for the judicious spending of taxpayer dollars.

Ms. Teresa J. Armstrong: Thank you. I noticed that you had said there were several other agencies that endorsed your presentation. Can you let us know if those agencies, or yourselves, were consulted before the drafting of this bill?

Ms. Louise Binder: None of the agencies listed—in fact, no patient cancer agencies that we've spoken to were consulted in advance of this legislation.

Ms. Teresa J. Armstrong: Do you know of any cancer survivors or patient advocates who have been consulted in the drafting of Bill 74?

Ms. Louise Binder: No, none that we have been told about. That indeed is the crux of our submission: that we really need to bring people together, so that we can ensure that whatever is determined to do with CCO, whether under this legislation or in some other way, is determined consultatively.

Ms. Teresa J. Armstrong: In viewing the importance of CCO to cancer survivors, do you think that the government has the responsibility to reach out to patients before making such massive changes to the health care system?

Ms. Louise Binder: Yes. There's no doubt that, for many reasons, cancer is—we don't want to say "special," but we certainly say "different." It's a leading cause of death for people in Ontario. It doesn't discriminate based on anything—race, age, sex, gender, economic status, geography. It's very important that we have an efficient, effective, accessible, comprehensive overall approach to it that focuses with professionals and experts, including patients, to manage the system. So, yes, we need that.

Ms. Teresa J. Armstrong: Bill 74 establishes a permanent patient-family council that appears to be working closely with the government on Bill 74. Have you been involved with this council?

Ms. MJ DeCoteau: We have not been involved.

Ms. Teresa J. Armstrong: Okay. Also, the Minister of Health has said that she has engaged thousands of patients in developing plans to overhaul the health care system. I have not yet met a patient who has said that they have been engaged. Can you share your perspectives on how patients have been engaged on Bill 74? You kind of answered that that's still the same, you don't know of any patients—

Ms. MJ DeCoteau: Yes. We don't know of any patients. Our deposition lists the numbers that we directly represent. Amongst our groups no one that we know of has been consulted.

1510

Ms. Teresa J. Armstrong: Okay. How would you propose an alternative way of engaging Ontarians who don't know what's going on at Queen's Park on how these massive changes will impact their health care system?

Ms. Louise Binder: I think it's very important that we reach out through media—social media particularly—and through patient organizations. We all represent a very broad swath of cancer patients and we certainly can use our networks to reach those patients.

Ms. Teresa J. Armstrong: Would it have been helpful if the government travelled this bill, perhaps, to areas where people are cancer patients as well as maybe northern and rural Ontario where sometimes they don't get that attention?

Ms. MJ DeCoteau: Yes, I think all that type of consultation would be very helpful.

The Chair (Mrs. Nina Tangri): Madame Gélinas?

M^me^ France Gélinas: You, as everybody else, have been very eloquent about the great work and the great outcomes that Cancer Care Ontario have brought to us. Now we know that they're being dissolved and a new super-agency is being created. Very few patients have had the opportunity to come and talk to us. Can you share from a patient's perspective what it means for you that Cancer Care Ontario will be no more?

Ms. MJ DeCoteau: I think in the context of today's patient experience there's a lot of expectation around shared decision-making. As cancer treatments become more and more complex, it's just so important that they have confidence that it's being overseen by really focused experts who are giving them the information they need, whether it's about detection, treatment or aftercare. Not only is cancer clinically complicated to treat; the physical,

practical and emotional toll on patients and caregivers is really acute.

The Chair (Mrs. Nina Tangri): One minute to go.

Ms. MJ DeCoteau: We keep saying that cancer is complex, but it's because it's a truly complicated disease. The more information we have, the more complicated the treatments are getting, and it's putting a burden not just on the patients to make these complicated treatment decisions but on the physicians as well.

M^me^ France Gélinas: You have given us a list of agencies who represent patients who support what you're saying today. How important an issue is it for patients? Is it one in 10 who find it important, one in 100? You represent 75,000 people.

Ms. Louise Binder: I think it's profoundly important to cancer patients that we have a system that meets their needs, but also we recognize that we want this to be done in an effective, efficient, outcomes-based approach.

One of the difficulties is that cancer research and clinical care and even prevention information is changing. It's so dynamic. We're learning so much through genetic information and trials of different kinds that the facility and the flexibility to be able to make change is so important. That's why we really want to ensure that we get all the stakeholders around the table to talk about what kind of leadership will really allow for that while absolutely ensuring that there's no unnecessary duplication—

The Chair (Mrs. Nina Tangri): Thank you very much. I'm going to go to the government side. Mrs. Martin?

Mrs. Robin Martin: Thank you very much for coming and for your presentation.

I just want to put on the record that Cancer Care Ontario is not being dissolved, which is what Ms. Gélinas has proposed here today several times. Cancer Care Ontario is being incorporated into this single agency that we are trying to set up, the Ontario Health agency.

The idea, really, is that Cancer Care Ontario is such a wonderful model, as you have detailed, that we want to make sure that we have that model in all other areas of care so that other patients—who don't have cancer, perhaps, but have diabetes or other illnesses—have a similar kind of attention paid to their illness. The idea is to use Cancer Care Ontario as a great model of how we can do better by integrating care. I just wanted to put that on the record.

I take it that you recall, because I recall meeting you at your Queen's Park day and speaking with you there.

Ms. MJ DeCoteau: Yes.

Mrs. Robin Martin: I believe you have met the minister several times, is that correct?

Ms. MJ DeCoteau: Yes.

Mrs. Robin Martin: I think I read here a statistic that one out of four people has cancer in Ontario.

Ms. Louise Binder: It's moving to one out of two.

Mrs. Robin Martin: And it's moving to one out of two. I think we could probably all agree that the minister and myself and you and everybody else has probably met somebody with cancer and spoken with them. Is that correct?

Ms. MJ DeCoteau: Yes.

Ms. Louise Binder: Absolutely.

Mrs. Robin Martin: No doubt. And it is obviously a disease which is taking a great toll in our society, and we want to make sure that we keep providing the best possible cancer care.

Our Ontario Health board is trying to bring the model of Cancer Care Ontario to other diseases, as I have said—to mental health and addictions, for example, and to diabetes—but the care that one receives though the local Ontario Health teams will be the same care.

Your own experience with Cancer Care Ontario—I take it that neither of you have met the CEO of Cancer Care Ontario, or you have met him as a representative of your organization?

Ms. Louise Binder: Oh, yes.

Ms. MJ DeCoteau: Definitely.

Mrs. Robin Martin: But not in your treatment.

Ms. Louise Binder: No.

Mrs. Robin Martin: Is that correct?

Ms. Louise Binder: Not in my treatment, no.

Mrs. Robin Martin: Not the CIO of Cancer Care Ontario?

Ms. MJ DeCoteau: No.

Mrs. Robin Martin: And have you met, in your treatment, any of the vice-presidents of Cancer Care Ontario?

Ms. MJ DeCoteau: No.

Ms. Louise Binder: Not in treatment.

Mrs. Robin Martin: Ms. Binder, I understand that you had some town halls before the last election.

Ms. Louise Binder: The last Ontario election?

Mrs. Robin Martin: Yes.

Ms. Louise Binder: Yes, I did.

Mrs. Robin Martin: And that you—

Ms. Louise Binder: Well, not me personally. My organization and some other organizations, actually, in partnership with the Schizophrenia Society of Ontario and Myeloma Canada.

Mrs. Robin Martin: Didn't the people who attended talk about the importance of integrating our health care system and breaking down the silos, at those town halls? That's what we heard.

Ms. Louise Binder: I always talk about breaking down the silos in the health budget. I sincerely believe that money in the health budget should follow the people and where they need help, rather than them having to fit into a silo in the budget.

Mrs. Robin Martin: Right. I think that accords with what we're trying to do, which is put the money to patient care, and put the patient at the centre of our health care system. Would you agree?

Ms. Louise Binder: Here's the difficulty for me—and perhaps you can help me with this. Most of the other organizations that you're proposing to include are what I would describe as general health systems management organizations, whereas Cancer Care Ontario and, I would say, the Trillium transplant processes are very discretely engaged with particular disease areas or particular disease issues. Somehow, to me, that's not the same. It's not the same in terms of the kind of expertise, knowledge and flexibility that's needed.

I entirely agree with you that cancer is an excellent model for diabetes, arthritis and other disease groups, but I don't see them in your legislation. I see, instead, primarily general health systems management organizations. With all due respect—and I might be wrong—my understanding is that the type of skills we need to be running those types of organizations is very different than the very detailed understanding of oncology across the spectrum that's needed to be flexible and to understand what's going on in the dynamic world of cancer and genetics today.

Mrs. Robin Martin: But the care providers, as we've discussed, are the same care providers. The ones you'll be dealing with, who have the expertise, are the same care providers on the ground, in the hospitals and in the radiation centres etc. All we're talking about, by bringing Cancer Care Ontario in, is the super-structure, the people you haven't met in your cancer treatment journey: the CEOs, the CIOs, those things.

The Chair (Mrs. Nina Tangri): One minute.

Ms. Louise Binder: But the individual cancer journey isn't the only issue. The other issue is how systemically the organization is being managed, so that the important systemic decisions are also being made. They make a difference as to how our individual treatment is being handled, and that's what we're concerned about.

Mrs. Robin Martin: Right, and that's exactly the part that we want to emulate for those other disease groups. I think we have the same objective—

Interjection: Good.

Mrs. Robin Martin: —and we want to use the cancer care model as the way to get there.

There was one other thing I wanted to ask you. Did anyone else have anything?

The Chair (Mrs. Nina Tangri): We're actually out of time.

Mrs. Robin Martin: Oh, sorry.

Mr. Deepak Anand: I just wanted to ask a quick question. Do you think—

The Chair (Mrs. Nina Tangri): Mr. Anand, we're out of time. We've just reached our six minutes.

I'd like to thank you for coming out and presenting to us today.

Ms. Louise Binder: Thank you very much for having us.

1520

CHIEFS OF ONTARIO

The Chair (Mrs. Nina Tangri): I'd like to call upon the Chiefs of Ontario, please. Please introduce yourself for the record. You have eight minutes to present, followed by six minutes each from the recognized parties.

Chief Elaine Johnston: Good afternoon. My name is Elaine Johnston. I'm the chief of Serpent River First Nation. I'm a registered nurse by profession, with extensive experience in health. I worked on the air ambulance, the first in Ontario, and in the hospital, in intensive care and emergency. I've been the health director at the Assembly of First Nations, a case manager and many others. So I bring that experience to you.

I acknowledge that we are on the traditional territory of the Mississaugas of the New Credit and the Haudenosaunee.

I am the co-chair of the Ontario Chiefs Committee on Health for the Chiefs of Ontario.

The Chiefs of Ontario organization was created by the First Nations in Ontario in 1975. It is a political forum and secretariat for collective decision-making, action and advocacy for the 133 First Nation communities located within the boundaries of the province of Ontario. The Chiefs of Ontario organization is guided by the chiefs-in-assembly, and works to uphold the self-determination efforts of First Nations.

I must clearly state that the 133 First Nations in Ontario are the treaty rights holders, and must be consulted directly on any changes to legislation and policy that may impact or infringe upon their inherent Aboriginal and treaty rights.

As a nurse, I'm going to give you two stories. One was that I worked in a community up in northern Ontario, and I was the only nurse in a community of about 6,000 people. We had a suicide a month. My role was to pronounce the death of the young person who had successfully committed suicide and to provide support to their family. What you need to know is that the suicide rates are six times the national average in First Nations communities.

The other time that I was a nurse, I was dealing with a diabetic who had amputations, dialysis, kidney and liver failure, and was in palliative care. I was a nurse case manager. I got called to the hospital to help. When I arrived, the hospital said, "Thank goodness you're here." The family also said, "Thank goodness you're here." We had to problem-solve the issue. The person had decided it was palliative care, so I had to get the family to take their loved one home, and to stay out of the hospital—as we're talking here about occupying beds in the hospital and hallway medicine. We were successful in being able to do that and have their loved one stay at home.

I must point out that there was little to no meaningful consultation with First Nations in Ontario prior to Bill 74 being introduced. Unfortunately, what this means for First Nations is that we are then forced to try to respond to legislation that does not respond to the realities and needs in our communities and does not respect our inherent Aboriginal and treaty rights. The requirement to consult and accommodate First Nations' interests is a must; it is also good practice.

The First Nations in Ontario do have concerns with Bill 74 and its contents, and also what it means when implemented. I believe we can agree that the way health care is planned and delivered in this province must change and improve. First Nations want to see structural changes to the way health care is designed and delivered for our people. But we certainly have concerns that Bill 74 will not bring about the changes that are so basically needed without consideration and action in response to First Nations input into this process.

First Nations have developed relationships with the provincial and federal governments, either bilaterally or trilaterally, and they must be respected, as the Minister of Health committed to on the day this new legislation was announced.

First Nations have the poorest health outcomes of any group in Ontario. Remember my opening story?

With respect to the content of Bill 74, I will first speak to the specific sections that mention First Nations or Indigenous people. The preamble of the bill states, "The people of Ontario and their government" must "recognize the role of Indigenous peoples in the planning, design, delivery and evaluation of health services in their communities." There is nothing inherently wrong with this statement. However, it is important to note that there are three constitutionally recognized Indigenous or Aboriginal groups in Canada— the First Nations, the Métis and the Inuit—with important cultural, geographic and linguistic differences between them. How will First Nations be involved in deciding this? How does the minister intend to recognize or create an Indigenous health planning entity—for example, section 44(2)(a), which states that the agency, Ontario Health, is required to "engage the prescribed Indigenous health planning entities in a manner that recognizes the role of Indigenous peoples in the planning and delivery of health services in their communities."

I mentioned earlier that we have not been properly consulted during the development of this legislation. You need to utilize our established processes. We recommend that you engage with the Chiefs of Ontario to manage further movement forward on the regulations.

There are many best practices that exist in the province in relation to the delivery of health care to First Nations, and there are many First Nations organizations that have been in existence for many years doing great work. Out of necessity and due to a lack of resources, we have been integrating services at the community level for decades, and we are very good at managing what we have. However, the need is greater than what we have, and that is why it is so critical for us to integrate.

Let's build on what is working. First Nations have the information and expertise to contribute to this discussion.

We recommend that Ontario work with the First Nations to identify these organizations that will eventually be recognized as Indigenous health planning entities. We understand that there will be Ontario health teams serving specific geographic areas up to a population of 300,000. How will northern and rural areas be accommodated, as they will not meet this threshold?

The next section of the bill that I would like to speak to is schedule 2, specifically section 8(1)(1). This section, which amends the Ministry of Health and Long-Term Care Act, states that the minister will establish an Indigenous health council to advise the minister about health and service delivery issues related to Indigenous peoples. The issue goes back to what I mentioned earlier, that there are three constitutionally recognized Aboriginal groups in Canada: the First Nations, the Métis and the Inuit, all very distinct groups with unique needs, challenges and priorities; legal, cultural, geographic and linguistic differences; and challenging jurisdictional issues.

With respect to jurisdiction, do you know the difference between a First Nations person having a heart attack in their First Nations community versus someone in downtown Toronto? Who's going to pay for drugs? OHIP or federal non-insured health benefits? Who's going to pay for services, for transportation to a specialist? Is it a flight or is it a medevac? Do they even have access to a specialist? How long would they be required to stay in hospital? We know it would be longer for those who have not had prior access to services.

I know you don't want to hear about past governments, but it is important for you to recognize that we did not have a healthy relationship with the government that introduced the LHINs.

The Chair (Mrs. Nina Tangri): One minute.

Chief Elaine Johnston: Clearly, you aren't happy with the LHIN system either. Neither are we. However, we want to establish a healthy, ongoing relationship with you.

Another recommendation is the establishment of a First Nations-specific health council, and not a pan-Aboriginal approach, which means lumping us in with Métis and Inuit.

Bill 74 will create Ontario Health, and we understand that the minister has already identified the board of directors to oversee Ontario Health. The First Nations in Ontario would recommend that the minister appoint a First Nations person to this board. We believe that having a seat at the table and having our voice heard at the highest levels will help us to make progress on the significant health challenges that our people and communities face.

Like the Premier and minister, First Nations also hold the goal to end hallway medicine and build a seamless system where people receive the right care at the right time and in the most appropriate setting. This is why we also recommend a First Nations person be appointed to the Premier's council.

You should be aware that the University of Manitoba undertook a "cost of doing nothing" study and have determined that the province will go into debt if they do not address First Nations' health needs. That is why we are encouraging you to work with us. First Nations have a lot to contribute to this conversation, and I encourage you to ensure that we have a strong voice in this discussion moving forward. Thank you.

The Chair (Mrs. Nina Tangri): Thank you very much. I'll begin with the government side. Ms. Triantafilopoulos.

Ms. Effie J. Triantafilopoulos: Thank you very much for coming and presenting to us today. What you had to provide by way of your submission is very, very informative, so I very much appreciate that.

I'm also very much struck by the fact that you talked about best practices for delivery of health to First Nations that, in fact, have been going on for decades. I wonder if you could expand a little bit further on that.

Chief Elaine Johnston: Sure. One of my roles was to set up a health access centre here in Ontario. What has

happened is that at the North Shore Tribal Council, we have—Maamwesying health services is a health access centre. So we've got culturally based training. We have land-based programming. We also have looked at trauma-informed mental health services. So there are examples in Ontario. Mine is just one example.

Ms. Effie J. Triantafilopoulos: I think all of us as legislators recognize the unique challenges, particularly with remote communities, rural communities and Aboriginal communities. I think that has got to be one of the critical transformational pieces we have to do as legislators through Bill 74 going forward. I wonder if you might have any comments.

Chief Elaine Johnston: Well, yes. I think it's really important that you work with us. That's why we're saying that the big thing is that we were not consulted. We're encouraging the government to work with us. Make sure that we're on these committees, on the Premier's council, and also work with us on the regulations, because if we really want this to work and look at positive health outcomes, then we need to be involved.

1530

Ms. Effie J. Triantafilopoulos: I agree. One of the things I wanted to bring to your attention is that our Bill 74 contains specific provisions that would recognize and respect the roles of Indigenous people in Ontario both in the planning and delivery of the care for their communities. You mentioned the preamble, and the preamble is one area that really highlights the government's commitment to recognize the role of Indigenous people in the planning, design, delivery and evaluation of health services in their communities.

In addition, you may know that the bill will establish an Indigenous health council to provide advice to the minister on health and service delivery issues really related to the Indigenous peoples. There are also going to be Indigenous health planning entities in a manner that recognizes the role of Indigenous peoples in planning and delivering health care in those communities.

I just wanted, for the record, to be able to state that.

You may be aware as well that the Minister of Health wrote on February 26 of this year to Ontario Regional Chief Archibald and stated at that time that the ministry is committed to work with First Nations through dedicated trilateral processes and relationship agreements, including existing agreements to explore options to transform First Nations health. I just wanted to convey that to you as well.

I wonder if you could also share with us what in the current regime and current environment are the challenges that your community is facing with the current regulatory framework that is not working.

Chief Elaine Johnston: As I mentioned, with the LHINs right now, the structure that is there, some First Nations have a relationship and some do not. There are jurisdictional issues that I did highlight already—because it's who pays what. For example, you have OHIP and then for the First Nations, which does not affect the Métis and the Inuit, is that we do have non-insured health benefits, which pays for services for First Nations.

This is why we are asking for a First-Nations-specific council, because you are going to enter into jurisdictional issues. You are going to enter into areas where you have more remote communities and more that are more connected to urban centres. It's access to services. Those kinds of things are really going to be challenging.

Ms. Effie J. Triantafilopoulos: I understand. Thank you so much.

The Chair (Mrs. Nina Tangri): Mrs. Martin.

Mrs. Robin Martin: You did mention mental health and diabetes in your two examples. Would you say those are the key priorities in your community where there may be gaps of care currently, or are there others?

Chief Elaine Johnston: I think that the chronic diseases—diabetes is one of them. You're dealing with all of the issues that come from diabetes, so heart disease, hypertension, kidney disease—there are people who are on dialysis. These people are, when you're talking about hallway medicine, occupying the hospitals. They're occupying the beds. How are you going to work with us so that they are not occupying those beds? There need to be services in the communities and access to those services, because that's also a problem. You don't always have that access.

Mrs. Robin Martin: Right. And are chronic diseases and mental health the main priorities that you would identify?

Chief Elaine Johnston: I would say that those are the main priorities

Mrs. Robin Martin: I should say "and addictions," right? We have mental health and addictions, and it's usually concurrent, unfortunately.

Chief Elaine Johnston: Yes, for sure.

The Chair (Mrs. Nina Tangri): One minute. Mr. Sabawy.

Mr. Sheref Sabawy: When you went through Bill 74, did you notice any specific parts of the bill which you feel are not giving the impression that the government is committed to work with the First Nations to deliver the commitment for health? Where is an area which you felt that it's not going with your vision about that?

Chief Elaine Johnston: Okay. Well, it gets back to, we were not consulted in the development of it. Second of all, our experience with the LHINs is, there was discussion about having a council, which never happened. So we're asking for a First-Nations-specific council, again, because of the jurisdictional issues. We were not appointed to the Premier's council. We were not appointed, so where has that dialogue happened with us in regard to that?

The Chair (Mrs. Nina Tangri): Thank you very much. I'm going to move to the opposition. Mr. Mamakwa.

Mr. Sol Mamakwa: Thank you, Chief Elaine Johnston, for your presentation. It's good to hear First Nations brothers and sisters share their stories about what's happening in our communities.

As you know, I'm from northwestern Ontario, a fly-in community. I get to experience, unfortunately, the inequity and inequality that exist within the health care system because of those jurisdictional ambiguities that you talked about.

There was a thing you talked about, about heart attacks. Just to frame a story, back in 2015, we had 28 airports in northern Ontario. In 2015, there were 2,750 medevacs from Ornge. We have to understand that each medevac costs about $12,000 to $15,000 to do. So when you do that in a year—that's a sickness system for our people. I'm sharing that story just because that's the reality.

You talked about the jurisdictional thing, when we talk about the province and the federal responsibility. I know that Chiefs of Ontario released a statement after Bill 74 was tabled. The Chiefs of Ontario said that First Nations were not consulted in the drafting of Bill 74. I'm just wondering if you've had an opportunity to engage in discussions with the government since then.

Chief Elaine Johnston: No. I do say, and it was mentioned in the preamble, that the minister did contact the regional chief the day before the legislation. She wasn't happy, because she was saying, "This is the first contact we've had in regard to this." So, there hasn't been, and this is why we're asking, from here on in, that you need to involve us and engage us, especially in the regulations. So, no, there hasn't been.

Mr. Sol Mamakwa: Okay. Do you know of any other First Nations in Ontario that were consulted before Bill 74 was tabled?

Chief Elaine Johnston: Not to my knowledge. I do know that right now, the health access centres, through the alliance that was mentioned earlier, are trying to get the information as to how they would be participating. But from my knowledge, there has been no consultation.

Mr. Sol Mamakwa: Also, in a statement by Regional Chief Archibald on Bill 74, she indicated that the bill does not contain recognition of First Nations jurisdiction in the health area, and specifically articles 18 and 23 of the United Nations Declaration on the Rights of Indigenous Peoples. Can you explain why the government should include these articles in Bill 74?

Chief Elaine Johnston: I think it's important to include those articles because it gets back to the heart of the jurisdiction. We have inherent rights and treaty Aboriginal rights, and it could become a legal issue, actually, if we're not going to take those articles into consideration. It is a basic human right. I think that when we're talking about health outcomes for our people—if you look at the stats, as I said, we have the highest diabetes health issues in our communities. They do need to take that into consideration.

Mr. Sol Mamakwa: Thank you. Diabetes is something that I'm very aware of in my region, and also mental health. In 2017, we had 38 youth suicides in our territory, whereby some very young girls died by suicide at the age of 12.

I'm just wondering, when we talk about the Indigenous health council, and when we talk about social determinants of health, how would you like to be involved in this process, where we address the jurisdictional stuff as well, federally and provincially?

Chief Elaine Johnston: I think that we need to have an appointment from the First Nations—that's what I'm saying—for a First-Nations-specific health council, because there are jurisdictional issues. I would like to see the Chiefs of Ontario, through our mechanisms, to have those appointed on that health council, because if the government appoints them, then it may not necessarily meet those thresholds—and also to identify those jurisdictional issues.

Mr. Sol Mamakwa: Would you be able to explain whether First Nations communities, Indigenous communities, should manage the delivery of health care in their communities?

Chief Elaine Johnston: I'm sorry, could you ask that question again?

Mr. Sol Mamakwa: Can you explain whether First Nations communities should manage the delivery of health care services in their communities?

The Chair (Mrs. Nina Tangri): One minute to respond, please.

Chief Elaine Johnston: Yes, they will. I know that many of the First Nations have mechanisms to be able to manage their own health. Some First Nations have capacity; some don't. But there may be groups of First Nations that might do it.

We would be in a better place to be able to say how we can improve on the health outcomes. It might be looking at traditional healing. It might be looking at addiction programs, land-based programs, working with our traditional healers. It's going to be varied across which First Nations are involved.

1540

Mr. Sol Mamakwa: One of the things I've struggled with since coming here is actually getting the province to get involved in First Nations health on-reserve. It's really difficult. How would you try to address that?

Chief Elaine Johnston: It is difficult. I don't think they understand what the issues are that we're dealing with in our First Nations.

It's not going to happen overnight. I hear Canadians say, "Well, why don't they just get over it?" It's not going to happen. It has been years of colonialism. But we know best how to address it, and I've seen positive outcomes.

The Chair (Mrs. Nina Tangri): Thank you very much for coming out to present to us.

Chief Elaine Johnston: Thank you.

NISHNAWBE ASKI NATION

The Chair (Mrs. Nina Tangri): I'd like to call upon Nishnawbe Aski Nation. If I can ask you to please introduce yourselves for the record. You have eight minutes to present, followed by six minutes from each of the recognized parties. Go ahead.

Mr. Ovide Mercredi: My name is Ovide Mercredi. I'm the lead negotiator in health transformation for Nishnawbe Aski.

The Chair (Mrs. Nina Tangri): Your microphone is on. Go ahead.

Ms. Natalie Hansen: Natalie Hansen, health policy analyst with Nishnawbe Aski Nation.

Ms. Mary Chakasim: Mary Chakasim, health transformation.

Mr. Ovide Mercredi: For the record, we have a written submission that we're tabling to the committee, but I also have this oral presentation I want to make.

I acknowledge the traditional territory we're on right now.

I was listening to my colleagues from the Chiefs of Ontario organization, and I clearly see we're of like mind.

The organization that we represent today was established in 1973. I thought I might spend some time teaching you about the political bodies that we have.

NAN represents 49 communities, and we cover a land mass of two thirds of the province of Ontario: 210,000 square miles. That should give you an idea of how difficult it is to provide equity and equality of services when it comes to health, because of the geographical basis, but also because of historical discrimination against our people when it comes to the provision of quality care.

We have seven tribal councils in NAN. We have, as I said, 49 communities, and our people speak four distinct languages: Anishinaabemowin, Oji-Cree, Cree and Algonquin.

We have reviewed your bill in the short time that we had, and I must say, it has been difficult to try to be positive about it. The bill itself, clearly, if implemented with the authority that is given to the minister, will breach treaty rights and treaty obligations. But it would also violate a commitment that was made by the previous government, which was also ratified by the current minister, with respect to our charter relationship with Ontario in health transformation.

Ontario is a treaty partner. It's one of those historical things that most Canadians don't understand or aren't even aware of. One of the signatories of Treaty 9 was the government of Ontario, not just the federal government. As a treaty party, you cannot make unilateral decisions about the impact of health care in our communities. You not only have to consult with us, but you need our consent when it comes to making any modifications about our health systems and our health programs in our communities.

That treaty was made in 1905, 1906, well before our time, but it's still very fresh in our memory. For many of our elders, the failure of the governments to honour the treaties is a shame on the country.

We assert, as we always have, the right of self-determination. We understand now that this is something that is constitutionally protected.

Also, we are fully committed to this idea that no government and no Parliament can alter treaties unilaterally, and that all governments have a responsibility to honour the crown, and the obligation of the crown is to act with respect and with integrity when it comes to Indigenous people in Canada.

If you look at our submission, under section 2.4 you will see that in February 2016 NAN chiefs from the Sioux Lookout area declared a health emergency. If you read the report, you will see why it was declared a health emergency. We dealt with, at that time, a call to the governments to come to us and to work with us in addressing the issues that were present at that time and still remain.

NAN First Nations also face additional challenges born through historical and present-day marginalization. These issues are made worse by inter-jurisdictional problems that exist between the governments as to who is going to pay for the services. For most people in Ontario, that's not an issue for them.

We have, under our charter relationship, principles governing health transformation in NAN—a commitment to recognize treaty and Aboriginal rights, but also a commitment to ensure that in future all health care services are operated under our jurisdiction, under our governmental bodies. Both levels of government made a commitment to move in that direction.

In addition to the charter that I'm referring to—our own charter with the governments—First Nations and NAN have a number of binding government-to-government agreements with Ontario, including the Sioux Lookout area four-party hospital services agreement and the Weeneebayko area health integration framework agreement.

The WAHIFA was signed 12 years ago by the Mushkegowuk communities in the James Bay area—along the west coast of James Bay, the southwestern shore of Hudson Bay—amalgamating two hospitals and a federal nursing station to establish the current health authority known as WAHA. The partners to the WAHIFA agreement are the government of Canada, the Ontario government and the following First Nations communities: Weenusk First Nation, Attawapiskat First Nation, Fort Albany First Nation, Kashechewan First Nation, MoCreebec Eeyoud and the town of Moosonee.

WAHA operates three hospitals in the area, along with an emergency room for each of the communities, five ambulance stations and a clinic, the chief of staff, a doctor and their vice-president of patient services, and the chief nursing executive and a nurse practitioner, who are both in the community—

The Chair (Mrs. Nina Tangri): One minute.

Mr. Ovide Mercredi: We have, as I said, issues with your legislation. I'll just summarize some of these problems that we have with the bill.

I read very slowly, so I should maybe get an extra minute.

First of all, we were not consulted about the changes that are being proposed and we have no idea how they're going to be implemented, and we're nervous about the powers that are given to the minister to force integration on communities if they don't comply with decisions made by some people to set up these teams without our involvement.

Our First Nations input is critical to the success of health care in northern Ontario—

The Chair (Mrs. Nina Tangri): Thank you very much. I'm going to move to the questions, and you can perhaps finish your—thank you. Mr. Mamakwa?

Mr. Sol Mamakwa: Mr. Mercredi, you can continue on with your presentation to complete your—

Mr. Ovide Mercredi: Thank you. You'd do the same.

Anyway, in support of all the First Nations, we would like to conclude by saying that all treaty rights, including the treaty right to health care, must be protected, and then we'll work to defend these rights.

Bill 74 unlawfully diminishes treaty obligations of both the federal and provincial governments. Ontario cannot unilaterally devolve or off-load these health care responsibilities to service providers who owe no direct treaty obligation to our people. The creation of the super-agency is a breach of the nation-to-nation relationship and imposes a bureaucratic layer, just like the LHINs did, interfering with the direct relationship that we should have with governments with respect to how we provide services to our people.

1550

The province needs to uphold the legal duty to accommodate and to consult with Indigenous people on any measures they take that impact on their treaty rights, and the treaty right to health is one of them.

But I also wanted to say that we did received an encouraging letter from the current Minister of Health about maintaining the status quo with respect to the charter that's part of our submission. She's prepared to acknowledge that the commitments made to honour the treaty rights, to honour self-determination, to honour the right of our people to create their own systems of health, their own models of health, under their jurisdiction is part of the commitments that were made by the previous government, which are now, according to the letter we received from the Minister of Health here, approved by her as well.

The Chair (Mrs. Nina Tangri): Mr. Mamakwa.

Mr. Sol Mamakwa: Thank you for your presentation. I know, on 2.4, there's an outline of the NAN declaration to health and public health emergency. I know that the status quo—and there are some stories in there. What I've learned also, being from that area, is that the status quo is construed as normal and acceptable in our region, but it would be unacceptable in any other part of Ontario and Canada.

There are some letters there, as well. It seems like there's a plan. I know you've been very clear on the engagement or no contact from the government in the drafting of Bill 74. Is that correct, that there has been no contact?

Mr. Ovide Mercredi: I'm hard-of-hearing. Can you repeat that?

Mr. Sol Mamakwa: Have you had an opportunity to engage in discussions with the government in the drafting of Bill 74?

Mr. Ovide Mercredi: No.

Mr. Sol Mamakwa: If you had been engaged prior to the drafting of Bill 74, what would you have asked the government to consider including?

Mr. Ovide Mercredi: I think I would have said to them that they should recognize that they're the settlers in this country and that they should respect the fact that Indigenous people have their own right of self-determination and that no measures should be taken by any government without their involvement or consent. I say that with all due respect to everybody in this room.

But the fact of the matter is this: We have the capacity in our communities; we don't have the resources in our communities. We have the human resources to run our own programs, but we don't have the financial resources to make it happen. In many cases, the hospital is the airplane for our people—or the highway is the hospital for our people. That's not the case for most of the people of Ontario. There's great inequity in terms of the access to programs and services that exist.

I would say, also, close the gaps, and I would also say, create equality, respect the equality, respect your own Charter of Rights and Freedoms, don't discriminate against our people. I think that would have resulted probably in a more productive approach to deciding how health should be dealt with in Ontario.

We see right now that, as it is, Canadians other than our own people are benefiting from our sickness and people are getting enriched by our illnesses. We don't want to see these teams being established by people in Sudbury or in Thunder Bay or in Sioux Lookout for us. We should be directly involved in deciding what these teams should look like and who should operate them, who should govern them and under what principles they should operate.

The Chair (Mrs. Nina Tangri): One minute.

Mr. Sol Mamakwa: Can you explain whether articles 18 and 23 of the United Nations Declaration on the Rights of Indigenous Peoples should be included in Bill 74?

Mr. Ovide Mercredi: It's self-evident, isn't it, Sol, that people have the right to be respected for what they believe to be their rights? The human right of self-determination is there. Why should Indigenous people be the last to be decolonized in this world? I think it's incumbent upon leaders of this country to stand up for self-determination and respect for our people.

Mr. Sol Mamakwa: I had a quick read on the Charter of Relationship Principles between Canada and also Ontario. It sounds like you have a framework already. It just needs to move forward and get that process going.

The Chair (Mrs. Nina Tangri): Thank you, Mr. Mamakwa.

We're going to move to the government. Mrs. Martin.

Mrs. Robin Martin: Thank you for your presentation, and thank you for being here today.

Programs and services, we know, must be designed, delivered and evaluated in collaboration with Indigenous partners to effectively meet the needs of Indigenous peoples, families and communities. Bill 74 does contain specific provisions that would, if passed, recognize and respect the roles of Indigenous peoples in Ontario in the planning and delivery of care in their communities. The preamble of Bill 74 highlights, for example, the government's commitment to "recognize the role of Indigenous peoples in the planning, design, delivery and evaluation of health services in their communities."

In addition, the bill would require that an Indigenous health council be established to provide advice to the minister "about health and service delivery issues related

to Indigenous peoples," and that Ontario Health will be required to "engage with the prescribed Indigenous health planning entities in a manner that recognizes the role of Indigenous peoples in the planning and delivery of health services in their communities."

The ministry is committed to work with First Nations "through dedicated trilateral processes and relationship agreements, including existing agreements, to explore options to transform First Nations' health." This was recorded by Minister Elliott in a letter to Ontario Regional Chief Archibald on February 26, 2019, that we referred to with the earlier presenter.

Again, thank you for your presentation.

Can you—and maybe some of your health policy advisers—tell us, for the nations that you represent, what some of their key priorities are for health care in your communities?

Mr. Ovide Mercredi: As I said before, closing the gap in services is an important priority for us. There's nothing in the legislation that tells us that the government is going to be spending more money to close the gap. We need infrastructure in our communities. It's non-existent, and so far, the Ontario government has never contributed to capital expenditures on reserves, and there's nothing in your legislation that tells me it's going to be done.

So, while the preamble sounds very nice to me, a preamble is a preamble, but the body of the legislation is totally different. The preamble is just that. It gives me no comfort whatsoever that the government will in fact work with us, as the preamble reads, which you were reading to us right now. I heard you read it prior to our presentation as well, so I gather that it will be the mantra of the Ontario government.

If we can stand by what you said, I think our leaders will work towards some kind of an understanding with the government of Ontario, but it does not mean that the legislation will be accepted.

Mrs. Robin Martin: Can you tell me anything about what your community is looking for? You said "gaps in infrastructure," but can you identify some of the specific gaps that are priority gaps for your community?

Mr. Ovide Mercredi: One would be dialysis treatment, for example. I think that's probably very obvious to people who have any understanding of the north. And, of course, when it comes to people having heart issues or heart problems, those facilities are non-existent in our communities. We have to be shipped away to some town, or some place like Kingston, in order to get some of these services. Part of it, when you say "closing the gap," is getting those on-site and closer to home.

Then we have our people spending hours and hours of their lives in receiving homes when they go to hospitals in Thunder Bay or Sioux Lookout or Moosonee. They have to stay away from their communities.

Many of our elders are dying in hospitals, and they have no option of dying at home. I think most Canadians can die at home; our people can't. That, to me, is an important issue.

Mrs. Robin Martin: Thank you. Can you describe for us some of the important roles that Indigenous peoples in your communities play in planning, designing, and evaluating their health system? Can you explain for us how it works?

1600

Mr. Ovide Mercredi: Right now, the reality is that those planning processes you're referring to are in fact under control of the governments. This is what we've been fighting for. That's what we mean by self-determination—taking that power away from the governments right now. There are people who have that ability, that capacity to do their own planning.

The Chair (Mrs. Nina Tangri): One minute.

Mrs. Robin Martin: You've indicated that the capacity is there. Are there people in your community, from your community, working on health planning and design now?

Mr. Ovide Mercredi: There's some health planning happening right now. We have the health authorities, we have the tribal councils running programs. We have that ability. What we need is a government that's willing to work with us in going further, ensuring that adequate resources are there, that the services are provided under our jurisdiction, under our authority, and that there's no interference by the other governments.

Mrs. Robin Martin: Thank you.

The Chair (Mrs. Nina Tangri): I'd like to thank you for coming out and presenting to us today.

ADDICTIONS AND MENTAL HEALTH ONTARIO

The Chair (Mrs. Nina Tangri): I'd like to call upon Addictions and Mental Health Ontario. If you can please introduce yourself for the record. You have eight minutes to present, followed by six minutes from each of the recognized parties. Go ahead.

Ms. Adrienne Spafford: Hi. I'm Adrienne Spafford, CEO with Addictions and Mental Health Ontario. Here with me today is our past board president, Vaughan Dowie, who is also the CEO of Pine River Institute.

I would like to start by thanking the committee for giving us the time to speak with you today. We are here as the voice of our entire membership, representing 200 addiction and mental health service providers all across the province, in places like Mississauga, Kitchener, Niagara and Thunder Bay.

As the leading provider of community addiction and mental health services, our members have decades, and in some cases a century's worth, of experience. For the most part, we were established by local leaders who had a personal connection to mental health and addiction, and who saw an unmet need. They are people who have worked in this field for years—often the only people who, at any given moment, are connected to their clients in the journey of recovery.

Some of this work takes place in hospitals, such as the Waypoint Centre for Mental Health Care in Penetanguishene, but most are community-based, local operations

like Halton Alcohol, Drug and Gambling Assessment Prevention and Treatment, and Peel Addiction Assessment and Referral Centre in Mississauga.

Through a wide range of services like treatment, counselling, withdrawal management, and housing, we help more than 300,000 Ontarians every year on their recovery journey. Because of this, we have a unique vantage point on Ontario's health care system.

We know that there are exceptional addiction and mental health care services in this province that are already working to reduce wait times and keep people out of hospital, because we see it every day. But we also know and agree that too many Ontarians are falling through the gaps, trying to access and navigate across these services.

Too many Ontarians are waiting too long on wait-lists, ending up in hospital when they should be receiving treatment in their community. Every year, still too many Ontarians die from overdose and die from suicide.

That is why AMHO members support the government's goal of building a patient-centric health care system. We want to work together with government to ensure that all Ontarians can access the mental health and addiction treatment they need, in their local community, when they need it.

We want to help Ontarians access services across the continuum of care, from hospital to withdrawal management to treatment, intensive case management, supportive housing and harm reduction.

We want to ensure that no matter where someone lives in this province, they receive the same standard of mental health and addiction treatment.

We want to ensure that Ontarians do not have to wait months to get access to essential health care services.

We think that it's time today to ensure that Ontarians struggling with their mental health or substance use receive the same average standard of care as someone diagnosed in this province with cancer, cardiac or renal disease.

We are hopeful about the possibility of this under the new model, but obviously are cautious about implementation, and we want to work with the government to get this right.

We can do better, but we believe "better" will require specific attention, direction and funding from government, like it has previously on other diseases, such as cancer. This work should be done in partnership with service providers.

I do believe that is the government's intention, including the work under way on a mental health and addiction strategy by the Deputy Premier and led by MPP Martin, and with the platform commitment on the table of $3.8 billion over 10 years.

However, with large health care system reform across the system being under way, we just want to make sure that this work on mental health and addictions doesn't get lost.

Since the Deputy Premier's announcement in February, AMHO has been holding regional meetings across the province to discuss these changes. I'm pleased to tell you that by the time we are done next week, we will have connected with more than 120 of our member organizations in person, specifically to talk about and answer questions on Bill 74, Ontario Health and Ontario health teams. I think this level of interest tells us that there is a high level of anxiety around these changes, but I think it also tells you that there is a commitment on our members' part to evolve and adapt.

What our members told us at these meetings is that government needs to protect locally run, locally governed, community-based mental health and addictions care and ensure these services are part of every Ontario health team; listen to and learn from community mental health and addiction front-line providers and leaders when it comes to system transformation and what patients need; and expand access to community-based addiction and mental health services to best support Ontarians, reduce wait times and tackle hallway health care, not by starting from scratch but by building on what is already working in the system.

Our members also asked me to deliver the message to you today that Ontario health teams should be required by government guidelines and measured by Ontario Health through an equity lens that pays specific attention to Indigenous people, Franco-Ontarians, the LGBTQ community, racialized communities, and gender.

We are also asking that Ontario Health be required to consider the additional cost and operational challenges of delivering equitable services in northern and rural and remote Ontario.

The written submission we are providing today is a joint submission on Bill 74 developed with our partners in the addiction and mental health sector at the Canadian Mental Health Association Ontario and Children's Mental Health Ontario. I know you have already heard from my colleagues Camille Quenneville and Kim Moran, and that the submission in front of you is probably familiar.

As leaders in community-based mental health and addiction service provision, we want to work with all of our government partners to get this transformation right. We are here to help the government make this health care system transformation a success for patients, clients, care providers and the taxpayer.

The recommendations from our joint submission are as follows:

(1) Community-based, local mental health and addiction providers must play a central role in the delivery of mental health and addictions care through Ontario health teams. Attention must not be paid just to mental health or addictions; priority should be placed on improving services and outcomes across the full continuum, with a focus on concurrent disorder.

(2) Ontario health teams must focus on providing Ontarians with continuity of mental health and addiction care across the lifespan, from children and youth to adults and seniors, with a particular focus on transitions.

(3) Ontario Health must identify, adopt and implement a standardized set of core services for addiction and mental health care across the province. When we talk about the

foundation of what was done so well in cancer, this is exactly what we're talking about in mental health and addiction. We want the government to know that AMHO is already working in partnership with CMHO and CMHA Ontario, as well as the Ontario Hospital Association, to develop this list. We want to make it as easy as possible for the ministry and Ontario Health to identify a core set of services and standards.

(4) Ontario Health must focus on the implementation of a strong, client-centred data strategy for mental health and addiction care—

The Chair (Mrs. Nina Tangri): Thirty seconds.

Ms. Adrienne Spafford: —so that the level of care provided through Ontario health teams can be measured and maximized.

(5) Ontario Health must establish a baseline of funding to community mental health and addiction service providers, and must commit to both protecting and growing these funding levels to support capacity building within our sector.

I can't overemphasize how much we agree with the Premier's council that one of the biggest factors in ending hallway health care is to increase capacity and improve quality outside of hospital hallways, by focusing on community support and services and on primary care.

The Chair (Mrs. Nina Tangri): Thank you very much. I'm going to begin with the government side. Mrs. Martin.

Mrs. Robin Martin: It's nice to see you here, and thank you for your presentation.

I was interested that you said just now that you have been conducting round tables around the province, specifically about Bill 74, I think you said, with your member organizations. I think you noted that some of them were saying they were anxious about it. Can you just tell us what kinds of things they said so we have the benefit of some of the work you've done? I know you haven't consulted all of your member organizations yet.

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Ms. Adrienne Spafford: Absolutely. We have had good conversations with many of them.

I think that, primarily, they're concerned that mental health and addictions, without that rigorous core service list, standardized services across the system and standardized sort of costs of delivering services—they're concerned, given that historically across all governments and the health care system, it's not like we can say there's been a strong focus on mental health and addiction up until this point. I think their main concern with Ontario health teams is that the model will be primarily governed by organizations that don't necessarily understand the best delivery of mental health and addictions. Frankly, they're worried about governance models that would require community governance to be given up.

They're also very concerned, with the move to standardization and a standard price point on a delivery of a set of services, that, especially in the early adopters, organizations could be picking clients who might be less expensive to deliver care for, that they might be picking the easier-to-care-for clients, and that clients might be able to fall through the cracks with that model. We would like to work with you on ensuring that's not possible.

I think, generally, it's a fear of the unknown. It's a huge benefit to me to learn from the members, but the biggest comment I hear coming out from them is, "It was so good to get this information. It was so good to have someone who could answer questions. My anxiety is just so much less after having had a two-hour dialogue on these changes." It's the fear of the unknown.

Mrs. Robin Martin: Okay. Well, great. One thing I do want to put on the record to assure your members is, we are proceeding with our mental health and addictions plan and the investments. We're going to try to do that as well as possible to build the capacity in the system so that it does play an important role.

I think that you know that one of the other reasons we're doing this is so that patients do not fall between the cracks, for the very reason that now they are. I know your members have lots of experience with people not getting services over the last number of years, as mental health hasn't been a priority.

Do your members or do you see advantages, then, with approaching it this way, in a way that we can make integrated teams?

Ms. Adrienne Spafford: I think that when they are able to take the fear out of, frankly, being gobbled up by a local hospital, when they are able to take that lens off of it and have access to some of the information about the best models that have worked—for instance, the bundled payment program at St. Joe's hospital and how that might apply in mental health and addiction—then yes, absolutely, they do see the possibility there for better integration and more coordinated services.

I think they're also very excited about the possibility of having the government able to focus on reducing barriers to improving care. There are rules that make it restrictive for organizations to be able to ramp up and ramp down care as somebody needs it through their illness, which is a life cycle thing in mental health and addictions: It's a complex, chronic illness. They're hopeful that some of these changes will be able to improve those outcomes, absolutely.

The Chair (Mrs. Nina Tangri): Ms. Kusendova.

Ms. Natalia Kusendova: I have a question specifically around mental health supports for youth and adolescents. We know that there are quite long waiting lists. I work in the emergency room, and often when I discharge my patients, when we're talking about youth and adolescents, there is a waiting list of up to 18 months. Do you have any thoughts on that or any recommendations on how to close that gap?

Ms. Adrienne Spafford: Yes, I'm going to let Vaughan handle that one, because Pine River Institute provides addiction treatment to youth. I would say, generally, that we fully support Children's Mental Health Ontario and Kim Moran and their recommendations on improving services and focusing investments first on kids who are really in crisis and need it the most. Our budget submission also included recommendations for a focused

investment in youth addiction treatment—Vaughan can speak to his wait times—because we know that while brains and bodies are still developing, as they are when they're kids—

The Chair (Mrs. Nina Tangri): Thirty seconds.

Ms. Adrienne Spafford: —the ability to get treatment is so much more important, and works.

Mr. Vaughan Dowie: Just very briefly, in our centre, which is a residential treatment centre, we have 29 beds that are funded through the government. I have 220 people waiting for those beds. We run a wait-list of about 12 to 15 months. Why do we have such a wait-list? Because we have such a low capacity in Ontario for residential treatment for youth. There are not enough beds, obviously, if there are 220 waiting for our 29. We have a deficiency between what we require and what we are actually able to deliver.

The Chair (Mrs. Nina Tangri): Thank you very much. I'm going to move to the opposition. Who would like to begin? Madame Gélinas.

M^me^ France Gélinas: Thank you. My first question is, I know that you were involved in the Premier's council table on mental health. I understand you were involved, or your organization. Was the Premier's council involved in the drafting of Bill 74?

Ms. Adrienne Spafford: Just to correct things, AMHO was not represented on the Premier's council or the working group.

M^me^ France Gélinas: Okay. Were you consulted in the drafting of Bill 74?

Ms. Adrienne Spafford: We received a technical briefing by the ministry in advance of the bill being introduced. We were invited to the minister's announcement and a technical briefing on the bill, on Ontario Health and on Ontario health teams after the bill was introduced with the ministry. We're very happy to be here today.

M^me^ France Gélinas: But nothing before.

Ms. Adrienne Spafford: We received a technical briefing by the ministry in advance of the bill being—

M^me^ France Gélinas: Okay. Once the bill was already written, the technical briefing was about the bill?

Ms. Adrienne Spafford: Correct, yes.

M^me^ France Gélinas: Okay. I just wanted to make sure.

We already know that not all mental health and addiction services are available equally, depending on where you live. How do you see the new super-agency having anything to do with equitable distribution of mental health services?

Ms. Adrienne Spafford: If Ontario Health is able to repeat in mental health and addictions what, say, Cancer Care Ontario has done in cancer care, our vision would be that Ontario Health would be responsible for identifying a core list of services—so things like supportive housing, case management, community addiction treatment and residential treatment. Ontario Health would be responsible for identifying standards for each of those services and supports, and then it would be the service providers who would deliver against that.

M^me^ France Gélinas: But you know that none of that exists in the bill right now. The new Ontario Health was not given a mandate to do that.

Ms. Adrienne Spafford: I don't think it's our read of the legislation that it wasn't given the mandate. You're right that that's not currently drafted. Those specific details and much of the operational elements of Ontario Health aren't in the bill. It's 74 pages; I assume that a lot of that would be done in regulation or by operational decisions.

M^me^ France Gélinas: Are you being consulted on what you would like to see in those regulations?

Ms. Adrienne Spafford: I don't think we've moved to that stage yet. Today we're here presenting on the bill, on Bill 74, and it would absolutely be our intention to be working with the government, with the ministry on those regulations, yes.

M^me^ France Gélinas: We all know that is in the bill. As long as you have three of the six—hospitals, long-term care, primary care and mental health and addictions are on the list—you can become a lead. Mental health and addictions always tends to be the poor cousin in health care. How do we make sure that those teams don't move forward without you?

Ms. Adrienne Spafford: Yes, that would be the key message that I'm delivering at committee today: Addictions and Mental Health Ontario and our partners at CMHO and CMHA want to work with government to make sure this model is successful in mental health and addictions.

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M^me^ France Gélinas: And does your organization or any of your 220 members ever express a position about having a private, for-profit agency as a lead for one of the Ontario health teams?

Ms. Adrienne Spafford: As a lead for one of the Ontario health teams? That has not come up at any of our member meetings—a private for-profit being one of the leads of the Ontario health teams. I think we will know more about that when the ministry's guidance document comes out. We're still waiting on a lot of information about how the Ontario health teams are going to actually look based on the guidance document that we're awaiting to come out any day.

M^me^ France Gélinas: In your view as to how they should look, is there a preference for private, for-profit leads or for not-for-profit leads?

The Chair (Mrs. Nina Tangri): One minute to conclude.

Ms. Adrienne Spafford: Certainly we represent community-based, not-for-profit organizations, and we have a strong belief and opinion that health care should be delivered through a not-for-profit lens and community-based governance.

M^me^ France Gélinas: Okay. Are any of your members going to be leads, putting forward proposals to become the lead of one of the teams?

Ms. Adrienne Spafford: I know that lots of our members are actively involved in discussions with health care

partners to become part of an Ontario health team and part of a consortium. Frankly, it would make more sense to us that the lead of an Ontario health team would more likely be in primary care or an acute-care organization that would have that robust infrastructure rather than a mental health or addiction, which is more of a niche service, because this whole model looks at collecting a set of health care services across a population.

The Chair (Mrs. Nina Tangri): Thank you very much. We really appreciate your coming out to present today.

Ms. Adrienne Spafford: Thank you very much.

ASSOCIATION OF FAMILY HEALTH TEAMS OF ONTARIO

The Chair (Mrs. Nina Tangri): I'd like to call upon the Association of Family Health Teams of Ontario. If I can please ask you to introduce yourselves for the record, and you have eight minutes to present, followed by six minutes each from the recognized parties. Thank you. Go ahead.

Ms. Kavita Mehta: On behalf of the Association of Family Health Teams of Ontario and its members, we thank the Standing Committee on Social Policy for inviting us to speak to you about Bill 74, The People's Health Care Act, 2019. I'm Kavita Mehta. I am the CEO of AFHTO. I've brought with me Ms. Beth Cowper-Fung, who is AFHTO's president and board chair—she's also the clinical director at the Georgina Nurse Practitioner-Led Clinic—and Dr. Allan Grill. He's currently AFHTO's treasurer and incoming vice-chair, lead physician of the Markham Family Health Team, and he's also the chief of the department of family medicine at Markham Stouffville Hospital.

For too long, patients and their families have experienced fragmentation in their care, often falling through the cracks of our very siloed health system. Bill 74 intends to create a system that is seamless and integrated, something AFHTO and its members in primary care support and have been advocating for years. Providing comprehensive care, from-womb-to-tomb care, is something that is done by primary care providers. It's something that has created, and is also built in, trusting relationships with their patients. AFHTO looks forward to working with government in true collaboration to ensure primary care is at the forefront of this comprehensive transformation.

I will now turn to Beth, who's going to talk about why it's very important that primary care lead.

Ms. Beth Cowper-Fung: Good afternoon. Thank you for having us here today. I'm very pleased to be here to present to the committee.

Primary care providers know our patients best. We know their families and their caregivers. We're there with them to celebrate the first new heartbeat when we check with a Doppler when someone is pregnant, all the way through to when we provide palliative care for the loss of a loved one. Primary care is the entry point to the health care system and where most Ontarians receive their care. Eighty per cent of a person's care is going to happen in the community or their home, and only 20% in a hospital, where it's an acute, episodic illness.

Dissolving the LHINs and creating Ontario Health provides an opportunity for primary care to directly coordinate and integrate care locally to meet the needs of the people that we serve.

We have seen in other jurisdictions that hospital-led integrated teams have had mixed results in cost savings, efficiencies and patient outcomes. In contrast, those that are primary care-led have had greater success in terms of cost savings, patient outcomes and satisfaction. Evidence also shows that interdisciplinary primary care teams were valued by both providers and patients, and impacted their decisions to join an integrated care team. Ontario's family health teams and nurse practitioner-led clinics have been providing integrated care from the beginning, and we are well positioned to lead, using lessons learned from other jurisdictions.

Our first recommendation is to require that primary care be part of Ontario health teams and that primary care teams be the lead in areas where there are high-functioning teams.

But to anchor Ontario health team development, we need a vision. My colleague Allan will discuss this further.

Dr. Allan Grill: Thanks, Beth, and again, thanks to the committee for inviting us to have the opportunity to speak on these issues.

As Ontario health teams start to develop, it's very important to have a vision. The College of Family Physicians of Canada has presented the concept of a patient medical home, or PMH, which AFHTO endorses. This vision has all the required principles for effective integration of care, which include accessible care, patient- and family-centred care, continuity of care—and that includes transitions in care, like when a patient goes from hospital to home—care that is socially accountable and adaptive to their local community, and finally, comprehensive team-based care with strong primary care provider leadership.

The patient medical home vision of qualified health professionals working as a collaborative team also aligns with the Institute for Healthcare Improvement's triple aim, that being enhancing the patient experience, improving population health and reducing costs. On top of that, this model will also support front-line providers, which is part of the quadruple aim, so they remain engaged with their patients and less susceptible to burnout.

Our second recommendation from AFHTO is that Bill 74 be strengthened by including the vision of the patient medical home when speaking about the integrated care delivery systems, or Ontario health teams, with specific notation made to the Minister's Patient and Family Advisory Council declaration of values, which came out recently.

Another key success factor for an effective integrated system is good governance. Participants developing Ontario health teams need to collaborate and build partnerships around expectations and responsibilities. Participation should be voluntary and involve those who are ready

for change. This is really about ownership; it's not about buy-in. Organizations will also have to look at how their current governance structures align, but as their relationship matures, a new governance model may need to be defined, especially if there's one fund-holder for the Ontario health team.

The third recommendation from AFHTO is to ensure there is substantial change management support, not just for providers who deliver care, but also for boards who have been charged with fiduciary and duty-of-care responsibilities. We recommend that Ontario health teams specifically outline governance of integration, including principles of collaborative governance and what the requirements will be of health service provider boards that are coming together.

I'll now turn it back to Beth for AFHTO's final recommendation.

Ms. Beth Cowper-Fung: Thanks, Allan. We strongly believe that there needs to be an integration of mental health and addictions and home and community care into primary care. This transformation provides an opportunity to do just this. Primary care treats the whole person, and that includes mental health and well-being. These very important resources need to be embedded as primary care team members, allowing for continuity of care.

This is also the case for the coordination of care and system navigation. There is a sizable gap between coordination of care that's needed in the community and what is currently taking place. The transition of home and community care coordinators to the LHIN from former CCACs continues to be a problem. LHINs were supposed to be in the business of planning, integrating, funding and evaluating local health systems. They should never have been placed in a position to deliver direct services, as this is a conflict of interest.

For our final recommendation, we recommend Ontario Health stay true to its purpose to support health service providers and not be involved in direct service delivery, including home and community care. We ask that the relationship between primary care and home care be strengthened, and transition the functions and resources of care coordination to primary care. This will bring greater efficiency and patient-centredness to care. Care will be integrated, allowing for seamless transitions of care for patients.

Ms. Kavita Mehta: I just want to thank Allan and Beth, and thank you to the committee for allowing us to present. We are very pleased to see this move forward—

The Acting Chair (Mrs. Belinda Karahalios): You have one minute.

Ms. Kavita Mehta: Oh, a minute. Well, we are at the end of our presentation, so I will say, if we can, that we'd like to open up the floor for any questions that you may have.

The Acting Chair (Mrs. Belinda Karahalios): Thank you very much. Over to the official opposition for questions: I recognize Ms. Armstrong.

Ms. Teresa J. Armstrong: Thank you very much for your presentation today. We've been asking presenters as they come in if they have been consulted before the drafting of the bill and, if so, when that timeline was that you were consulted before the drafting of the bill.

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Ms. Beth Cowper-Fung: The Association of Family Health Teams has been quite fortunate in that two of us from the association sit on the primary care council for the Premier's council for ending hallway medicine. Myself, as the president, and Allan—

Interjection: Rob.

Ms. Beth Cowper-Fung: —and Robert Annis, the past president, both sit on that committee. We had our first meeting in November, so we both are fortunate enough to be there to provide some insight into primary care. There are 14 people, I believe, on that committee, and we do all hail from primary care.

Ms. Teresa J. Armstrong: How many meetings since?

Ms. Beth Cowper-Fung: Three since.

Ms. Teresa J. Armstrong: Okay. You are on the Premier's council, you had mentioned?

Ms. Beth Cowper-Fung: The subcommittee for primary health care on the Premier's council.

Ms. Teresa J. Armstrong: And your participation on that committee—do you feel that your input has actually contributed to the drafting of the bill?

Ms. Beth Cowper-Fung: I feel that our input is listened to. We've got both government and ministry people present, so I do feel that our input has been listened to as we're moving forward. We look forward, as we go forward more, to having more integration in terms of collaboration with patients, as well as providers more broadly.

Ms. Teresa J. Armstrong: Can you share with us whether you believe Bill 74 has the legislation provisions to enable what the government hopes to implement in restructuring the health care system, which is seamless integration across health care providers? Do you think that's going to accomplish that?

Dr. Allan Grill: I think that working in a family health team and in team-based care—and Beth works in a nurse practitioner-led clinic—we have personal experience on the benefits of team-based, comprehensive, coordinated care. Working in that model, I can tell you that care seems to be more efficient. There's increased access to publicly funded services. There are improved health outcomes, studies have shown, and there is also improved patient and provider satisfaction.

If you're able to take a model that we've worked in, that we think is working well, and you scale it up properly and build Ontario health teams, and you've set up good governance and you collaborate with health care providers that are all in the business of improving patient care, then we think this is a step in the right direction to allow patients to have access to the integrated care that they require.

Ms. Teresa J. Armstrong: But the legislation that is proposed, all those things being equal, if it rolls out the way it is, in this form, do you know if it will be seamless care? There won't be interruptions in patient care? Is it all going to be—no disruption in the community care?

Ms. Kavita Mehta: I don't know if we can predict what the future looks like. I certainly think that it gives the grounding to actually come together, for partners to come together. I think a lot of what we would like to see is maybe in the details of implementation, and I think that's something that can help inform government.

To Allan's point, we've got a decade of experience around inter-professional team-based care that is integrated, and we have a lot of lessons learned that we can share with government. If we can translate those lessons in the details of the implementation of the plan, I think there's a lot the legislation will actually enable us to do.

Ms. Teresa J. Armstrong: In your fourth recommendation, you kind of directed the hospitals. You want them to be operational but not directly involved. How important is that to the success of this legislation and the policies that they are claiming are going to be rolled out for better patient care?

Ms. Beth Cowper-Fung: We would say that's extremely important, and certainly one of our stronger recommendations in terms of making sure that the people on the ground, who have been doing the work and have been for a decade doing that kind of care, understand how the transitions in the community occur and what needs to be strengthened. So we very much feel that primary care should be at the table planning some of these changes.

Ms. Kavita Mehta: Yes, and I think that the hospitals are partners. One thing we don't want to see is a hospital-driven province; I don't think anybody wants to see that the care is actually provided in community care. But I think this legislation and the opportunity to come together and have these conversations is going to be able to level out the playing field so that everyone can work more collaboratively together.

Ms. Teresa J. Armstrong: But based on your recommendation 4, it's not clear that would be the case.

Ms. Kavita Mehta: Recommendation 4 is related to primary care coordination—

Ms. Beth Cowper-Fung: Care coordinators being embedded in primary care.

Ms. Kavita Mehta: —care coordinators being embedded in primary care. We don't actually—

Ms. Beth Cowper-Fung: Currently they're with the LHIN.

Ms. Kavita Mehta: Yes.

Ms. Teresa J. Armstrong: So maybe I've got the wrong number, but you don't want hospitals to actually coordinate the community care piece? You want them to be—

The Acting Chair (Mrs. Belinda Karahalios): There is one minute remaining.

Ms. Teresa J. Armstrong: —operational in the whole legislation. Is that clearly the structure of this legislation—the role of the hospitals in this integration?

Ms. Kavita Mehta: I don't know if we've actually done a deeper dive into that. I would say that our recommendation forward is specific to mental health and addictions and care coordination supports being built into primary care and actually being integrated.

M^me^ France Gélinas: Chair?

The Acting Chair (Mrs. Belinda Karahalios): Madame Gélinas.

M^me^ France Gélinas: I just want to make sure, because some groups we talked to think that family health teams are not included in the integrated care at all. They talk about CHCs, nurse practitioner-led clinics, but they don't talk about—have you been confirmed that FHTs will be part—

Ms. Kavita Mehta: I mean, they are named as an HSP in the legislation, absolutely. FPs and NPLCs have both been named as HSPs, as they were in the previous LHSIA legislation as well.

M^me^ France Gélinas: Okay. And OMA negotiations allow for that to happen?

The Acting Chair (Mrs. Belinda Karahalios): Thank you. I now turn it over to the government side. I recognize Mr. Sabawy.

Mr. Sheref Sabawy: Thank you very much for taking the time to submit to the committee.

Based on your experience outreaching, especially in the northern and rural areas, I see that your model might look more flexible and much faster adapting to the situations and the demography. I would like to ask you how you evaluate opportunity now with the new Bill 74, to be part of that, as a core part of the delivery of the service for the front end?

Ms. Beth Cowper-Fung: The nurse practitioner-led clinic that I'm the clinic director of and work in as a nurse practitioner is 90 kilometres north from where we're sitting right now, so sub-north, as my northern colleagues would call it. We actually have—

Mrs. Robin Martin: You may as well live downtown.

Ms. Beth Cowper-Fung: Exactly. It's the sort-of north.

We've had strong communication and strong ties to our colleagues in the past in terms of mental health. We go out and do outreach to two mental health service care provider homes so that folks don't have to leave. The hospitals have already been in touch with us. We sit on the local health link committee. We already have really good ties in the smaller communities. I think that there's a bit of barrier breakdown when it comes to the smaller communities, because we are all working together already. I think that this bill will give us the opportunity and some of the structure to be able to work more closely.

Ms. Kavita Mehta: And I just want to add that when you talk to our teams in the north or in the rural areas, there are a lot of lessons that can be learned there because they all get along pretty well. The barrier busting is a lot less than it would be in the urban settings. I think we've been looking to them to see how partnerships and integration actually can work.

Mr. Sheref Sabawy: Yes, perfect. My next question would be your concept about measuring improvement, which uses data analysis to understand more about directions to improve your service. How do you see that experience adding to Bill 74 to scale up the model you have now to cover a bigger footprint on the new administration?

Ms. Beth Cowper-Fung: The importance of being able to have metrics on work that we do is enormous. I think it's been a real disadvantage to the folks who are in solo practice; they haven't had the administrative support to be able to do those things that we have in teams. That's where team-based care, where we can actually measure it and our patients have the advantage of team-based care, is so important. We've been able to show that and look overseas to see what's happened in other countries in terms of team-based care. Being able to use that metric to scale up, I think, is very important.

Ms. Kavita Mehta: I just want to add that one of the things that we've been able to do is really incorporate quality improvement and management, as well as improvement from the get-go in inter-professional team-based care. There's a lot that we can bring forward. Again, I think over a decade's worth of experience also includes over a decade's worth of how you can measure integrated care delivery.

The other thing I think is very critical is that the devil is in the details. In the details of implementation, you need the providers to own what they want to measure. It needs to be meaningful to them. It needs to be something that they themselves recognize needs improvement. I think that's an ongoing change management principle we would like to see throughout the implementation.

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Mr. Sheref Sabawy: My final question would be in regard to your concept about team care, which is like integrated service, which is almost the same spirit of Bill 74—having one entity built around the patient himself or herself and seamlessly moving from one part to the other under one umbrella. Can you give us, from your experience, the benefits of having that?

Dr. Allan Grill: And my microphone just turned on. Great.

Thanks for asking that question. I'm going to give you a quick example. There are many we can use. Health Quality Ontario and the Ontario Hospital Association both have written documents on transitions in care—meaning that you have a patient and they have an ailment, and they end up somewhere outside their home: hospital, let's say, long-term care, rehab etc.

If you use hospitals as an example, what ends up happening is that when a patient goes into hospital, they're sick, they get confused and they're in an unfamiliar environment. They're dealing with health care providers they don't necessarily know, because it's episodic care, and there's not a great relationship there, right off the bat. Then they improve and they get discharged. When they get discharged, there's a whole bunch of plans. There's a medication list, specialist follow-up, and maybe there's home care required. What often happens is, it's not necessarily coordinated that well in the current system, right? So, you then have patients who don't get the follow-up they need, and what happens? They get readmitted to hospital, especially the chronic-disease vulnerable patients.

In Markham—and we're not unique to this—we started a transitions program.

The Chair (Mrs. Nina Tangri): One minute to conclude, please. Thank you.

Dr. Allan Grill: Our patients came to us with recommendations. What we did was assign a nurse practitioner to go into the hospital, get notification of when patients are admitted and help coordinate the discharge. We have a pharmacist who does medication reconciliation. We then have follow-up with the primary care provider within seven to 14 days. The patient is very familiar with us. We help coordinate all the care that they need post-discharge, so they don't end up back in hospital. It reduces costs, and it improves patient outcomes and patient satisfaction.

That's just one example—I could name many more, if we had more time—where we think we could scale this up and benefit patients.

Mr. Sheref Sabawy: So, basically, you created a small Ontario Health within your organization.

Dr. Allan Grill: Yes.

Mr. Sheref Sabawy: So you are familiar with the bill, then. Thank you very much.

The Chair (Mrs. Nina Tangri): Thank you very much. There are 15 seconds—

Interjection: No, that's okay.

The Chair (Mrs. Nina Tangri): Thank you very much for coming out and presenting to us.

Dr. Allan Grill: Thank you.

Ms. Kavita Mehta: Thank you so much.

ONTARIO MEDICAL ASSOCIATION

The Chair (Mrs. Nina Tangri): I'd like to call upon the Ontario Medical Association. If you can please introduce yourself for the record. You have eight minutes to present, followed by six minutes from each of the recognized parties. Thank you. Go ahead.

Dr. Nadia Alam: Madam Chair and committee members, thank you for the opportunity to present and address the Standing Committee on Social Policy. My name is Nadia Alam. I am the president of the Ontario Medical Association. I represent the 40,000 doctors of Ontario. I'm a family physician and anaesthetist in Georgetown.

With me today is Jim Wright, chief of the economics, policy and research department at the OMA, and a children's orthopaedic surgeon.

On behalf of the OMA, we are pleased to offer our support for the broad changes introduced by this bill, specifically the focus on improving patient care and integration, and the prioritization of a sustainable and digitally enabled health care system.

As doctors, we are trained to use evidence to inform decision-making, and that's exactly what we have done. Upon reviewing the best evidence, we have found that the experience in other jurisdictions clearly demonstrates that doctors are essential to the success of health care transformation. Specifically, their leadership in terms of system design, governance and implementation is vital.

We want to take a moment to just reflect and express our appreciation for what we truly believe to be a renewed partnership with government. Over the past several

months, we have recognized a new path forward with government, and we are excited to be collaborating with you as we co-develop this integrated health model in Ontario.

The OMA has long advocated for an integrated health care system. Integration is what doctors want and it's what patients want, and we're thrilled that it is now what the government is prioritizing.

We have provided you with advance written copies of our submission. In the interest of time, we will focus on three of our recommendations, but we would be pleased to take questions related to our other recommendations or other issues, following our remarks.

My colleague Dr. Jim Wright will now take you through our first key recommendation.

Dr. Jim Wright: Good afternoon, and thank you for the opportunity to speak today.

As I'm sure you all know, other areas of the world, including the United States and the United Kingdom, have unequivocally demonstrated that physician-led integrated models are the best at reducing cost while simultaneously improving the quality of care.

We applaud the government on its ongoing commitment to put patients at the centre of care and integrate care around the patient.

In order to do this successfully, primary care is the fundamental building block. Primary care is the patient's main point of entry into the health care system, and it's where the patient's health care needs or concerns are initially assessed and where ongoing treatment, follow-up and referrals are provided as needed. Doctors are the most effective leaders in primary care.

For this reason, we strongly urge the government to enshrine this fundamental principle in the legislation to achieve ultimate success. To that end, we are proposing an amendment to the bill to ensure that integrated care delivery systems are led by doctors and are centred in primary care.

In addition, the results from other jurisdictions consistently demonstrate the importance of voluntary participation in integrating care. There are many doctors in Ontario who are keenly interested in the upcoming changes. In fact, just last week, we had a meeting and it was discussed, and nearly all of the doctors present questioned how they can participate.

As with any change, however, we will achieve far greater success by empowering doctors to participate. We risk failure if change is mandated. This health system reform will take years to implement, and the OMA is here to help support doctors in that implementation. However, it cannot and must not be mandated.

We're not looking to be critical or raise flags. However, we must caution you: If there is an indication that the government may be forcing any sort of integration on doctors, this reform will fail.

Within the profession, there is significant alarm regarding the removal of the exclusion of doctors as health services providers. I assure you, doctors want to participate in an integrated care system. This need not, however, be legislated. There are far more effective and time-tested options to moving forward. We are currently developing a contractual model and we would be pleased to work with the government to formalize this.

Therefore, we respectfully and strongly urge that the exclusion of doctors as health services providers be preserved. We have proposed an amendment to Bill 74 to include this exemption of doctors as HSPs, consistent with that which was previously captured in the LHSIA legislation.

Dr. Alam will now review our other key recommendations.

Dr. Nadia Alam: We want to touch briefly on the importance of having doctors in an advisory role at Ontario Health before I move on to my final point. We noted that the bill sets out the requirement to include a patient and family advisory council. However, no similar council exists for providers. Therefore, we have proposed that formal mechanisms be developed to ensure that Ontario Health collaborates with and seeks advice from doctors and physician leaders by way of what we have called a health provider council. We recommend that the OMA be a named member of this council to represent doctors in Ontario and have included a proposed amendment to this effect.

We want to take the final moments of our presentation to focus on the critical need to prioritize the development, support and integration of a functional, seamless and useful health information system in Ontario.

We have all been talking about an electronic health record for nearly two decades. True integration is absolutely contingent on the development of such a system. From a technology perspective, there are a myriad of ways that information can be integrated, but it is important to ensure that technology does not create a further barrier by adding considerable complexity, unnecessary variation or administrative burden for both patients and providers in accessing health information.

With the increasing rates of burnout among doctors, we all have a duty to ensure that anything that is introduced be supportive to providers in practice. A provincial lens should be applied when considering integration both within the different OHT services and across the province.

In addition, we have raised some concerns over the years regarding perceived barriers to effective information-sharing, stemming somewhat from confusion regarding what is permitted within privacy legislation. All too often, providers find themselves receiving unclear guidance on what is and what isn't permitted. We have many suggestions for enhancement to the Personal Health Information Protection Act which we believe will help create the enabling system required for effective information-sharing.

The Chair (Mrs. Nina Tangri): One minute, please.

Dr. Nadia Alam: At the same time, we encourage providers to come together with the ministry and the Information and Privacy Commissioner to ensure alignment on legislative intent.

I want to close by again thanking you for this opportunity and express our continued willingness to co-develop these new changes together.

We would be pleased to take questions.

The Chair (Mrs. Nina Tangri): Thank you very much. We'll begin with the government side. Who would like to ask the first question?

Mrs. Robin Martin: I will start.

The Chair (Mrs. Nina Tangri): Mrs. Martin.

Mrs. Robin Martin: Thank you very much for your presentation. I look forward to reading it. I didn't get a chance to read it all while you were speaking, but it looks like you've covered a number of things that will help us as we're going forward, so thank you very much for doing all that work.

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We know that Ontario's doctors play a very important role in ensuring that patients receive the care they need. I was wondering if you could describe for us how you see the changes we've proposed in this legislation helping in how doctors provide care to Ontario's patients.

Dr. Nadia Alam: I guess I'll start. I think the biggest thing that we see is an opportunity for integration. Right now, the system is so fragmented that it is nearly every day that I hear stories of patients falling through the cracks. The system has to change. The way it currently is is untenable.

What we see here is an incredible opportunity to fundamentally change how health care is delivered in Ontario. That integration piece will be key to moving forward, and we're very excited—not just for the opportunity today and not just for the opportunity that we've had so far to help you co-develop legislation to get it right the first time.

Mrs. Robin Martin: Anything to add?

Dr. Jim Wright: I guess the only thing I would add is, this is based on experiences in other jurisdictions, just to reinforce my point that physician-led—whether you call them accountable care organizations in the United States or integrated care organizations in the UK, Netherlands or Sweden, if they're physician-led, they're much more likely to be successful both in improving quality of care and at the same time reducing inefficiency and reducing costs.

Mrs. Robin Martin: Thank you very much. Other than the ways you've already suggested, how do you foresee working with the government? How can the OMA help us get this right, other than the ways you have already told us about?

Dr. Jim Wright: We see that it's likely that many physicians or family health organizations will be coming and looking to us for advice. So we're going to coordinate—and have begun that coordination—with the government to make sure that the information they receive is consistent, because that will be vital.

Also, as we both learn how to make these teams effective, we will be working together to make sure that the teams are supported. The aim of ultimately receiving 50 to 80 teams that cover the entire province is a massive undertaking, so we hope to be partners in achieving that goal.

Mrs. Robin Martin: Thank you.

The Chair (Mrs. Nina Tangri): Mr. Sabawy.

Mr. Sheref Sabawy: Just out of curiosity and for the benefit of the rest of the committee, how do the members of the OMA find the change? How did they receive the change? Are they excited or do you think the majority of them, or some of them percentage-wise, think that it's a good opportunity for doctors and physicians and medical staff to have a better environment—concentrating and focusing on doing the medical job other than the administration and trying to move the patients between the different entities?

Dr. Nadia Alam: I've been in practice now for about 10 years. Over the past 10 years, I've watched the system deteriorate—not because we don't have excellent providers. We have excellent providers. We've got excellent hospitals. We've got people who are all hands on deck all the time. But unfortunately, the demand outstrips the resources that are available. We need to find a way to create a system that's sustainable, that's patient-centred and that's focused on providing the right care at the right time for the right patient.

I'm not alone in this. As president of the OMA, I've heard far and wide about stories of how patients have fallen through the cracks, of how physicians have reached out for supports and have found them lacking, of how patients have struggled to get the care they need in the different settings that make up our health care system.

Physicians see this as a great opportunity. They're cautiously optimistic about where the government is going. As you know, the details matter. My colleague here has mentioned already how important it is to have a physician-led system that's based around primary care. There are also other nuances that we appreciate from our research on what can create a sustainable, effective health care system that doesn't just produce excellent quality outcomes, but also provides cost sustainability for the government and provides a patient-centred system, which is really what patients are looking for in this day and age.

I believe that the majority of our physicians are excited about the changes and are hopeful about the change. They're hopeful that there is significant political will to see this through.

Dr. Jim Wright: I would say there's enormous excitement among the physician group, not just in meeting the needs of their patients—but also by enhancing the integration, it's going to take away what is already a burden on physicians, to do that integration themselves, and that frees them up to do what they really want to do, which is looking after their patients.

There is another part of the OMA, which is called OMD, which is a primary care health information system. The physicians are incredibly excited about the opportunity to actually achieve a seamless health information system, which this has the potential to achieve, and we in the OMA are pleased to participate.

The Chair (Mrs. Nina Tangri): Thank you very much. I'm going to move to the opposition. Who would like to begin? Madame Gélinas.

M^me^ France Gélinas: Thank you so much for coming. My first question is kind of a direct one. Did the OMA have the opportunity to formally be consulted before the writing up of Bill 74?

Dr. Jim Wright: Yes, we did.

M^me^ France Gélinas: And when did that start?

Dr. Jim Wright: Probably about six to eight weeks ago. We've had approximately—I can't tell you absolutely for sure, because there have been meetings both with the health policy group, but also with OMD to talk about digital health and virtual health, so approximately a half-dozen meetings.

M^me^ France Gélinas: So that started about six to eight weeks ago? The bill was tabled about three and a half weeks ago. Three weeks before the bill was tabled, you started to have conversations about Bill 74?

Dr. Jim Wright: Yes, at least that period of time.

M^me^ France Gélinas: Okay. And were any of your suggestions taken into account when you saw the written-up bill?

Dr. Jim Wright: We've had an opportunity to provide feedback. We, of course, didn't necessarily see the bill in its final formulation, but we see many of the things that we think are important in achieving integrated care delivery systems reflected in this bill.

M^me^ France Gélinas: Okay. I was rather surprised when I saw the change in the exemptions for physicians. As you noticed, in LHSIA, there were exemptions for physicians as health service providers. In Bill 74, those exemptions are not there. Physicians are not there. Was this something you had suggested?

Dr. Jim Wright: We believe the exemption of physicians as HSPs is quite important. Any sign that physicians would be forced to integrate, we think, detracts from the idea of voluntariness, which is so vital to achieving the kind of integrated care delivery systems we see worldwide. The idea that, as designated as an HSP, somehow they would be forced to integrate, we think goes against the spirit of voluntariness and co-operation.

Dr. Nadia Alam: The other thing that I would add to that is that we would like to also see the inclusion of community-based specialists as part of the ICDSs. Currently, they need to be part of it just because they provide a valuable service outside in the community. While the majority of specialists work in hospital-based systems, we do have some vital services that are provided by community-based specialists.

M^me^ France Gélinas: Absolutely. What will happen if the changes are not made to physicians being a health service provider?

Dr. Nadia Alam: We feel that this is the start of a new partnership. We honestly do believe that. So we're working as much as we can to work with the government, to partner with the government to activate and engage physicians around the province, so that we can work together to create the kind of legislation that will work right the first time.

M^me^ France Gélinas: So it's not there now, and you're hoping very much that it's going to be in an amendment to the bill that will be accepted, but we don't know for sure? All right.

You've made it clear that you would like it to be physician-led, anchored in primary care, but you've just clarified that you want community-based specialists to also—would they be part of the leadership, or will the leadership be really anchored in primary care?

Dr. Jim Wright: It has to be centred in primary care, and I think that's probably a consistent message you've heard from many of the people coming before this committee, but the governance needs to include all of the important constituents. We would see that the most effective model is a total continuum of care that includes all aspects of care that might be relevant to the patient group. That would include community-based physicians.

M^me^ France Gélinas: So, specialists and primary care? Okay.

The hospital association was here. They made it clear that they have some of their members who want to be early adopters. It seems that the discussion with the government is going pretty good that this will happen. Have you been afforded the same courtesy that some of your members will also be early adopters and you've identified in which community those will be and what that will look like?

Dr. Jim Wright: We've certainly had some discussions with some very excited groups who have a long history of working effectively together and integrating care, so we absolutely have that kind of interest.

1700

I would only direct you to the literature, primarily in the United States, which has shown that primarily hospital-based accountable care organizations have not achieved the kinds of savings or improvement in quality that comes from primary care and physician-led. That has very much directed our focus.

The Chair (Mrs. Nina Tangri): One minute to conclude, please.

M^me^ France Gélinas: I have utmost respect for negotiations, so don't share any negotiation news with me; I'm not interested. But would the OMA agreement allow for respectful payment of physicians if they become leads of Ontario health teams?

Dr. Nadia Alam: This is why we feel it's important to include an exemption for physicians and medical professional corporations as HSPs. We know that there are existing agreements and existing legislation, including the rep rights agreement, including the binding arbitration framework. This is why we're here today. This is why we'll continue to come to the table, because we've very interested in partnering with government to help make the kinds of changes that make this legislation make sense.

The Chair (Mrs. Nina Tangri): Thank you very much. We appreciate your coming out today.

REGISTERED PRACTICAL NURSES ASSOCIATION OF ONTARIO

The Chair (Mrs. Nina Tangri): I'd like to call upon the Registered Practical Nurses Association of Ontario. If you could please introduce yourself for the record, and you have eight minutes to present, followed by six minutes from each of the recognized parties. Please go ahead.

Ms. Dianne Martin: I'm Dianne Martin and I'm the chief executive officer of the Registered Practical Nurses

Association of Ontario. Good afternoon. Thank you very much for the opportunity to speak with you today.

I am also a nurse, and I have the privilege of standing up for nurses every day. RPNAO is a professional association that champions the critical role of RPNs to Ontario's health care system. We also build the profile and professional capacity of RPNs so that we can better care for our patients and better support our fellow health workers.

According to the latest available statistics, there are about 43,000 registered practical nurses in Ontario providing excellent care to patients across every corner of the province. Ontario's RPNs are knowledge-based health professionals who combine skill, judgment, passion and compassion on the front lines of the health system. We provide care in a variety of settings, including hospital, long-term care and in patients' own homes. As the second-largest group of regulated health professionals working at the front lines of care, we have a keen interest in the government's plans to transform the health system, and we were pleased to participate in the government's announcement about these changes in February.

RPNs know from experience where our health system is doing well and where it can be improved. Today, I'm here to share some of those thoughts as the government moves forward with Bill 74, The People's Health Care Act.

For years, RPNAO and our members have drawn attention to a number of pervasive challenges in Ontario's health system. We've called attention to things like long wait times, lack of integrated service, and siloes that make it difficult for patients and their families to navigate a complex health system. Over the coming years, we know the demands and strains on our health system will only continue to grow as the population ages. We need to look for new ways to make sure that Ontario's health system can meet the complex needs of patients and ensure that front-line professionals have the support they need to deliver the best care possible.

RPNAO supports the government's objective of building an integrated health system that puts patients at the centre of care. We believe that this legislation presents us with a real opportunity to transform our health system in a way that ensures seamless continuity of care between hospitals and care in the community, for example, or in long-term care.

We believe the ability of this legislation to achieve that objective relies on successful implementation. We have some key recommendations for the government to consider as it moves forward.

Firstly, if we are trying to build a truly integrated health system where patients get the excellent care they deserve, we need to remove the existing barriers to care. It's been a long time since the legislation was looked at, and nurses in particular have changed a great deal since the legislation was written that governs the practice of nurses.

We have to make sure that all health care professionals are putting their education and experience to best use. This means ensuring that those with specialized knowledge are focused where they have the most impact. To help achieve this, we are recommending the government make modest changes to RPNs' scope of practice to bring better care to our most vulnerable people and better value to our health system.

These are practices that RPNs perform every day. However, they can only do so after being instructed by a nurse practitioner or a physician, and in some cases, a registered nurse. We suggest that rather than waiting for an order, in the right circumstances, registered practical nurses be given the authority to independently decide and initiate these common practices that they do every day, which include wound care and starting an IV.

Patients who are in urgent need, including those in emergency situations or in remote and rural communities, don't have time to wait while an educated and competent RPN seeks permission to provide the care that he or she is already qualified to give.

We are confident these changes will remove barriers to integrated, high-quality and timely care on the front line, and give patients and their loved ones more confidence in the care they're already receiving.

Secondly, we won't achieve an integrated system without better integration of nursing care. Our current system has nurses siloed by sector. We need to be looking at the promising practices from other jurisdictions to break down those siloes.

For example, I recently returned from Australia, where I met with their nursing leaders to discuss models of care. I was impressed by the degree to which they have embraced a patient-centered model. In Australia, the same nurses who care for you in hospital are often the ones who follow up with you during home visits, to ensure a seamless continuity of care.

Last year, on a visit to Finland, I learned about their collaborative staffing models in long-term care. While we in Ontario require by law that an RN is on-site 24/7, in Finland they have an efficient system where their RPNs have access to a dedicated phone line for a registered nurse and a physician in an emergency room of a hospital with whom they can collaborate to identify solutions to emerging resident needs in the evenings, nights and weekends when the RN isn't there. The RN is there Monday to Friday. This has decreased many of the transports to hospital, and improved the ability for residents to have rapid care, rapid response to issues they might be having, and to stay in their home.

The government should work with front-line health professionals across the province to examine how we can adopt these kinds of simple yet innovative approaches to eliminate barriers to integrated care.

Finally, we think the government efforts to build an integrated health system also require the development of a robust health human resources strategy. We're not going to get rid of hallway health care unless we have the professionals at the bedside, available to offer the kind of expert care that patients need.

While we know that the number of RPNs is expected to grow in coming years, we are concerned about the expected shortages of RNs on the horizon. These are

shortages that are already beginning to be lived in many nursing environments.

The Chair (Mrs. Nina Tangri): One minute, please.

Ms. Dianne Martin: Already, we are hearing from our members about the impact that the stress and growing workloads are having on their well-being. Without further efforts to ensure we have the professionals that we need in our health care system, those stresses will only multiply.

We strongly encourage the government to continue to work with us and other health care stakeholders, to build a strategy so that we have the health human resources in place to support the government's vision of integrated, patient-centered care.

We look forward to continuing to work together with you to strengthen Ontario's health care system. We thank you again for the opportunity to present to you today, and I look forward to your questions.

The Chair (Mrs. Nina Tangri): Thank you very much. I'll begin with Mr. Mamakwa.

Mr. Sol Mamakwa: Thank you, Dianne, for the presentation.

I'm Sol Mamakwa. I'm the MPP for the riding of Kiiwetinoong. I have 27 fly-in communities that I represent, mostly First Nations.

Some of the services that are provided—when we talk about care, a community of 1,000 people will get physician services five days per month, which is 60 days per year to access physician services. In that community of 1,000 or 1,200 people, they have three RNs that provide that service in these nursing stations, these clinics, and that's the extent of the health care system that exists.

I'm just telling you this story because when we talk about provincial and federal responsibility, that's one of the struggles that I've been having—the province won't take any responsibility or accountability with respect to services on-reserve because of that jurisdictional potato of services to our people. It's at the cost of people's lives. It's at the cost of children's lives.

1710

Just going back to your presentation, you spoke about Australia. You spoke about home care. You spoke about how they work in home care, and also the RPNs that work there and also in hospital. I'm just wondering if they have the same rate of pay when you talk about that.

Ms. Dianne Martin: I'm sorry, what is the—

Mr. Sol Mamakwa: The same rate of pay.

Ms. Dianne Martin: The same rate of pay?

Mr. Sol Mamakwa: Yes.

Ms. Dianne Martin: So home care is a little different in Australia. Sometimes, if someone needs it for an extended period of time, there will be an agency assigned, and I'm less clear about how integrated—they are fully integrated in terms of communication. As far as pay or who they work for, who is the employer, I don't know. But in terms of most patients who are discharged from hospital, the nurse just has one employer; it's just that he or she cares for patients in more than one location.

Also, the other part of my presentation, where I talked about removing barriers that have been in place since our education was quite a bit less than it is now—it's those sorts of barriers being removed that would allow your community to have at least one more thing to add to the access that you're lacking. It certainly wouldn't solve all problems, but it would at least be one thing that could be added at a greater, broader depth and breadth of scope of practice for any care provider that you have. It would be a small part of what you need, which is a big solution.

Mr. Sol Mamakwa: So if jurisdiction is a barrier, what would you suggest for RPNs to provide service on-reserve?

Ms. Dianne Martin: Well, right now, for example, if you are an RPN in a remote area—the legislation was written before we had, say, the ability to start an IV, so RPNs who work in remote areas tell us that they will encounter patients who are in an emergency situation, and they have to do a mental thought process that consists of, "Do I step outside the law and start an IV while the veins are still accessible to help save this person, or do I stay within the law and not do this life-saving measure until emergency help can get there?" That's an example of what that looks like in a community like yours.

Mr. Sol Mamakwa: Okay. Thank you. I'm wondering if you had an opportunity to formally consult with the drafting of Bill 74. If so, can you tell us when you started consulting with Bill 74?

Ms. Dianne Martin: Formally addressing Bill 74, no, but formally meeting with the government to express all of our thoughts related to nursing, we've been doing quite frequently. We have met with the minister a couple of times. We have met with round tables to talk about long-term care and mental health. We have met with the Premier himself, and we have met with many of the staffers, all to put forward our ideas on what we think nursing has to start to look like in the new environment—

The Chair (Mrs. Nina Tangri): One minute.

Ms. Dianne Martin: —and we've been doing that since October.

Mr. Sol Mamakwa: Do you know how many members of your association work at the 20 crown agencies that are being dissolved by Bill 74?

Ms. Dianne Martin: No, I don't know what any sort of—of course, we're a professional association; we're not a union, so we don't track where they are employed. As a result, we have no idea if or how many of our members will be affected in terms of their employment.

Mr. Sol Mamakwa: We know also that there have been some nursing jobs lost at Grand River Hospital and Health Sciences North. The government has said that no front-line jobs would be lost by the health transformation. What do you make of this claim?

Ms. Dianne Martin: When we're talking about things like hallway health care, my concern really is greatest around when beds are closed. If I can try to recall—I was in Australia when all that was in the news, and I tried to follow as closely as possible, but I just got back—

The Chair (Mrs. Nina Tangri): I'm going to just stop you there, and we're going to move to the government side where perhaps they'll allow you to complete—

Ms. Dianne Martin: I had an answer for that, but now we'll never know.

The Chair (Mrs. Nina Tangri): Ms. Kusendova.

Ms. Natalia Kusendova: Thank you, Ms. Martin, so much for your deposition here today.

I'm a registered nurse. I work in the emergency room. I have to tell you that the RPNs in our team are some of our most valued team members. As a new nurse, I went to them so many times to ask for guidance, help and wisdom. I know that in our emergency room, they play a vital role and there is no way that our team would function without them. So thank you for representing those voices, because they are so important in our health care system, in acute care and throughout the health care continuum.

I listened to your presentation and I wanted to ask if we could get a written copy of the recommendations—it wasn't provided to us—just so we have that.

Ms. Dianne Martin: Yes. We actually have a table that describes those scope of practice recommendations that we will get to you. Yes.

Ms. Natalia Kusendova: Thank you. I can't help but agree with several points of what you mentioned today: removing existing barriers to access to care and better integration of nursing care. We know that nursing care is siloed right now, and there isn't that continuity of care between acute care into home care—whether it's long-term care. Those handoffs are not warm handoffs, as we would like to see them.

Exactly what we're trying to accomplish with Bill 74, if passed, is to centre the care around the patient, as you've mentioned in your deposition. I've said that so many times today, but right now in our health care system, the care is centred around the bricks and mortar where the patient happens to be and not around the patient. With these Ontario Health teams, what we are trying to accomplish is to centre the care around the patient, to have the same professionals follow the patient throughout their health care journey, regardless of where they are located.

I just wanted to ask you, how do you see the role of RPNs contributing to this new, integrated care system in Ontario, if Bill 74 passes?

Ms. Dianne Martin: Actually, I see RPNs contributing in the exact same way as RNs. We do the same job; we just do it with different patients. The RN is doing it with the more complex patients, with the less predictable outcomes. The RPN is doing the same job with the people who are more established on a path of care.

I see us doing exactly what I was describing there. As background, I am a childbirth nurse. In Australia, the childbirth nurse cares for the mother through to discharge, which is pretty quick, as you probably know, and also then goes to the patient's home for the next couple of days. The same nurse does that.

Regardless of what your situation is, whether you've had a lot of health teaching around your cardiac situation or whatever, having that nurse going home and making sure—having her day where she drops by the people's homes and makes sure that all of that is going according to plan, someone who knows your care intimately: That, to me, is the epitome of care.

To go to the point about more remote areas: In Australia, how they do that is such an integrated way of communicating and sharing all knowledge with—in the palliative care units, not a step was taken where the doctor in the receiving community way up in Alice Springs wasn't on the phone, consulting through that whole process.

That's how I see it moving forward. Really, all of that is built around a patient. We've been talking about building around patients for a very long time, but we have not done it. But that is what "built around patients" looks like, and it's not going to be easy to create.

Ms. Natalia Kusendova: Thank you. I just wanted to comment on the scope of practice that you've mentioned. Bill 74 is meant to be an implementation bill. Scope of practice for RPNs, RNs and all kinds of health providers is something that the government is currently looking into and is under consideration, but it's just not part of this particular bill.

What I wanted to get more of your thoughts on is the role of RPNs in long-term care, because we know that the previous government has largely underfunded long-term care. Now, we've announced about 7,000 new long-term-care beds, with a total of 15,000 in the next 10 years. We know that the nursing care provided in long-term-care facilities is largely provided by RPNs. Can you share some thoughts on that?

Ms. Dianne Martin: Yes. We have done what I believe is the seminal piece of work that looks at the work of nurses in long-term care. What we did was we looked at the number of patients that nurses have to provide care for. Yes, we do have PSWs who do a lot of the personal care, and thank goodness for that, but nurses can be giving meds for 30 to 100 people, which means we can't follow the standards of practice—which you know well—when we're doing it, and no patient is getting the amount of full care that they should get when it comes to monitoring that piece, whether most of that care happens by RPNs.

1720

The Chair (Mrs. Nina Tangri): One minute.

Ms. Dianne Martin: But then the RPNs also tell us the moral distress when they cannot just take the time to stop and hug and hold a patient who is suffering from a great deal of loneliness.

Nurses aren't even able to give the meds properly, and then they're not able to do the rest of the compassion part of their job either. That has got to change.

Ms. Natalia Kusendova: Absolutely, and I couldn't agree more with you.

With this health care transformation, what we're trying to achieve is to use those funds and to actually put them into the front lines. Do you agree that that's a step in the right direction?

Ms. Dianne Martin: Every time that there's a change made in health care, nurses tend to be the shock absorbers. Whenever there is not enough money to support the change or whenever the changes are made without the input of nurses, quite often they don't work very well. The

workload for nurses increases, even with the best intentions of those who make the laws and the rules, and nurses are becoming crushed under all of the changes.

The Chair (Mrs. Nina Tangri): Thank you very much. We appreciate you coming out to present to us today.

ONTARIO CHIROPRACTIC ASSOCIATION

The Chair (Mrs. Nina Tangri): I would like to call upon the Ontario Chiropractic Association.

Ms. Nancy Gale: Is there a place where—either is all right?

The Chair (Mrs. Nina Tangri): Your choice. If you could please introduce yourself. You have eight minutes to present, followed by six minutes from each of the recognized parties.

Ms. Nancy Gale: Okay, and I don't think I'm standing between you and dinner tonight; I think there is one other.

The Chair (Mrs. Nina Tangri): Go ahead. Thank you.

Ms. Nancy Gale: Good afternoon, members of the Standing Committee on Social Policy and staff. On behalf of the Ontario Chiropractic Association, I thank you for giving us the time today to consult on Bill 74. I am joined today by my colleague Marg Harrington, who is the director of health policy and program development. I'm Nancy Gale, the VP of communications and stakeholder management at the OCA.

I have worked in both acute care and home and community care, and I have seen connected care that works for patients. I've also seen when the system gets in the way of patients receiving the best care possible. I am optimistic about Bill 74. In the preamble, it states it is establishing a "new model of integrated public health care delivery which will put each patient at the centre of a connected care system anchored in the community." We could not agree more, and that's what we're here to talk to you about today.

As the Ontario government progresses through the consultation of Bill 74, we recommend that you include health care professionals who can provide patients with effective care. We also recommend that you preserve and build on the proven integrated care models that are working today as you move forward with the transition of Bill 74.

In the next seven minutes, I will share three recommendations and I will tell you about three proven solutions that exist today in what Bill 74 calls the "integrated care models."

Recommendation 1: Include all professionals in interprofessional care in the community. How do we realize that? You're doing it already today.

Here is my first suggestion of a viable solution: The Primary Care Low Back Pain Pilot programs bring physicians, nurse practitioners, RNs, RPNs, pharmacists, chiropractors and others together to give patients faster access to diagnosis and treatment of back pain. There are 12 chiropractors working at six of the seven locations today. By the way, this integrated care model is fully aligned to Bill 74's belief that "public funding should be directed to front-line services." Because the primary care low back-pain program is direct care, none of the funds are spent on physical infrastructure or administrative overhead. One hundred per cent of the funding pays for health professionals delivering direct care funding to the program.

Launched in 2014, primary care low-back pain programs have treated about 5,000 patients, and 93% of patients say their quality of life has improved, 87% of patients say the program gave them access to low back pain care that they otherwise would not have been able to access, and the program saw a 71% reduction in diagnostic imaging.

More importantly, if we're talking about putting patients at the core—in your package, there's a story about Lisa Morris. You may have seen her at our advocacy day. She was addicted to opioids, trying to manage her low-back pain. She is now opioid-free, and it was through the primary care low-back pain program. That story is in your package.

In the description of a health service provider, your bill recognizes family health teams and nurse practitioner-led clinics. It also references a "person or entity that provides physiotherapy services in a clinic setting that is not otherwise a health service provider." We ask that the standing committee consider including chiropractors in that description, so that Ontario health teams can continue to replicate or build on the success of other programs.

Recommendation 2: We think Bill 74 should enable consideration of programs that work for people, even when that funding comes from multiple sources, if they're at the core of the program and it's not bricks and mortar.

Our newest program, Health2Work, provides people receiving Ontario Works in the Waterloo region with access to MSK care—which is one of the leading causes of disabilities worldwide. Funded by Ontario Works, chiropractors treat MSK conditions—that means back pain, strains, sprains, neck pain and headache. Health2Work integrates with local health services and social services—in this case, Langs Community Health Centre, Ontario Works and the region of Waterloo. It was officially launched in February 2019—it's very new—and already, five clients now have jobs and are no longer on Ontario Works. That is phenomenal.

You can ask Leroy. There's a story about Leroy and what it means to him to be off social assistance and back at work in a job that does not exacerbate his pain. It's also in your package.

Like the primary care low back-pain program, Health2Work complies with Bill 74's prohibition in section 34. Patients receive care from the program at no direct cost.

Our third solution is a really great example of what Bill 74 is trying to achieve, on several levels. Created by a surgeon, ISAEC enables family physicians to refer patients who may be surgical candidates for a rapid low-back pain assessment by chiropractors and other health professionals. We recommend that this program proceed and have a place of consideration within the new Ontario health teams.

Surgeons trust chiropractors to assess and direct patients to the most effective care. In fact, the hiring panels of surgeons, physicians, hospital administrator staff and clinicians selected over 50 chiropractors to either lead or practise in ISAEC. Specifically, with ISAEC, patients will wait less than two weeks for an assessment by a chiropractor. And you can't beat this: Patient satisfaction in that program is 99%.

This leads me to my third recommendation. We recommend to the standing committee that Bill 74 include the complementary optimization of all professional health human resources with appropriate, safe enhancement of scopes that will reduce wait times, provide equitable access to rural communities, and focus taxpayers' money on effective direct care.

I realize that Bill 74 does not include scope expansion or scope enhancement, but we humbly bring it to you as a consideration, as a complementary expansion that will really serve the needs of Bill 74.

The Chair (Mrs. Nina Tangri): One minute, please.

Ms. Nancy Gale: For 10 years, the chiropractic association, the college and the school have requested enhancing the scope of practice for chiropractors, so that they can simply care for patients the way they've been trained to do. We think this red tape—forgive the pun—is a pain in the back.

In fact, by enabling scope enhancement for chiropractors alone, the savings to taxpayers is between $15 million and $23 million, because you don't need to have a physician do anything but provide a referral.

Here's a quick example: A patient has a hematoma. A chiropractor is concerned and needs to confirm for a diagnosis. That patient has to book an appointment with a family doctor, take time off work and get the appointment. The physician bills OHIP. They go and get the test. They go back to the physician, and so on. Scope enhancement simply enables a chiropractor who is trained and certified to read that lab test, to be able to do that directly and cut out the red tape, so that you are actually putting patients at the core.

The Chair (Mrs. Nina Tangri): Thank you very much. I'm going to move to the government side to begin. Mrs. Martin.

Mrs. Robin Martin: Thank you very much for your presentation. It's nice to see you again. I think I just saw you fairly recently, but we're happy to have you here today to present on this bill.

1730

I'm sorry; I was trying to listen, but there were a number of things going on over here. I'm not sure you told us how many chiropractors are currently licensed to practise here in Ontario.

Ms. Nancy Gale: There are about 4,700 chiropractors in Ontario who are licensed.

Mrs. Robin Martin: The training of chiropractors—we discussed some of this the other day—it is quite extensive. Is that correct?

Ms. Nancy Gale: It is. First of all, they graduate from a program and then spend four intensive years in chiropractic, where the college provides extensive training in musculoskeletal conditions. They are provided technology solutions, assessment and manual therapies so that they can quickly diagnose and provide appropriate care.

Marg, did you want to touch on a few other details?

Ms. Marg Harrington: Yes, just that the Canadian Memorial Chiropractic College—we're lucky to have it in Ontario. It trains nationally to serve other provinces. Many stay in Ontario. It also trains internationally. It conducts research. We'd be happy to have any of you tour. It's a world-class facility right here in Ontario, and we're very fortunate to have it.

During that training, chiropractors get the latest research. They have anatomy labs with simulation models. There's biochemistry. There's a full range of everything that's needed for in-depth, comprehensive education related to musculoskeletal care.

Mrs. Robin Martin: Thank you very much. I think I mentioned to you that I have been there because I had a chiropractor helping me with knee pain. It was very successful, so I was very pleased. But it is a beautiful facility.

The other thing I wanted to ask you—and you mentioned some of this—was settings in which chiropractors work and provide services. You've mentioned the primary care low-back pain clinics, but can you elaborate on some of the other settings in which we might find chiropractors working in the community?

Ms. Nancy Gale: For the Health2Work, for example, they are in community health centres. For the ISAEC program—that's where surgical candidates have their initial assessment, recognizing that so few patients are actually surgical candidates and yet wait a very long time, and everybody else waits for that surgical consult—that is actually done within their own practice, so they don't to have to physically be in any bricks and mortar.

Chiropractors, though, work in a number of areas. There are a number of PhD researchers in chiropractic. There are specialties in sports chiropractic that will work with sports teams and are virtual. There are many chiropractors who actually just do home visits: They bring a mobile table and they're able to do mobile care. There is veterinary chiropractic. Interestingly, there's quite a leading practice in that. There is a specialty for seniors' care. For example, Dr. Carlo Ammendolia, a renowned chiropractor, works through Mount Sinai Hospital. He's a PhD. He is an expert in spinal stenosis, and he provides care through that hospital setting.

So it can be in a bricks-and-mortar, it can be mobile, it can be in clinics, community health centres—wherever the patient is, where they live.

Mrs. Robin Martin: With that background, can you help us understand how you see chiropractors working within the model that we're trying to set up with our local Ontario health teams?

Ms. Marg Harrington: What we're hoping for is that the legislation will recognize the various practitioners who contribute to the health of Ontarians. Chiropractors are generally private providers. They work in their own clinics. What we're looking at is potentially a model where

a family health team would either add a chiropractor or they would refer out to the provider for their patients. The hospital with a long-term-care facility, home care and family physicians could use chiropractic clinics as a community resource and seamlessly integrate care in that way.

Ms. Nancy Gale: Another option, of course, is that—400,000 patients present at an ED. Ninety-seven per cent of them will be sent home without care, and they've waited hours—and they may also receive an opioid prescription. If there were a chiropractor—the triage nurse would say, "Based on these conditions, I want you to see a chiropractor." Then could you, in fact, redirect more efficiently and more quickly to have a chiropractor see that patient?

That doesn't mean that we're encouraging more patients to go to the ED, but you can't simply say, "I'll set up a clinic, and we'll redirect all of the patients."

The Chair (Mrs. Nina Tangri): One minute.

Ms. Nancy Gale: When patients are in need, they will go to the ED, but they shouldn't have to wait hours if a chiropractor were simply part of that system, either on-site or in the community.

Mrs. Robin Martin: You mentioned the story of Lisa Morris. Can you describe for us how a chiropractor helped her overcome her opioid—I guess we don't have much time.

Ms. Nancy Gale: Very briefly, Lisa had been suffering from chronic pain for a very, very long time. She had been given opioid prescriptions, and then they were stopped and she was buying her opioids from somewhere else. Our chiropractor who works very closely with that team asked a very simple, in-scope question, and that was, "Lisa, would you like some help reducing that opioid dependency?" and she said, "God, yes." She actually said those words. So he went to the pharmacist and the prescribing physician and they worked together. He helped her manage her pain—he said he helped her make friends with her pain—and she was able to taper off. She is on zero opioids right now, and working.

The Chair (Mrs. Nina Tangri): Thank you very much.

Mrs. Robin Martin: It's a wonderful story. Thank you.

The Chair (Mrs. Nina Tangri): I'd like to move to Madame Gélinas.

M^me^ France Gélinas: Thank you so much for coming here this afternoon.

The first question is quite simple. Bill 74 was introduced about three weeks ago. Were you consulted before the bill was introduced as to what was going to be in the bill?

Ms. Nancy Gale: The Ontario Chiropractic Association was not, but we had the benefit of hosting an advocacy day on November 20, so much of what we're talking about today is what we were talking about November 20. This is not a fly-by-night, "Oh, let's come up with some ideas." We feel that those programs are examples of how chiropractors, in optimizing all health resources, can be a viable partner in this system.

M^me^ France Gélinas: Okay. Since the bill was tabled, about three weeks ago, have you had any opportunity—except for today—to connect with the government to bring your ideas forward?

Ms. Nancy Gale: We have met with some MPPs as part of our outreach, which began November 20, to be able to share our ideas—not specifically to say, "Here's Bill 74," but because we think we're so aligned to what the spirit of the legislation is.

M^me^ France Gélinas: Very good. I'm familiar with the primary care low-back pain programs, one of which is in my community in Sudbury at Shkagamik-Kwe, but I remember them coming to me because the funding for this particular program was not operationalized. They did not know if they were going to be able to continue the program because they did not know if the present government was going to fund it. Are we the only one?

Ms. Marg Harrington: No. You're right, France. The funding for several years for the—they were pilots at the time—was on a year-by-year basis. The Ontario Chiropractic Association funded an evaluation conducted by the Centre for Effective Practice. The results were very good, in terms of reduction of imaging, reduction of medication use. As a result of that, the funding for those seven programs for the 2018-19 fiscal was integrated into the base budgets of the family health teams' nurse practitioner-led clinics.

M^me^ France Gélinas: But not for Aboriginal health access centres? Mine is not a community health centre or a nurse practitioner-led clinic. It's an Aboriginal health access centre—not mine, the one in Sudbury.

Ms. Marg Harrington: Yes, I had understood that they were all treated the same because it was recognized that it was an important program, and that they all got into base budgets for those teams.

M^me^ France Gélinas: Okay, so that was the budget that the Liberals put in just before they lost power, but it was actually—the money has flowed this year?

Ms. Marg Harrington: Yes, the programs have been continuously operating.

M^me^ France Gélinas: But no new sites have been granted?

Ms. Marg Harrington: No.

M^me^ France Gélinas: Okay. So the sites that were there—I think there were seven—all seven of them are still operating the same way they were before, but the program never grew?

Ms. Marg Harrington: The program has not grown. We'd love to hear in the upcoming budget that it was.

Ms. Nancy Gale: We did do pre-budget consultations in Sarnia—

Ms. Marg Harrington: —focused specifically on expanding the program because of the tremendous results that it has had on keeping people out of emergency departments. The integration of team-based models of care is a perfect example. I think the bill is just expanding on that whole concept about the importance of integration, bundling services around the patient needs.

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M^me^ France Gélinas: That leads into my next question. Are any of the sites where your members work already in

an integrated team—are any of those sites early adopters and looking like they're going to be one of the first out the door to be recognized as an Ontario health team?

Ms. Nancy Gale: We're not privy to whether any of those seven programs have submitted to government to be an Ontario health team.

M^me^ France Gélinas: And the same thing with ISAEC? How many sites do you have for the surgery referral?

The Chair (Mrs. Nina Tangri): One minute, please.

Ms. Marg Harrington: There was approximately one in each LHIN. Many times, the funding flowed through the hospital, so I'm assuming—I'm just guessing; it's speculation here—that that program would be funded as part of any integrated model that the hospital was involved in. But, again, it's just speculation.

M^me^ France Gélinas: Have you been given any hope that the request for changes to your scope of practice is actually going to go through? You've been asking for a change to your scope of practice for some time, and you mentioned it again today. Has anything changed that I'm not aware of?

Ms. Nancy Gale: No. We were encouraged today when we heard that scope is being looked at. That was what you said earlier. We just think it's critical because, as the representative from the RPN association said, chiropractors are trained and skilled to do this. You're simply enabling the best to optimize all of your health human resources, to be able to work in those settings and not be tied up in the red tape of who is allowed to do what.

We see it as a very effective complement, which is why we were recommending that it be given consideration, although it's not part of Bill 74. We think it's a complement—

The Chair (Mrs. Nina Tangri): Thank you very much. We appreciate you coming out to present to us today.

Ms. Nancy Gale: Thank you.

UNIFOR

The Chair (Mrs. Nina Tangri): I'd like to call upon Unifor. If I can ask you to please introduce yourself. You have eight minutes to present, followed by six minutes from each of the recognized parties. Please go ahead.

Ms. Naureen Rizvi: Thank you. Good afternoon. My name is Naureen Rizvi, and I'm the Ontario regional director for Unifor. I've been elected to represent the interests of our 160,000 members across Ontario, 25,000 of whom are health care workers right here in our province.

With me is Katha Fortier. She is the assistant to our Unifor president, Jerry Dias. She's also responsible for the health care sector and bargaining of all health care files as well.

The Chair (Mrs. Nina Tangri): Go ahead.

Ms. Naureen Rizvi: Unifor is Canada's largest private sector union. We represent over 315,000 members working in all major sectors of the economy. That also includes members working in a range of public sector services.

First, I would like to raise our concerns with the process in which Bill 74 has been pushed through by this government.

From the beginning, this legislation, that would radically transform the province's health care system, has been developed behind closed doors, with limited public input. The public first learned about the government's intentions through internal leaks. While the legislation has not passed through the final reading, the government has already moved to dissolve the boards of the public agencies that are supposed to be rolled into Ontario Health. The government has already appointed Ontario Health's board of directors without any public consultation or input.

Unifor is concerned about how this government's treatment of Bill 74 undermines our basic democratic processes. The two public hearings, in Toronto only, are simply not adequate, especially since we are facing the largest restructuring of our health care system in this generation.

Many voices are being shut out of this conversation, given that more than 1,400 people asked to make oral submissions to the committee. Their voices have not been heard. The government's sidestepping of our democratic processes by implementing this legislation before it has even passed through the Legislature, and rushing it through at a reckless pace, is extremely concerning for all Ontarians.

As for the bill itself, there are so many red flags and questions around accountability and the centralized power held by Ontario Health. The government has prevented the public from having any input on the composition of the board and has instead filled it with political appointees. Further, any subsequent board meetings will not be open to the public, while the public will have limited access to documentation related to restructuring. Unifor is very concerned with the creation of an unelected board of directors with immense power and less accountability.

Bill 74 raises many concerns with the creation of the new integrated care delivery system. The minister's ability to designate ICDSs without public consultation and Ontario Health's unfettered powers to integrate services are problematic.

The centralized power to push integrations, mergers, amalgamations and so on would result in the concentration of health services being controlled by a small number of large health care teams. This "bigger is better" restructuring approach is very likely to result in the loss of local services for many Ontarians.

Ms. Katha Fortier: One of the biggest concerns about Bill 74 is how it opens the door to privatization and for-profit care. The bill does not include a stated commitment to the provision of health services by not-for-profit organizations, nor does it include a commitment to the principles of the Canada Health Act, like the principle of publicly administered care. This raises questions about the government's intentions and its privatization agenda.

An ICDS can be designated to include a mix of for-profit and not-for-profit health care services, according to the bill. The minister would also have the power to order

certain types of integrations that may result in a combination of for-profit and not-for-profit services.

In communities across Ontario, we have already felt the impact of the creeping privatization of health care services. We've already seen that the quality of care that seniors receive in for-profit long-term-care homes is compromised by the profit-driven model. Private clinics that perform diagnostic testing and minor surgeries, among other things, are known to inflate government costs and increase the number of unnecessary tests and treatments in their drive to make a profit.

When it comes to workers in the health care sector, we remain concerned about Bill 74's impact. Currently, the rights and collective agreements of public sector workers are protected in the instance of a workplace merger or amalgamation, as set out in legislation like the Public Sector Labour Relations Transition Act. This legislation raises questions about whether PSLRTA would apply in cases where health care services are integrated under an ICDS, which could result in significant labour relations issues.

If there's anything we've learned about the large public outcry toward this bill, it's that the government must take a step back and properly consult with Ontarians regarding the impact of this wide-ranging bill. Significant concerns regarding the accountability and oversight of the super-agency are only the beginning amidst the steps to completely overhaul the structure of the health care system in the province.

The impact of amalgamating and integrating services on local communities could be devastating, especially given that there would be no meaningful opportunity for these communities to provide input on these changes. The government also needs to be upfront about its privatization agenda, and we would like to see them actually commit to publicly administered care and not-for-profit services with any restructuring of the system. Finally, the impact on health care workers, who will be caught in the middle of any restructuring efforts, must be addressed.

We thank you for hearing our views on this issue and we refer you to our written submissions that you should have today for more details regarding our recommendations. We, of course, are happy to answer any questions that you have.

The Chair (Mrs. Nina Tangri): Thank you very much. We'll begin with Ms. Armstrong.

Ms. Teresa J. Armstrong: Thank you for being here today and presenting on behalf of the front-line workers that you represent. We've been asking each group if they were formally consulted on Bill 74 before the drafting of the bill, and if so, when were you consulted?

Ms. Naureen Rizvi: If I can just answer: We have not been consulted. Nobody has approached us from the government seeking any input, considering we have 25,000 front-line workers. This has been our only opportunity, and being one of the largest unions in Ontario, I was the last person presenting. We're happy to be able to get a chance in, but 30 people out of an entire province—30 organizations, 30 labour unions, whoever. Only 30 people have had an opportunity to present on something that is remarkably transformative.

1750

Ms. Teresa J. Armstrong: You've also raised the concern that Bill 74 threatens the quality of care. I saw that in your presentation. Can you further explain how Ontarians may be impacted by the provisions of Bill 74?

Ms. Katha Fortier: Well, one of the systems that we see privatization the most in in our health care system is the long-term-care homes, which of course happened mostly throughout the late 1990s, when thousands of hospital beds were closed and licences were given to mostly for-profit corporations to operate nursing home beds in the province. That really switched the balance, so that the majority of the nursing home beds in the province are operated on a for-profit basis.

They're in the news on a regular basis. It's not a surprise that the three largest chains are facing mass lawsuits about care. We know the conditions of care. In fact, I challenge any of you around the table to watch our six-minute challenge, which talks about a PSW having six minutes to get a resident up and prepared for breakfast in the morning. The conditions of work are the conditions of care in those homes, and we feel that particularly where they are a profit-driven home where we represent members, literally thousands of members, the system is completely different than the operations in an organization that is perhaps run by a not-for-profit, a municipality or a region, where they're actually putting what would be profits back into care for the residents.

Ms. Teresa J. Armstrong: The government said that no front-line job would be lost by the health transformation. Can you tell us what you make of that claim?

Ms. Katha Fortier: Well, I guess we'd dispute that claim. We already know—we represent workers at Grand River Hospital, and they've already had several layoff notices of nurses and other front-line care workers. We think this is probably just the beginning.

Ms. Teresa J. Armstrong: I've seen some of your ads on Chartwell. Can you tell us a little bit about that? Expand a little bit on what that ad means and how it fits into the theme of quality of care.

Ms. Katha Fortier: That campaign is specifically geared to Chartwell retirement homes. Chartwell operates nursing homes and retirement homes, and we represent workers in both. In many cases, particularly where a new, beautiful home is built—you see them come up all over, in cities across the province—they're shiny and lovely-looking, but what happens inside is that most of the workers there make minimum wage or just slightly above minimum wage.

In fact, in seven of our nursing homes, when minimum wage went to $14 an hour on January 1, 2018, one or more classifications of workers got a raise from that. We are stuck in a bargaining rut, as you would call it. Unfortunately, these workers—we wouldn't consider this a health care organization. The Ontario Labour Relations Board always finds that retirement homes fall under the Hospital Labour Disputes Arbitration Act, the same legislation that governs hospital employees, because they are providing

health care. In fact, thousands of residents in retirement homes actually require nursing-home-level care.

With that, we're having a dispute with this employer, and we're trying to shame them, because these should not be minimum wage jobs. These workers need to be recognized. The staff turnover is incredibly high. People don't stay in those jobs, despite caring very much for the residents.

Ms. Naureen Rizvi: If I can just supplement, for anyone who's not familiar with the conditions in long-term care—

The Chair (Mrs. Nina Tangri): You have one minute.

Ms. Naureen Rizvi: —you should watch the MarketWatch documentary. It was very, very telling.

The Chair (Mrs. Nina Tangri): Madame Gélinas.

M^me^ France Gélinas: What do you figure is the chance that Chartwell becomes one of the lead agencies of an Ontario health team?

Ms. Katha Fortier: Well, that would be terrifying. Every example of privatization, make no mistake, is about lowering the wages and working conditions of employees.

I'll give you an example of the medical labs of Windsor, where we represent the workers. They had a three-week strike two years ago. They hire lab technologists and lab technicians. When they started the private labs, the doctor who operated it paid actual lab technologists and lab technicians the same as they made in the hospital and attracted them out there, out of the hospital job, with the same wages, nicer hours and patients who would walk in; it was all lovely. We organized them about 12 years ago, and some workers had not received a wage increase in over 15 years; their wages had been frozen. As they get more people in to work, the wages are lower and lower.

Again, this was a workplace that was impacted by minimum wage. If you can imagine, the technician who is performing your phlebotom and doing your EKG is paid minimum wage. It's a little bit shocking. These are organizations that thrive on paying the least—

The Chair (Mrs. Nina Tangri): Thank you very much. I need to give a bit of time to the government. Mr. Anand?

Mr. Deepak Anand: Thank you so much for coming—absolutely, your input is extremely valuable for us.

When we talk about Bill 74, it is about building a public health care system. In your submission, you actually advocate for a publicly administrated health care system that leaves no Ontarian behind. So it's actually in line with what you're talking about. What we're talking about through the bill is centred around the patient and redirecting money to front-line services, improving patient experience through integration and providing better and connected care. I was looking at the submission. You're kind of saying you believe it will result in the loss of local services for many Ontarians, where what we're saying is, through integration of those services, there are going to be local teams. So there's a bit of a disconnect.

My question to you is, do you think integration would be a benefit or a loss? Do you believe in integration or are you against integration?

Ms. Naureen Rizvi: Well, I guess it would depend. The bill is not clear on how any of this actually will play out. I think what is clear is that you have appointed a board of directors for this super-agency, who are public appointees, not health-care focused. If this is a public service, then the public deserves and actually has the right to be part of consultation, public policy and all the rest of that. None of that has really taken place in a meaningful way. You have a two-day hearing, but that's about it. So how those are integrated and how that falls out on workers and the communities is unclear to us—except the one thing the government had said, that there would be no job losses. At Local 1106 of Unifor and Grand River Hospital in Kitchener, we have seen job losses; the opposite of what is being said. In terms of public service's potential to make sure, while you're looking to find different ways to transform the health care, that there is no impact—it's not the case at all.

Ms. Katha Fortier: If I could just add, too, I don't think that Unifor philosophically has an issue with patient-centred care or integration; what we have a problem with is the potential to create a for-profit hospital in this province. I understand what you're saying, and I think a lot of the times all parties will agree on the philosophy of a publicly administered health care system. I don't think anybody here is advocating for for-profit hospitals for the province of Ontario, but tell me, in the bill, what prevents that from happening? Tell me, what in the bill prevents Chartwell from actually being the operator of a hospital? I don't see it.

Mr. Deepak Anand: Natalia wanted to ask something.

The Chair (Mrs. Nina Tangri): Actually, pursuant to the order of the House, it now being 6 p.m. we are to adjourn.

I'd like to remind everyone that the deadline to file amendments to the bill with the Clerk of the Committee is 12 noon on Thursday, April 4, 2019. Amendments must be filed in hard copy.

This committee will meet on Monday, April 8, at 9 a.m. for clause-by-clause consideration. Adjourned.

The committee adjourned at 1800.

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Vice-Chair / Vice-Président
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