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Comité permanent des finances et des affaires économiques

Pre-budget consultations

Consultations prébudgétaires

2nd Session
42nd Parliament

Tuesday 11 January 2022

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Mardi 11 janvier 2022

Chair: Ernie Hardeman
Clerk: Michael Bushara

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON FINANCE AND ECONOMIC AFFAIRS

COMITÉ PERMANENT DES FINANCES ET DES AFFAIRES ÉCONOMIQUES

Tuesday 11 January 2022

Mardi 11 janvier 2022

The committee met at 0900 in room 151 and by video conference.

PRE-BUDGET CONSULTATIONS

The Chair (Mr. Ernie Hardeman): We're ready to start the meeting, so we'll call the meeting to order. We are meeting today to continue public hearings on pre-budget consultations for 2022 for the northeast region of Ontario.

As a reminder, I ask that everyone speak slowly and clearly. Please wait until I recognize you before you start speaking.

Are there any questions before we begin? If not, each presenter will have seven minutes for their presentation, and after we've heard from all of the presenters, there will be 39 minutes of questions from members of the committee. This time for questions will be divided into two rounds of seven and a half minutes for the government members, two rounds of seven and a half minutes for the official opposition members and two rounds of four and a half minutes for the independent member.

BEEF FARMERS OF ONTARIO
ONTARIO ASSOCIATION OF PROSTHETICS AND ORTHOTICS
ONTARIO MEDICAL ASSOCIATION, DISTRICT 9

The Chair (Mr. Ernie Hardeman): This morning, our first panel—we'll call the members. The first presenters will be from the Beef Farmers of Ontario.

We will ask the Beef Farmers of Ontario to come forward and speak, but just before we do, I believe MPP Vanthof has joined us this morning. If they would just introduce themselves and tell us where you're at.

Mr. John Vanthof: John Vanthof, MPP for Timiskaming–Cochrane, in Cobalt at minus 36.

The Chair (Mr. Ernie Hardeman): Oh, cold place in Cobalt. But anyway, thank you very much.

With that, we'll turn it over to Beef Farmers of Ontario.

Mr. Rob Lipsett: Good morning. My name is Rob Lipsett and I'm a beef farmer from Grey county in Ontario. I am the president of the Beef Farmers of Ontario. Joining me today is BFO's executive director, Richard Horne, and we'd like to thank you for the opportunity to appear before you here today.

The beef industry is an important economic driver of Ontario's agri-food sector, contributing $2.69 billion to Ontario's GDP on an annual basis. Gross sales from the beef sector exceed $13 billion annually and sustain more than 61,000 jobs, and there is significant opportunity to build on these contributions.

Despite the beef industry's positive impact on the Ontario economy, our sector is faced with growing competition, with cheaper imported products and more frequent and volatile shifts in global commodity markets. This is creating significant financial risks to our farmers, risks that cannot be sufficiently mitigated by on-farm management, private insurance programs or robust marketing efforts. The supply chain disruptions and market price volatility that we've experienced during the COVID-19 pandemic has only intensified these challenges. Escalating production costs associated with primary farm inputs, equipment, carbon tax, a rising minimum wage, energy costs and others are making it more challenging to do business.

However, all is not bad. Demand for Ontario beef products is strong and growing, both domestically and internationally, and our commitments to sustainability are being rewarded by processors, retailers and consumers.

Despite rising consumer prices, farmers are not receiving a fair price for their labour. Stagnant market returns with rising production costs and two years of a global pandemic underscore the need for well-designed and well-funded business-risk-management insurance programs that take some of this volatility out of the production equation.

Fortunately, Ontario recognized this need many years ago through the creation of the Ontario Risk Management Program, or RMP for short. For farmers in the beef, lamb, pork, veal, fruits, vegetables and grains and oilseed sectors, RMP is a cost-shared insurance program designed to help stabilize the sector by providing partial financial protection for Ontario farmers against market volatility and production risks. RMP fills a critical gap for agricultural commodities in Ontario that are not protected by the supply management system.

Unfortunately, the program remains critically underfunded with many sector insurance plans covered under RMP unable to pay out calculated insurance benefits in full, given the current funding cap. For context, in the two program years since the pandemic hit, RMP was only able to pay out approximately 44% and 29% of calculated insurance benefits for beef farmers given the program's

funding cap for 2020 and 2021, respectively. Since the program was capped by the previous government, beef farmers have only received, on average, 58% of their calculated insurance benefits. A good analogy here would be if your house burned down and your insurance provider provided you with only enough funds to rebuild a portion of your home. This doesn't work.

While we are thankful for the province's leadership in delivering an additional $50 million for this program in 2020, which was part of a 2018 campaign commitment, the program remains in dire need of additional funding. Simply put, the current funding cap will not allow the program to function as originally designed, nor is it responsive enough to handle "black swan" events like COVID-19.

All this is to say that I'm here before you today to ask that you join our commodity partners from the pork, lamb, grains, veal, and fruit and vegetable sectors to support our request of an increase in funding for this important program by $100 million. That would bring the program cap to $250 million annually. I would like to be clear that only a portion of the $100-million increase would be allotted to the beef sector.

Committing to increase the province's investment in RMP is a commitment to partner with Ontario farmers, who contribute 35% of the costs through annual insurance premiums. Any program increase provided by the province through this budget will be matched at the current cost-share ratio by Ontario farmers themselves.

Partnering with Ontario farmers means more than just an added expense; it represents an investment with a proven return for the Ontario economy. Two separate studies conducted on the economic return of RMP demonstrated significant ROI for the province. The latest study by Cummings et al. showed that for every dollar invested in RMP, it generates a $2.24 economic return. Increasing the program by $100 million would therefore provide $224 million in new economic activity and bring the total program return to more than half a billion dollars annually.

Funding the program at $250 million annually would help ensure the program is adequately resourced and more responsive to changing market demands. This will help us weather the pandemic and post-pandemic storm that has crippled our supply chains and increased production costs and market risk. Ensuring this program is sustainable will also allow farmers to better manage risk and focus on greater innovation, maintain and hire employees, and take advantage of new market growth opportunities.

The Chair (Mr. Ernie Hardeman): One minute left.

Mr. Rob Lipsett: This is a good deal for Ontario farmers, the province and Ontario taxpayers. We hope that you support our request.

Thank you for the opportunity to present to you today, and we will welcome any questions during the question period.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation, Rob. Our next presenter will be the Ontario Association of Prosthetics and Orthotics.

I didn't mention it before Rob started speaking—he did a very good job of introducing himself. We ask everyone to introduce themselves for Hansard to make sure that we attribute all the comments being made in Hansard to the appropriate person.

Our next one, as I said, is the Ontario Association of Prosthetics and Orthotics. I believe it's Mary Catherine Thiessen.

Ms. Mary Catherine Thiessen: Thank you. My name is Mary Catherine Thiessen. I'm a certified orthotist working in the Kingston area and I provide additional service to the James Bay population. I am joined today by my colleagues Bryn Jones, who is a certified prosthetist-orthotist in the Niagara region, and Kristin Schafer, a certified prosthetist who works at Health Sciences North, which serves a large northern catchment area. Together, we represent the Ontario Association of Prosthetics and Orthotics, or OAPO. Thank you to the Standing Committee on Finance and Economic Affairs for the opportunity to participate in your pre-budget consultations.

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OAPO is the not-for-profit professional association representing Ontario's prosthetic and orthotic health professionals. Certified prosthetists and certified orthotists are the only health care professionals recognized by Ontario's Assistive Devices Program with the authority to provide prosthetic and orthotic treatments. Our members are critical front-line health care professionals that tens of thousands of patients across Ontario rely upon to evaluate, build and fit the medically necessary, custom-made prostheses, or artificial limbs, and orthoses, or braces, they need to live, work and learn independently.

The patient population includes people born with missing or underdeveloped limbs; those who have lost limbs due to injury or medical amputation for causes such as diabetes or necrotizing fasciitis; and patients with neuromuscular conditions like multiple sclerosis, cerebral palsy or individuals affected by long COVID. These patients deserve prosthetic and orthotic treatments that are up to the current standard of care and medically appropriate for their pathology and improved quality of life.

Unfortunately, Ontario's outdated funding for prosthetic and orthotic treatments is putting an unsustainable burden on our patients. This is true of the ADP program as well as regional ODSP funding. The Ministry of Health's Assistive Devices Program's prosthetic and orthotic policies and pricing have not received any meaningful change to reflect increasing costs or improve standard of care in over 15 years. In the case of ODSP, at age 65, patients are transitioned to the federal program, and they are now expected to pay medical expenses that were initially covered by ODSP. This is at a time in their lives when they need more support, not less.

As a result, prosthetic and orthotic patients are receiving proportionately less funding support every year from ADP, and orthotic patients are also unable to receive the ADP funding for many necessary treatments. This forces patients and their families to face an ever-increasing out-of-pocket cost burden, which is often offloaded to charitable organizations that can no longer sustain the current demand requested of them. For example, I had an obese

patient who needs a custom knee brace with a titanium joint for safety. The joint exceeded the maximum cost allowable. Therefore, the entire brace is not covered through ADP due to the current policy.

In prosthetics, the ratio of funding that is being paid by the patient has increased significantly in 15 years due to the rising cost of components. Patients are going to charities for the remainder, and charities can't keep up. For example, Kristin had a patient from Kirkland Lake who had to travel to Sudbury for his care and rehab. He owed only $2,400 on an extremely basic leg. He had to go to the social worker to help get the funding. The Red Cross ended up helping them out. The War Amps had already donated $1,000. This process added unnecessary burden to an already strained health care team, not to mention the psychological strain on the patient.

Without access to additional funding for prosthetics and orthotics through ADP, even more patients will be unable to afford the critical assistive devices they need. In 2018, the Auditor General of Ontario identified inconsistent and outdated pricing reviews as a major problem with the Assistive Devices Program, resulting in patients receiving compensation for prosthetic and orthotic devices well below the actual cost and leaving them ineligible to get funding support for more appropriate treatments. We have been working diligently with ADP to rectify this issue, and it is our understanding that ADP recognizes the impact that this shortfall in funding for prosthetics and orthotics is having for vulnerable patients, but they are very limited in their ability to provide greater support without specific additional funding from the provincial government.

An immediate investment of $9.7 million annually in additional funding through ADP specifically for prosthetic and orthotic treatments is required to address over a decade of significant underinvestment that is preventing thousands of patients from receiving the standard of care that they need. This additional funding will not only support the needs of patients today and going forward, but it will ultimately reduce ongoing health care costs due to reduced quality of life and long-term health impacts, such as inappropriate or ill-fitting treatments that cause patient complications; the need for costly and avoidable clinical attention to address serious infections, subsequent amputations or other physical ailments; and properly built and fit prosthetic and orthotic treatments that reduce fall risk, which is an unavoidable cost to our health care system.

Inadequate funding also places a significant strain on space in our health care system, as patients in hospitals and rehab facilities cannot be safely discharged until they have the prosthesis or orthosis they need.

As front-line health care providers, we understand that COVID-19 places a tremendous pressure on every dollar invested in Ontario's health care system. However, the ongoing and growing pressure on our patients, which pre-existed the pandemic, has only continued, and it cannot be ignored.

The Chair (Mr. Ernie Hardeman): One minute left.

Ms. Mary Catherine Thiessen: We urge the Ontario government to make this modest but important investment, to ensure that patients who require prosthetic and orthotic care are able to access and afford the treatments they need and deserve in order to live independent, fulfilling lives.

Thank you for your time, on behalf of our OAPO members and the patients we serve. We would welcome any questions during the question period.

The Chair (Mr. Ernie Hardeman): Well, thank you very much for your presentation.

Our next presenter is from the Ontario Medical Association, district 9, northeast. I believe the speaker is Dr. Stephen Cooper, the chair. Again, I ask each one, as you speak—I think there are more people here. Each time you speak, introduce yourself for Hansard, to get the name right.

Dr. Stephen Cooper: Thank you. I am Dr. Stephen Cooper and I'm joined today by my colleague Dr. Sarah Newbery from Marathon. Thank you for the opportunity to present to this committee as the government develops this 2022 budget. The message from Ontario doctors is simple: Health care spending must be prioritized, especially in northern Ontario, where the situation is most dire.

I have been a rural doctor on Manitoulin Island since 1992, and I'm speaking today in my role as the OMA chair of district 9, better known as northeastern Ontario. That's Wawa to Temiskaming Shores, Moosonee to Parry Sound. It's a large area that includes downtown Sudbury and remote Manitouwadge; mining and resort communities; remote and downtown Indigenous communities; and a large francophone community, as well as Italian and French communities; the health science centre that is striving to be world-class, and health centres like the one that I work in provide general cradle-to-grave care delivered by all-purpose nurses and physicians.

I don't need to tell you that access to health care in the northeast is problematic. Just over 89% of people in the northeast report having a primary care provider, well below the Ontario average of 94%. The region also has the second-highest proportion of people over 65 and the second-highest proportion of those over 75. We're old. The life expectancy of the north is 2.5 to 2.9 years lower than the Ontario average.

Today, northern Ontario is short 325 family doctors, internists, psychiatrists, pediatricians, anaesthesiologists and other subspecialists. Many of my patients have to travel to Barrie or Toronto for specialist care. Manitouwadge has been being without a doctor for a number of months. Matheson, Iroquois Falls, Chapleau and Cochrane have less than half the number of doctors required. Timmins and North Bay have difficulty filling their ED roster, and the shortage of GP, anaesthesia and general surgeons risks surgical and OBS programs in smaller cities.

COVID-19 has exacerbated the wait times for patient care. It's not just a number. My patients are unable to return to work from a lack of access to orthopedic surgery and mental health, and are waiting to see specialists for difficult-to-diagnose-and-manage problems.

The north was disproportionally affected by mental health and addiction challenges before the pandemic, and

the situation has worsened significantly. I can say from my shifts in the emergency department that the challenges in mental health and addiction are the most common problem I see.

Let me touch on virtual care. Like you, the pandemic has pushed us to embracing work virtually. To many patients and physicians, this has been a wonderful addition to health care. For the north, with its large geography, virtual care has always been critical to providing access to medical care, mental health and addiction medicine. It's time to accept virtual care as standard and make the temporary OHIP codes permanent. Great as it is, virtual care must never be considered as a replacement for clinical shortages in northern Ontario. It does not and should never replace in-person care.

So, lots of gaps in health care need to be addressed. Where to start? Last year, the OMA undertook the largest stakeholder and public consultation in its 140-year history to understand where those gaps are and how to fix them. The eight-month consultation began in northern Ontario and included round tables of northern Ontario leaders representing a broad range of sectors.

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The result is Prescription for Ontario: Doctors' 5-Point Plan for Better Health Care, launched in Sudbury in October. It's a road map of 75 recommendations to get health care on the road to recovery, but also contains 12 specific recommendations to improve delivery of care in northern Ontario. It comes down to five priorities: reduce wait times and the backlog of services; expand mental health and addiction programs in the community; improve and expand home care and community care; strengthen public health and pandemic preparedness; and finally, give every patient a team of health care providers and link them digitally.

For the shortage of physicians and health care providers in the north, the OMA recommends the following:

—commit that all Ontarians should have equitable access to care in their own communities;

—the incentives and supports for doctors and health care professionals to practise in northern Ontario should be reviewed and updated; it's currently not;

—a greater focus on education, training and opportunities to optimize collaborative care in remote communities;

—funding opportunities for specialist and subspecialist trainees to do electives and core rotations in the north; and

—ensure that medical students and residents have the skills and opportunities they need to be confident to provide care in rural and remote practices.

We note and welcome the government's recent investment of $10.6 million in northern Ontario to train 500 workers in hospital and long-term care, and home care providers. It's a good start, but remember: The social determinants of health are non-medical factors that influence health outcomes. This connection has been obvious during the pandemic, as the highest rates of COVID-19 continue to be in communities with low incomes, that are racialized and with poor housing. That's why the OMA is also calling for a collaborative partnership with Indigenous Services Canada and Health Canada to address issues of safe drinking water, and adequacy of health care facilities and resources in Indigenous communities.

The Chair (Mr. Ernie Hardeman): One minute left.

Dr. Stephen Cooper: We must also address the education gaps in Indigenous communities, as education directly affects health. So better education, better health.

The types of investments just described are not only critical to the health of northerners but also the northern economy. The pandemic has proved we cannot have a strong and sustained economy without a robust health care system. We need to keep small business alive, restaurants full and schools open. The link is more pronounced in northern Ontario. One of the first questions businesses and professionals ask when they are thinking of moving to the north is, "What is the health care like there, and are there human doctors available in the community?" A strong health care system in the north would not only support our important resource, recreation and retirement industries but help attract new businesses, residents and investments, bringing with it new opportunities for our younger people.

Thank you. I would be pleased to be asked any questions.

The Chair (Mr. Ernie Hardeman): Thank you very much for that presentation.

Before we go to the questions and answers, I believe that MPP Mantha has joined us. If he would like to introduce himself and tell us where he's located, we'll carry on.

Mr. Michael Mantha: I am located in the Robinson-Huron Treaty area, in Elliot Lake. I'm at home enjoying today's committee presentation. Good job, Dr. Cooper.

The Chair (Mr. Ernie Hardeman): Thank you very much for the introduction.

Now we'll go to the questions. Questions will be in two rounds. The first round will start with the opposition, then the independent members and then the government.

We may have noticed at the start that I didn't mention that at the one-minute mark, I would announce that there is one minute left and then we get cut off. It seems rather impolite of the Chair to cut off a presentation or a question-and-answer that is very interesting, but obviously, for the sake of timing, we have to do that.

With that, we'll go to the official opposition. I believe it is MPP Gélinas.

M^me^ France Gélinas: Thank you, Chair. I would like to thank everybody who presented this morning. We're all very interested. I will share my time with MPP West, so I'll have to be brief.

I have questions for the prosthetics and orthotics. You said an increase of $9.7 million annually for prosthetics and orthotics through the ADP. Could you give us an example so all my colleagues understand? Let's say you have an above-knee prosthetic to do. How much would it cost right now, and how much does the patient have to pay out of pocket?

Ms. Mary Catherine Thiessen: Kristin?

Ms. Kristin Schafer: Good morning. I'm Kristin Schafer. I work at Health Sciences North in Sudbury. On average, a very basic above-the-knee prosthesis would run

anywhere between $7,000 and $9,000. The assistive devices portion would probably round out to between $5,000 and $6,000—Bryn can corroborate that or not—so our patients are usually typically left with anywhere between $2,500 and $4,000 out of pocket to pay. It's not insignificant.

Mme France Gélinas: Let's say it's an active person who needs more than just the basic above-knee prosthesis. How much would that cost?

Ms. Kristin Schafer: Then you start looking at the types of components that are in position on a prosthesis. You can have high-functioning mechanical knees, and you can range all the way to microprocessor knees. Microprocessor knees are anywhere in the range of $50,000 to $70,000 a piece, and that's just for the knee unit. The Assistive Devices Program caps out; they'll only cover approximately $3,500 on the highest, most-expensive knee, so it's very limited.

Mme France Gélinas: So if the government was to do the $9.7-million investment into ADP specifically for prosthetics and orthotics, what difference would it make to the patients themselves?

Ms. Kristin Schafer: It should reduce their out-of-pocket expenses and—

Mme France Gélinas: To what amount?

Ms. Kristin Schafer: I don't think I can answer that one.

Mme France Gélinas: Anybody who can?

Ms. Mary Catherine Thiessen: Bryn, would you be able to take that?

Mr. Bryn Jones: Bryn Jones. I'm in Niagara. I'm a prosthetist here.

Reducing the amounts: The way it's capped, it would probably take, if Kristin said it was—sorry. The amount that we're asking for, the $9.7 million, is to bring us up to 2021, versus where everything was before. Back in 2021, it used to cost clients around $1,000 for their prostheses, for the same one, versus now where it has gone up to $3,000. So we'd see a reduction there of probably a couple of thousand dollars per client, as a rough estimate.

Mme France Gélinas: So how did you come to $9.7 million? Why is it not $9.5 million? Why is it not $10 million?

Mr. Bryn Jones: Yes, $9.7 million was pretty specific. We just took the cost-of-living increase since the last update to the ADP program. When we took that, it worked out to be that, based on the ADP having annually, say, around $32 million that goes to prosthetics and orthotics in Ontario, we would need an influx of $9.7 million to bring us up to 2021 in terms of cost of living.

Mme France Gélinas: Okay. Thank you.

My next question is for Dr. Cooper, or somebody else. Dr. Cooper, you did mention that we have some incentives to bring people into the north, but right now they do not work. Could you give us examples of other forms of incentives that could help us with our health human resources in northern Ontario?

Dr. Stephen Cooper: It's Stephen Cooper. I think probably the best thing to do would be a review of the incentives that we currently have. I wouldn't say that they don't work. They have been effective in increasing the number of physicians; particularly in the early 2000s, we saw a bump. But we've just seen a flattening and then a slight diminishment recently, so they need to be reviewed.

I think factors that promote physicians to work in rural and remote communities and on-call—focusing on those particular areas would really help alleviate some of the physician shortages in the north.

Mme France Gélinas: Thank you.

My colleague Jamie West had a question.

Mr. Jamie West: Similar to that, Dr. Cooper, I was wondering: A friend of mine is a doctor practising in Sudbury. She went to Ottawa U and had a difficult time coming to Sudbury and finding placements in the north.

I'm wondering, when you talk about the 325 specialists that we have a shortage of, are there incentives? Is it easier now? This is 15 or 20 years ago. Is it easier now for medical professionals to practise in the north, especially those who come from the north and want to practise in the north?

0930

Dr. Stephen Cooper: No, I don't think it's any—I think it was a little bit easier back about 20 years ago. One of the problems we have, and it specifically is around resident training—we recognize that training residents is an important part of getting doctors to move to the north and helping support them in their training. So, basically, if you're a surgery student and you want to do rotation in Timmins, there needs to be accommodation for you there. So you could be at the University of Toronto doing your general surgery program, but it would be great to do a six-month rotation in Timmins, and there needs to be some accommodation for that. Currently, it's not adequate.

Mr. Jamie West: Sorry. Dr. Newbery, did you want to say something? I apologize; it's just time.

Dr. Sarah Newbery: Yes, please, if I could. Sarah Newbery, associate dean, physician workforce strategy at NOSM. I would echo what Dr. Cooper has mentioned and indicate that there is no longer funding for travel or accommodation for residents, so when people want to come to do a rotation here, they are maintaining their apartment and their accommodations wherever they're doing their training—Ottawa, Kingston, Toronto—and also having to pay the travel and accommodation to come to northern Ontario.

The Chair (Mr. Ernie Hardeman): One minute left.

Dr. Sarah Newbery: So looking at how we enhance the funding and support for all elective learners, those who would like to come and practise or do a training opportunity in a rural community, as well as specialty and subspecialty trainees—if we can enhance those opportunities, I think we will well serve the north with our future physician workforce.

Mr. Jamie West: Okay. Thank you.

I think I have 30 seconds, so maybe I'll ask the question, but it won't get out. It was for the Ontario Association of Prosthetics and Orthotics. You talked about how at age 65 you get pushed to the federal program, and people on

ODSP have to pay more out of it. I deal with a lot of people on ODSP who can't afford rent and food. How realistic is it for them to be able to purchase the orthotics and prosthetics that they need?

I think we're going to run out, so maybe the next round—oh, go ahead.

Mr. Bryn Jones: Bryn Jones. After 65, it's the—

The Chair (Mr. Ernie Hardeman): We've run out of time. We'll have to save the answer for the next round.

With that, we will go to the independent member.

Ms. Mitzie Hunter: Good morning, everyone. I want to thank you all for presenting today and for giving us your perspective on ideas for enhancing this budget that will reflect the needs of people who live in the northeast of Ontario.

I wanted to pick up on some comments from the Ontario prosthetics association, specifically as it relates to seniors who are transitioning from provincial supports to federal supports but then find that they have to pay out of pocket for certain things. This is something that certainly concerns me in terms of care at a time when the need is greatest. Can you speak specifically to what your concerns are in that area and what you would hope the province would do to address it? Is it Mary who is taking that on? Okay.

Ms. Mary Catherine Thiessen: I can answer, and Bryn can kick in after. In orthotics, Ontario pays 75%. If they're on ODSP, ODSP kicks in the 25%. So in any kind of custom-made orthotic brace, they would end up having to pay that 25%.

I'm going to turn it over now to Bryn for the prosthetics answer.

Mr. Bryn Jones: It works the same way in prosthetics, such that if you're on ODSP—it's a little different regionally on ODSP, but before 65, the remaining 25% of the cost is picked up by ODSP, the issue being that once they transition to the federal program, that funding source disappears and then they're left with what would be our figures from before. What cost Bob nothing before 65 will now cost him $3,000 after 65, and it's at a time, as MPP Jamie West mentioned, when they don't have enough money for food and rent, let alone for a medical device. If they can't afford it, those people end up sitting longer, they end up in wheelchairs and they end up just deteriorating faster, so it then puts another burden on the health care system.

Ms. Mitzie Hunter: Which would be covered by other parts of the health system, I would imagine—more urgent care and acute care, right?

Mr. Bryn Jones: Correct.

Ms. Mitzie Hunter: Okay. You also touched on but didn't expand on your concern around long COVID and its effect on people, and the need—can you expand that a little bit for the committee?

Ms. Mary Catherine Thiessen: Yes, so our members are now seeing patients who have been in extended, long hospital stays. One of the effects would be drop foot; the person now does not have control over their ankle muscles and needs a brace in order to continue and to help them walk. We don't know whether that muscle strength will return, but those braces are necessary in order to keep them upright and mobile. That is something that is now emerging. We will just have to wait and see the extended long-term effects. That's also common in other areas where people are in hospital for long, long periods of time and they're inactive; that can happen.

The Chair (Mr. Ernie Hardeman): One minute left.

Ms. Mitzie Hunter: Okay, so because of the long stays within hospitals that are linked to COVID, therefore it's resulting in increased demand?

Ms. Mary Catherine Thiessen: Yes, that seems to be—oh, Bryn had something to add. He's muted.

Mr. Bryn Jones: We have several members who have cases that they wouldn't have had otherwise, otherwise healthy people who went into hospital because of COVID-19 and have come out without the use of their legs. I have a client myself who doesn't have the use of his quadriceps muscles now. We've had to make full leg braces for both legs. The only attributing factor was the fact that he went in with COVID-19, went into a coma, came out and now doesn't have the use of those legs.

Ms. Mitzie Hunter: Okay. Thank you so much.

The Chair (Mr. Ernie Hardeman): Thank you. That concludes the time.

We'll now go to the government. MPP Pettapiece?

Mr. Randy Pettapiece: I want to thank all the presenters this morning for their presentations.

I'd like to focus on the beef industry, if I could, and direct my questions to Rob Lipsett. You've identified a number of things, challenges, that are facing the beef industry and certainly the food processing industry as a whole, not only due to COVID, but certainly we've seen some pressures before COVID hit. I want to direct my comments to the processing industry and the concern with the beef industry. We've now spent nearly $40 million through the Meat Processors Capacity Improvement Initiative and the Strategic Agri-Food Processing Fund to help processors update their facilities and this type of thing.

I wonder, sir, if you could outline some of the challenges you still face with the processing industry and whether capacity of these processors has met your demands or met your needs as we move forward here.

Mr. Rob Lipsett: Thanks for the question, MPP Pettapiece. I'll do my best to address it and I'm sure that Mr. Horne will jump in if I've missed anything. The biggest challenge I think we're facing in processing right now is that we've seen a huge demand for local food, but 25 or 30 years ago we lost all our small local abattoirs that picked up the processing for that sector. They're citing things—the ones that remain—and just a lack of labour. As you mentioned, COVID didn't help that, as the majority of workers in the processing industry are foreign immigrants or foreign temporary workers, and with COVID we just haven't been able to get that labour force into the province to address that concern.

There were some regulation challenges earlier on when some of those plants started to close, and that was the

reason they did close. I've heard stories of a few people who are looking at some of the funding to expand current production, but they're looking at infrastructure funding. They fully utilized the previous funding for PPE and making the workplace safe. I hold out hope that in the next five years they would access some of this infrastructure funding platform and expand, and we can alleviate some of the stress that we're seeing building in backlogs at the currently operating plants.

0940

Mr. Randy Pettapiece: Are you still looking at backlogs? How long does it take you to book cattle in now?

Mr. Rob Lipsett: For the smaller abattoirs, the last time I called personally, I was given a time frame of 16 months from the day I called. I can't service customers a year and a half, two years out. That just doesn't work for the business plan. But that's very common.

The bigger federal plants: We usually see backlogs and disruption and high peak times at the beginning of barbeque season, the May-June period. They're trying to put as many cattle through as they can. That re-cycles again in November and December as they get into the winter stocking of grocery shelves. So those still remain. Prices get depressed for about four months a year as we deal with the backlog, and that trickles back to producers that have animals ready to go into the food chain and just know where to send them. We have a lot of issues that spin off of that slight, little processing backlog.

Mr. Randy Pettapiece: Thank you.

I will yield to MPP Robin, Chair.

Mrs. Robin Martin: Thank you very much, MPP Pettapiece, and thank you, Mr. Lipsett, for answering some of the questions we had for the beef farmers.

I certainly want to thank all of our presenters here today for bringing their perspectives on all of these important issues to the committee. It's a mini-microcosm of the kinds of issues we face in the government in Ontario, which are all over, really, and are all important. So thank you again.

Yesterday, we also had the pleasure of having Dr. Newbery here with us presenting with another OMA district. I actually had asked her a question which she didn't get a chance to answer—I don't know if she recalls, but I do—which was, one of your principles in the OMA's report about the prescription for Ontario is every individual should have a team of health care providers linked digitally. Of course, part of what we're trying to do with our Ontario health team reconstruction of our health care system is to link health care providers around patients, digitally and otherwise.

I had asked Dr. Newbery if she felt that the Ontario health team initiative was a good step in that direction and if there were things we could do to improve it. I wonder if Dr. Newbery could just pick that up where we left off.

Dr. Sarah Newbery: Yes, thank you so much for the invitation to respond. Again, Sarah Newbery, and I'll open it to Dr. Cooper in a moment as well.

I do think the Ontario health teams have the potential to be a really helpful opportunity to better integrate care around populations, both in the northeast and in the northwest. I think we're seeing those slowly evolve. But the intent to bring a team of professionals together around patients and to ensure that we have shared access to information through digital linkages is really, profoundly important.

One of the things we're struggling with, in part because of the physician resource challenges and health human resources broadly, is creating the time for our health care professionals and our physician leadership to be able to step in and really support the Ontario health teams in the way that they need to be supported to be maximally effective. I think that that has been a challenge and part of the reason that we've seen a variation in the way in which Ontario health teams have evolved in northern Ontario.

The Chair (Mr. Ernie Hardeman): One minute left.

Dr. Sarah Newbery: I'll turn it over to Dr. Cooper in case he has a comment on this as well.

Dr. Stephen Cooper: Ms. Martin, the OMA, before COVID, was putting a lot of resources into supporting physician engagement in OHTs. There's a lot of documentation, so we're behind you 100% on that as an organization—allowing physicians to join at what's best for their own community, appreciating the fact that there needs to be some local input—

Mrs. Robin Martin: Absolutely.

Dr. Stephen Cooper: It's a wonderful system—a wonderful idea, anyway, or concept.

Mrs. Robin Martin: Yes. Okay. I do have some further questions for you. I know they're going to cut me off soon, but I was going to ask, Dr. Cooper, about mental health, because that was something you mentioned. I know that we have improved investments in mental health every year since we've been elected. I think we have annualized funding of an over $525-million increase, which helps; and we also came out with our Roadmap to Wellness to try to chart where these investments should go—

The Chair (Mr. Ernie Hardeman): Time's up. Thank you very much. We'll have to wait for the answer in the next round, which we will start immediately with the official opposition. MPP Bisson?

Mr. Gilles Bisson: MPP Vanthof can go first.

Mr. John Vanthof: Thank you, Gilles.

Before I turn to the Beef Farmers of Ontario, I'd just like to thank the medical association for bringing their issues up, because I represent Matheson and Cochrane and Kirkland Lake, and a doctor shortage—when you have one doctor for 5,000 people, it's hard to deal with that. That is the number one issue in northern Ontario.

But I'd like to turn to the beef farmers. Thank you for coming. I think you have been talking about the Risk Management Program for a long time, and we have been fully in support, actually. We, the NDP, propose to put in $50 million a year every year. At that point, we would be where? We'd be higher than where you're proposing today.

I think a lot of people don't understand that what this program does—and you explained it, but I'd like you to take another good shot at it—is insures your risk against

the market. You put all the ingredients in—you pay for the diesel fuel, you pay for the feed, you pay for everything—but you have no guarantee what you're going to get at the end of the day. What this program does—if it was not capped—is it would give you a level of payment that you know you could pay your bills. But now, because it's capped, there's no guarantee. You could only get 40% of what you paid for.

Could you please say how frustrating that is and how much better this program would work if it was actually fully funded?

Mr. Rob Lipsett: Thank you, MPP Vanthof. I think the best way that I can describe how important the program is to farmers and especially to beef farmers is in the past two years, we've done a lot of work on a redesign of the current programming. Out of that investigation, a really shocking number—and I hadn't even noticed it on my own farm, because when you pay bills, you pay them one at a time. But in Canada, the overhead expenses on farmers has gone up 78% since 2013 and our gross revenue figures have gone down 13%. That just shows the importance of a program.

And I will touch on what MPP Martin brought up: mental health. The biggest stress factor on a farmer in our country is financial. So there's a two-pronged approach here: If we can fund the program properly, it will relieve a lot of that mental stress. There aren't very many farmers in the province who don't subscribe to this program. They've proven that it's popular, and it seems to be the right answer.

I just hear, over and over, farmers who talk about that if the program could be funded properly, expansion is an option which creates more jobs—we need employees—and you would see less people exiting the industry. COVID maybe has amplified it a little bit, the amount of people who are beginning to throw their hands up and walk away, just feeling stonewalled by a lack of progress on program redesign or restructure. This cash infusion—as we've acknowledged, the RMP program is the best program for Ontario farmers. We'd just like to see it work properly.

Mr. John Vanthof: Thank you.

I'll turn the floor over to Mr. Bisson.

The Chair (Mr. Ernie Hardeman): Mr. Bisson?

Mr. Gilles Bisson: I've got a quick question to Dr. Cooper, because I don't think there's an MPP, at least in northern Ontario, and I would say it would be the same in a number of other areas, who is not getting phone calls with constituents trying to find a family doctor. It's a very difficult thing.

I was intrigued by one of the things that you talked about, and I just wanted a bit of a clarification. The residency program from the Northern Ontario School of Medicine is normally within a hospital setting. Are there any examples where the residency is actually being done in a family health team setting or in a medical clinic, and is that possible?

Dr. Stephen Cooper: Yes. Public health is a great example of a residency program that is absolutely not centred in a hospital. If you do your residency in public health, you'll certainly only be in a hospital occasionally. The family medicine residency program is very much—hospital is de-emphasized, there's a fair bit of emergency experience and core rotation in obstetrics and surgery, but most of your training will be in a family medicine office.

0950

Mr. Gilles Bisson: But the family health teams—that's my question: Are they using family health teams?

Dr. Stephen Cooper: Family health teams? Yes. Family health teams are a little bit of a different concept, because that's basically the primary care centre, whereas the residents are training with the physicians who are part of the family health team but just part of it. But we also have nurse practitioners and PAs who come to our family health teams, so we train many different specialties or professionals.

Mr. Gilles Bisson: But they would be working under the supervision of a doctor—the same thing as the nurse practitioner, in some of them.

Dr. Stephen Cooper: Yes. Well, the nurse practitioners come to our office. They train under the doctor. They train under the nurse practitioners and get some experience with a PA. We're really working on interprofessional improvement and communication. Part of that is when you're a professional, but also when you're training. The school has been very good about making sure that trainees get experience with all kinds of health care providers.

Mr. Gilles Bisson: Okay. Thank you.

I think Mr. Mantha has a question.

Mr. Michael Mantha: Yes. I wanted to thank Dr. Cooper and Dr. Newbery. You guys are highlighting exactly what's going on as far as challenges throughout northern Ontario. Across the north shore, we are in crisis with the doctor recruitment program here. We're very much aware of what's going on in Thessalon, in Bruce Mines and so on.

I want to go to Dr. Newbery. Dr. Newbery, please submit your article you just recently wrote to the committee so that they can review it. That's where I want to go to: your first sentence and your last sentence. You said we have the solutions here; we're just missing the will. Do we have the will to do any of it? Can you expand on that particular response? Where do we need to put that will?

The Chair (Mr. Ernie Hardeman): One minute.

Dr. Sarah Newbery: Thank you so much. It's Sarah Newbery speaking. I think there have been many, many ways in which solutions to the physician workforce shortages that have been chronic in northern Ontario and are at crisis level, to your point now—many solutions have been brought forward. I think we need to look at how we better support physicians. We need programs for mentorship. We need better programs for networking. OHTs may be part of the solution.

We need to relook at our incentive programs for recruitment and retention of physicians. We need to look at the kinds of supports that we create for physicians once they're in practice. How do we transition those new grads into practice, and how do we do that well when there may

no longer be a seasoned mentor in those practices? That takes a funding commitment, and it takes a commitment to the way in which we value primary care and family medicine in rural communities across the province. I think that combination of commitment to understanding the importance of the role of family physicians in our communities—

The Chair (Mr. Ernie Hardeman): Okay, we'll have to leave the rest to the next answer.

We now go to the independent. MPP Hunter?

Ms. Mitzie Hunter: It's a great discussion we're having, and I want to thank all of the presenters today. Thank you to the beef farmers for outlining your request to the committee.

However, I do want to spend my time on the Ontario Medical Association, just to better understand some of the comments that were made this morning. One of the comments was that you would like to see the government make the OHIP code for virtual care permanent. I would like you to articulate what impact this would have, particularly on standard of care for people who are in northern regions, as we're focusing on the northeast today. If you could just expand on that comment, please.

Dr. Stephen Cooper: Thank you, Ms. Hunter. Right now, the government and the OMA did pivot really quickly to create codes for virtual care. The north, with its large geographical area, really depends on the ability, particularly in specialty care, to be able to communicate with a specialist without leaving their own community. It has been a real saving for the travel fees.

Those codes will expire in September. I am hopeful and confident that it needs a little push to make sure that we make those codes permanent. It is important both for south and north.

Ms. Mitzie Hunter: Okay. That's great. Thank you.

I know we touched on this yesterday, Dr. Newbery, but I do think it's worth really emphasizing the needs in the north or the gap that is there for specialists. We talked about mental health and well-being and the fact that there is a higher demand, given some of the challenges with geography, transportation, population spread relative to that geography, around mental health and well-being, yet we see that there is a shortage of psychiatrists. I'm wondering the things that you believe are needed to close that particular gap.

I wanted to also ask about the family physician issue, but I think it was well covered also. I know that that's a repeated concern when I am in the north, whether it's Timmins or Cochrane. We were talking about the northwest yesterday. Officials have talked about that need.

Also, I just want to use this as an opportunity to thank those family physicians in the northern regions who are just working well overtime and just trying to keep up with the needs and with the demands at a cost and expense to their own well-being and of the members of their family. So I just want to acknowledge that as well. But as it relates specifically to the specialists and in the area of psychiatry as it relates to mental health and well-being—I don't know if that's to Dr. Cooper or Dr. Newbery. You're unmuted, Dr. Newbury; go ahead.

The Chair (Mr. Ernie Hardeman): One minute.

Dr. Sarah Newbery: Sure, thank you. I'll turn it to Dr. Cooper in a moment.

We know that we need 40 psychiatrists simply to meet the hospital needs, the consulting psychiatry needs, and particularly child psychiatry is a significant need. We know many youths are sent from northern Ontario to London, for example, for in-patient care. We know, though, that we also need many, many more community supports and that whole inter-professional team: social workers, addictions counsellors etc.

But the psychiatry piece is really important, and broadly across the north, we have a ratio of specialists to family physicians of 0.6 to 1. In the rest of the province, it's 1 to 1; nationally, it's 1 to 1. That ratio isn't off because we have too many family physicians; it's because we have too few specialists. So family physicians, to your point, are increasingly burdened with managing mental health issues in an under-resourced environment. Increasing training of psychiatrists at NOSM and in other schools may help to address that shortage, and using the virtual tools that we have and enhancing those may be helpful as well. Thank you.

Ms. Mitzie Hunter: And reinvesting in telemedicine.

Dr. Sarah Newbery: Yes, indeed. Thank you.

The Chair (Mr. Ernie Hardeman): That concludes our time.

We will now go to the government. MPP Martin?

Mrs. Robin Martin: Thank you again, Chair. I was just going to go back to where I was. I keep getting cut off in my questions; my timing is off, obviously, this morning.

I was talking to Dr. Newbery, and I did just want to comment: You had mentioned and answered in another question how it's really important that we support our recent graduates, our doctors in the north especially, to make sure that they have the mentorship and networking—and I think training can also be challenging sometimes in the north, from what I understand—that they have those things around them so that OHTs may be part of the solution, especially when there are more up and fully running etc.

You also specifically said how we transition graduates into practice—and, I think, how we transition them into new areas of practice is also really important. I don't think that just applies to doctors; I think that applies to PSWs and to nurses as well. For example, in home care, sending off new PSWs to work by themselves in someone's home when they have little experience is probably quite a daunting thing for them to face without some of that linking and support. That's certainly part of what the OHTs are trying to address.

But I was mentioning to Dr. Cooper specifically that we have been trying to make investments in mental health, including in the north. We announced $32.7 million to help improve specialized mental health and well-being of the province's most vulnerable children and youth by addressing increased demand for those services during

COVID-19, which is also a northern issue. We certainly know we have to have culturally appropriate care and improved commitment to working collaboratively, which I think you mentioned, with our Indigenous partners and communities to co-develop programs. We recently invested $12.8 million to expand and enhance culturally appropriate mental health and addiction services for Indigenous peoples, families and communities across the province.

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Those two investments are just examples, but I'm wondering if you can comment on how those are helping. I know we have a shortage of psychiatrists even in the south, so obviously we have a greater shortage in the north, as you've been pointing out. Are these kinds of programs helpful to alleviate some of the strain, and are there other programs—I don't know, the online cognitive behavioural therapy, for example—that can also help alleviate some of the strain while we try to get more trained psychiatrists available across Ontario? I just wondered if Dr. Cooper or Dr. Newbery could comment.

Dr. Stephen Cooper: MPP Martin, I just wanted to say the investments that governments have made in mental health have made a huge improvement. I've been doing this job for 30 years, and 30 years ago, if you had a mental health issue, there really weren't a lot of services for you. Now, OTN interviews my patient in the hospital, a psychiatrist recommends medications, the crisis worker comes down from upstairs, sees the patient and sets up in a home community. That is night and day from what it was like 20 or 30 years ago.

But we're still seeing an increase in patients coming in to the hospital with mental health issues. I can't explain why there has been this increase—well, other than maybe COVID—but there has been a huge issue, so more needs to be done to understand the upstream problems. But I very much appreciate some of the work that has been done, and I can tell you that it has made a huge difference to delivering care here.

Mrs. Robin Martin: Thank you. I really appreciate you saying so. Certainly, when I started, the first year I worked with Minister Elliott—I'm the parliamentary assistant there—she said that mental health is the priority. We did consultations across the province to try to figure out where the gaps are. We had some mental health services, but they were not necessarily talking to each other or to other health care providers, so people don't necessarily know what's there. I think we've gone some way to remedying that, but I don't think we've gone all the way.

Really, I just wanted to know—and I don't know if you have any further suggestions aside from more psychiatrists, or maybe you can help me with how we get more psychiatrists to the north, if there are specific things that would induce them. Have you known if clients are benefiting from, for example, the programs I mentioned or the cognitive behavioural therapy that is online, which, I assume, people in the north can use as well, presuming their Internet is good enough to do so? I know that has off-ramps to psychiatrists in-person where necessary. I don't know if that's working as well in the north. Any comment on those particular things?

Dr. Stephen Cooper: I think patient-directed health care is going to be key to helping deal with some of the wait-lists and backlog. It doesn't have to be all getting more specialists in. So that's a really good point. That's the BounceBack program you're talking about. That's a really great program.

Some of the things we could look at, looking upstream: I think local housing, particularly in rural communities for people with mental health issues, needs to be addressed. Looking at some of those upstream causes for the mental health issues will be a key part to reducing the mental health burden on the health care system and on patients.

Dr. Sarah Newbery: If I could add, I think one of the things that we do need to recognize is that to access many of the programs like BounceBack, you do need to have a primary care provider to refer to you that program and also to support management if things become a bit more complicated. As we continue to struggle with primary care physician workforce issues across the north, access to some of the very important and valuable programs that have been created remains limited and difficult for many patients who can't, in fact, access a family physician or nurse practitioner. Looking at how we build that whole system of care will be an important piece in terms of dealing with mental health and addictions issues broadly.

Mrs. Robin Martin: Okay. Well, thank you, and I will look your article up if I don't see it through the materials provided.

Just a quick question for the association of prosthetics and orthotics: Thank you for your presentation, and thank you to MPP Gélinas for walking us through the $9.7 million and how that came about, because it wasn't entirely clear to me where the number came out. I know that this is something you're advocating for. I'm wondering if there are any particular other things that your organization would be advocating for to improve care for your patients.

Ms. Mary Catherine Thiessen: We're looking for a couple of different policy changes as well. One of the things that we talked about in our presentation was the example of the orthotics patient who needed a titanium knee joint for a brace. The policy states that if the cost of the component is above the maximum amount, we are not allowed to bill for that component, and that then negates the entire brace.

So if we were allowed to bill above what that maximum was, then we could offer more options to our patients for their care if they were willing to pay out of pocket for that. That doesn't increase the amount of—

Failure of sound system.

Mrs. Robin Martin: I think she went—

The Chair (Mr. Ernie Hardeman): We've lost her, but it was also right on time, because time was up. That does conclude the questions from the committee, so we want to thank all the panellists this morning for your great presentations and helping us move forward with this consultation.

I want to remind you that the deadline for written submissions is 7 p.m. on Wednesday, January 26, 2022. So any answers that were cut off this morning that would be helpful in our deliberations, if we get it in a written submission, we will take that into consideration as we're preparing our report. Again, I thank everybody for participating this morning.

I think that's all the business we have this morning for the committee, so the committee is adjourned until 9 a.m. on Wednesday, January 12, 2022. We will continue the pre-budget consultations 2022 for the Ottawa region. That will be tomorrow morning at 9 o'clock. This committee stands adjourned.

The committee adjourned at 1006.

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