SP-17

ISSN 1710-9477

Legislative Assembly
of Ontario

Second Session, 39th Parliament

Assemblée législative
de l'Ontario

Deuxième session, 39e législature

Official Report of Debates (Hansard)

Tuesday 22 March 2011

Journal des débats (Hansard)

Mardi 22 mars 2011

Standing Committee on Social Policy

Health Protection
and Promotion
Amendment Act, 2011

Comité permanent de la politique sociale

Loi de 2011 modifiant
la Loi sur la protection
et la promotion de la santé

Chair: Shafiq Qaadri
Clerk: Susan Sourial

Président : Shafiq Qaadri
Greffière : Susan Sourial

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Room 500, West Wing, Legislative Building
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Toronto ON M7A 1A2
Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario

Service du Journal des débats et d'interprétation
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

Tuesday 22 March 2011

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Mardi 22 mars 2011

The committee met at 1602 in committee room 1.

SUBCOMMITTEE REPORT

The Chair (Mr. Shafiq Qaadri): Ladies and gentlemen and colleagues, I welcome you to the Standing Committee on Social Policy. As you know, we're here for proceedings on Bill 141, An Act to amend the Health Protection and Promotion Act. We have a number of presenters today, but before that, I will invite a member of the subcommittee to please present the latest subcommittee report, for which purpose I will invite Ms. Sandals or Mr. Ramal.

Mrs. Liz Sandals: Probably better him.

Le Président (M. Shafiq Qaadri): Monsieur Ramal, s'il vous plaît, procédez immédiatement, tout de suite.

Mr. Khalil Ramal: Thank you, monsieur le Président.

Your subcommittee on committee business met on Monday, March 7, 2011, to consider the method of proceeding on Bill 141, An Act to amend the Health Protection and Promotion Act, and recommends the following:

(1) That the committee hold a public hearing in Toronto, at Queen's Park, on Tuesday, March 22, 2011.

(2) That the clerk of the committee, with the authorization of the Chair, post information regarding the committee's business once in the following newspapers, as soon as possible: the Globe and Mail, the Toronto Star and L'Express.

(3) That the clerk of the committee, with the authorization of the Chair, post information regarding the committee's business on the Ontario parliamentary channel, the Legislative Assembly website and with Canada NewsWire.

(4) That the committee invite Dr. Arlene King, chief medical officer of health of Ontario, to appear before the committee on Tuesday, March 22, 2011, and that Dr. King be offered the same length of time for the presentation as other presenters.

(5) That interested people who wish to be considered to make an oral presentation on Bill 141 should contact the clerk of the committee by 5 p.m. on Wednesday, March 16, 2011.

(6) That, following the deadline for receipt of requests to appear on Bill 141, the clerk of the committee provide the subcommittee members with an electronic list of all the potential witnesses who have requested to appear before the committee.

(7) That, if required, each of the subcommittee members supply the clerk of the committee with a prioritized list of the witnesses they would like to hear from by 2 p.m. on Thursday, March 17, 2011. These witnesses must be selected from the original list distributed by the committee clerk.

(8) That the groups or individuals initially be offered 10 minutes for their presentations, including time for questions, and that if all groups and individuals whose requests to appear were received by the deadline can be accommodated in 15-minute timeslots, they then be offered 15 minutes for their presentations.

(9) That the deadline for receipt of written submissions be 5 p.m. on Tuesday, March 22, 2011.

(10) That amendments to the bill be filed with the clerk of the committee by 12 noon on Thursday, March 24, 2011.

(11) That the research officer provide the committee with a summary of witness presentations by 5 p.m. on Thursday, March 24, 2011.

(12) That the committee meet on Monday, March 28, 2011, for clause-by-clause consideration of the bill.

(13) That the clerk of the committee, in consultation with the Chair, be authorized to commence making any preliminary arrangements necessary to facilitate the committee's proceedings prior to the adoption of this report.

The Chair (Mr. Shafiq Qaadri): Are there any questions and comments or urgent items before we adopt the subcommittee report, as read? Madame Gélinas?

M^me^ France Gélinas: I was voting in favour.

The Chair (Mr. Shafiq Qaadri): Fine. So let's consider that unanimous.

HEALTH PROTECTION AND PROMOTION AMENDMENT ACT, 2011

LOI DE 2011 MODIFIANT LA LOI SUR LA PROTECTION ET LA PROMOTION DE LA SANTÉ

Consideration of Bill 141, An Act to amend the Health Protection and Promotion Act / Projet de loi 141, Loi modifiant la Loi sur la protection et la promotion de la santé.

The Chair (Mr. Shafiq Qaadri): We'll now move to our presentations. As you know, we have, I believe, three presenters, each of whom will be offered the exact same 15 minutes in which to make their presentations, and any questions will be addressed in the time remaining. The time will be enforced with military precision.

OFFICE OF THE CHIEF MEDICAL OFFICER OF HEALTH

The Chair (Mr. Shafiq Qaadri): I now invite, from the Ministry of Health and Long-Term Care, Office of the Chief Medical Officer of Health, Dr. David Williams, associate chief medical officer of health.

Welcome, Dr. Williams. I invite you to be seated, and please identify your colleague. I invite you to officially begin now.

Dr. David Williams: Good afternoon. My name is Dr. David Williams. I am the associate chief medical officer of health, protection and prevention. I'm here on behalf of Dr. Arlene King, Ontario's chief medical officer of health. Dr. King wanted very much to be here today, but unfortunately, she's unable to attend because she's out of the country. Accordingly, I'm currently the acting chief medical officer of health for Ontario.

I'm here to speak to Bill 141, the government's proposed amendments to the Health Protection and Promotion Act, from the point of view of the Office of the Chief Medical Officer of Health.

The purpose of this proposed legislation is to strengthen Ontario's response to future major public health events and emergencies, such as a pandemic. Our experience with H1N1 provided us with the opportunity and responsibility to review how we responded and how we might better respond the next time there is a need. It provided us with an opportunity to ask, "What if?", to think about other possible scenarios and eventualities and to allow those to help guide our future response.

I want to reinforce, however, that these amendments are not a criticism of the local response. On the contrary, the system and the professionals who work within it performed admirably. For that, they have our heartfelt thanks.

Public health units across Ontario worked very hard to implement the largest mass immunization program ever, and they mobilized to do everything necessary to protect the public's health. That was evident time and again during the H1N1 pandemic. For example, public health units worked in close collaboration with various partners, including First Nation organizations, federal, provincial and local organizations, other public health units, and their communities. Due in large part to this coordinated effort, Ontario fared very well during the H1N1 pandemic, but there were challenges and many lessons learned.

1610

In her preliminary report on the H1N1 response, released in June 2010, Dr. King recommended a strong, centralized approach to pandemic response, one that the current legislation doesn't permit. She suggested that the chief medical officer of health must have the authority to direct public health units in real time. The proposed legislation will provide greater support to local public health units and enable them to respond to a public health event or emergency with greater consistency.

There are times when local public health units would benefit from more clarity and a standardized approach when faced with a major health event like the H1N1 pandemic. Ontario has one of the most decentralized public health systems in the country, and that has many advantages, such as tailoring services to meet local needs. But in the case of an emergency, Ontarians would benefit by more consistency and standardization across the province.

In summary, the proposed amendments would strengthen the province's ability to plan, manage and respond to future pandemics, provincial, national or international public health events and/or other emergencies that affect the health of Ontarians. Specifically, the amendment is proposed to create a new authority for the chief medical officer of health.

The proposed legislation would give the chief medical officer of health enhanced oversight authority to help ensure that Ontario's response is better coordinated. If the legislation is passed, the chief medical officer of health would have the authority to direct boards of health and local medical officers of health to adopt measures during a future public health emergency if he or she feels that Ontarians would be better protected by a coordinated response to an outbreak or emerging public health event. Such directives would be enforced for six months or less if the CMOH so decided and such directives would be limited to very specific situations—for example, to cases of infectious diseases, environmental health and public health and emergency preparedness.

The proposed amendments would also ensure that the appointments of acting medical officers of health are approved by the chief medical officer of health and the Minister of Health. Again, this proposed change is not intended as a criticism of the current acting MOHs, or medical officers of health, who have performed well and demonstrated their commitment to public health across the province. Rather, consistency in training will support consistency of action and a consistent language, all extremely important during an urgent event.

Currently, acting medical officers of health appointments do not require approval by the chief medical officer of health or the minister. However, the appointment of a medical officer of health and an associate medical officer of health are approved by the minister, which allows the minister to review the proposed appointment by the board of health. The approval of an acting medical officer of health by the minister and the chief medical officer of health will align the process with that of a medical officer of health and an associate medical officer of health appointment. This will also provide another screening step to ensure that acting MOHs—medical officers of health—are fully qualified to take on that role.

The amendments would also expand the minister's power to use a public space, on the advice of the chief medical officer of health, for public health purposes, like holding an immunization clinic. Accessing public spaces would support local MOHs at a time when they are occupied with handling the emergency locally. Let me note that the proposed amendment refers only to public premises whose owner is already part of the broader public sector. The definition of "broader public sector" is taken from the Financial Administration Act and includes, among others, schools, colleges, universities, entities that are a health service provider and municipalities. The current compensation scheme in the HPPA, or Health Protection and Promotion Act, would be extended so that the occupier of the premises would be entitled to compensation for the use and occupation of the premises in accordance with the Expropriations Act. There is no doubt that Ontario's public health system and, by extension, Ontarians would benefit from these proposed amendments.

Thank you for this opportunity to speak to you, and now I'm pleased to answer your questions.

The Chair (Mr. Shafiq Qaadri): Thank you, Dr. Williams. We have about two and a half minutes or so per side, beginning with Ms. Jones.

Ms. Sylvia Jones: As I understand it, the amendments would give the chief medical officer of health more authority. Were there examples during the H1N1 crisis where directives were not being followed through in a timely manner and, thus, the motivation for this amendment?

Dr. David Williams: As noted in Dr. King's report, the areas of concern dealt mostly with immunization, where we had to carry out our largest mass immunization program in such a way that it was consistent throughout the province—dealing with priority groups first, and going through that process. Knowing that health units had different abilities to respond, it was important that we follow a pattern so as not to confuse the public, those in decision-making and in the media, so that there was consistency and one health unit did not feel different than another.

At times, there was variation carried out because local health units felt that they wanted to proceed in a time fashion that they felt was reasonable. Yet there was a concern to Dr. King that there was a lack of consistency. Thus, there was confusion among Ontarians.

Ms. Sylvia Jones: So there may have been examples where local health authorities acted sooner than when the chief medical officer of health was suggesting the immunizations could take place? Is that the example?

Dr. David Williams: Acting sooner than was consistent with the rest of the provincial partners and the other health units in the province.

Ms. Sylvia Jones: You mentioned that currently, acting medical officers of health don't have to be signed off on by the chief medical officer. Is that correct?

Dr. David Williams: That's correct.

Ms. Sylvia Jones: Today, how many positions of acting medical officer of health are there?

Dr. David Williams: Eight or nine—it's nine, actually.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Shafiq Qaadri): Thank you. Je passe la parole à M^me^ Gélinas.

M^me^ France Gélinas: Continuing on what my colleague just said, we all read the report. We know that there have been challenges with H1N1. Are you absolutely positive that giving power to the chief medical officer of health would have solved—I don't see the link between giving the chief medical officer of health directive-making power and how that would have helped out in the H1N1 rollout that we lived through a year ago.

Dr. David Williams: I think if you look at the context, when we're looking at the directive powers, there is oftentimes consultation with the health units. There is an agreed-upon direction or action, but there may be some medical officers of health who have a different opinion and, unlike the majority of their peers, would like to go in a different direction. At that time, there's a desire by even fellow medical officers of health to ask for the chief medical officer of health to set a standard or a direction that everybody would adhere to to ensure consistency.

The difficulty is, when there isn't consistency, one has to explain, even between one health unit and another, why one is doing something different than your peer next to you, and that often is a matter of confusion to the public, some of which goes across boundaries between health units.

The directive would direct health units to follow a certain timeline for the benefit of giving a consistent provincial response throughout the province.

M^me^ France Gélinas: But it seems to me what that will do is bring some coordination at the communication point, but it's not going to improve public health.

The decisions that are made at the local level are with the intention of improving the public health of the people they serve. It could come at a price where communication is not as clear as we would want, so to me, it seems like we're putting clear, concise, understood communication above quality public health outcomes.

1620

Dr. David Williams: One of the key things in a public health response when you're dealing with risk, whether it's risk-management assessment—a cornerstone and part of the overall process is risk communication. So one can't separate communications—

The Chair (Mr. Shafiq Qaadri): Regrettablement, madame Gélinas, votre temps est expiré. To the government side. Mrs. Sandals.

Mrs. Liz Sandals: A couple of things. First of all, just a comment, I guess, that I think what we need to do is learn from the past, from H1N1 and SARS, and think about an even bigger event potentially in the future. Do we have the capacity to handle that, and how would we handle it?

It seems to me, even looking back at H1N1 from my perspective in Guelph, that it was often quite confusing because people look at Toronto media and consume

Toronto media, and if that doesn't match what's going on in Guelph, then it's quite confusing to people. I'm sure that Ms. Jones would have sort of the same effect in her riding, where local information isn't necessarily consistent with the media that people are watching.

At any rate, I wanted to just clarify, if I may, because in her question Ms. Jones asked about the following-through of directives. My sense now is that part of the issue here is that the chief medical officer of health doesn't really have the authority to give a directive. There can be consensus and people may follow the consensus, but the CMOH does not in fact have the authority to give a directive. Could you comment on that?

Dr. David Williams: That would be correct. Not only with H1N1 but in supporting other CMOHs in the past there was the same issue: The need for consensus-building was always there, but it does take time, and time doesn't permit to gain a consistent approach, and the power for the CMOH to do that was not and currently is not in the act.

Sometimes it is even the wish of a majority of medical officers of health in the field that there be a stance that would ensure that each of them would carry it out, because it is difficult, having previously been a medical officer of health, to explain why your peer to one side or the other is doing something different in a way that makes sense and yet does not undermine the overall approach.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Sandals, and thank you, Dr. Williams and entourage, for your deputation on behalf of the Ministry of Health and Long-Term Care, Office of the Chief Medical Officer of Health.

ASSOCIATION OF LOCAL PUBLIC HEALTH AGENCIES

The Chair (Mr. Shafiq Qaadri): I now invite the next presenter, the Association of Local Public Health Agencies, to please come forward: Dr. Paul Roumeliotis, chair of the Council of Ontario Medical Officers of Health, and colleague Linda Stewart, executive director. Welcome, and I invite you to please begin now.

Dr. Paul Roumeliotis: Thank you very much. Good afternoon. Bon après-midi. I'd like to thank you for this opportunity for us to comment on Bill 141. My name is Dr. Paul Roumeliotis, medical officer of health of the eastern Ontario health unit and current chair of the Council of Ontario Medical Officers of Health. This is Linda Stewart, executive director of ALPHA, who is with me today.

We understand that this bill has been through a few drafts, and we have had dialogue with the chief medical officer of health and her office about the proposed changes. However, I wish to clarify that public health units were not consulted about the need for an amendment to the HPPA. The need appeared to be a foregone conclusion, and we were asked to comment only on the wording of an amendment that would permit the CMOH to issue directives to medical officers of health and boards of health during an emergency situation, a power that some argue already exists within the current HPPA.

Further, we would like to note that, historically, changes that have been made to the HPPA have occurred only after careful consideration and thorough review of multiple reports and consultations, like SARS. In contrast, Bill 141 was tabled following the recommendations of a single report that has been described by its author as "informal and initial." Despite our requests for a delay of legislative changes until the Ontario H1N1 report was released and to allow medical officers of health, boards of health and other stakeholders time to enter into a robust dialogue, the legislation was tabled.

Basically, we feel that a more comprehensive review of the issues following H1N1 and a meaningful consultation with the field would have led to a clearer understanding of the potential areas for improvement within our public health system. Such a process may indeed have indicated a need for additional CMOH powers, but it may also have indicated alternative approaches and identified additional required modifications that would collectively further enhance and strengthen our public health system's ability to protect the health of all Ontarians, especially during an emergency.

Having said this and given that there is apparent resolve to pass the bill, we're prepared to work with the CMOH office and public health division to contribute to writing the specific regulations, and we would like to make the following comments and suggestions.

As the bill stands now, we welcome the clarification provided in the bill regarding possession of premises for public health purposes. We understand the purpose behind the new approvals required relating to the appointment of acting medical officers of health, but we would ask that special consideration be given to acting medical officers of health who take the position with a commitment to go and get trained. There's a difference between having somebody be there for a couple of months versus somebody that's going to be there for a couple of years and then be a fully appointed medical officer of health.

We are most interested, however, in the sections regarding the chief medical officer of health's rights and responsibilities for issuing directives or orders to public health units across Ontario during an emergency.

Regarding the issues of directives specifically, we've made some suggestions for wording changes that we believe help the bill to be more in keeping with the existing wording in the Health Protection and Promotion Act, and those are detailed in the report that we have submitted to the clerk.

One particular wording change is of utmost importance. This is in the new clause in 77.9. The clause allows for an order to be issued during an emergency and that the policies or measures are necessary to support a coordinated response to a situation or to otherwise protect the health of persons.

We are concerned that this clause allows the chief medical officer of health to issue a directive primarily

intended to achieve coordination at the provincial level. The essence of the Health Protection and Promotion Act is to protect the health of our population, and we coordinate, organize and deliver our services with this in mind. While a certain amount of coordination can be important in any public health response to an emergency situation, it may not be the best means to ensure the best possible response throughout the province.

As public health leaders locally, we believe that central directive applications need to be customized according to local needs and circumstances. In fact, this is a great feature of our system. We know from experience that removing the flexibility to tailor centrally developed standards and directions to local circumstances puts emphasis on standardizing an approach at the potential expense of ensuring the best public health outcome. Again, this is our priority.

The difficulty inherent to increasing centralized coordination in the public health system where local autonomy is a cornerstone was illustrated during the H1N1 response. As you know, centralized attempts to standardize the rollout of the H1N1 vaccine with inflexible rules about priority populations resulted in public confusion and local dilemmas for public health agencies. Most importantly, it undermined the local decision-making powers to make the necessary changes and adaptations to procedures to protect the health of the public and to ensure the best public health outcomes locally for the population that we serve. To ensure that a coordinated response does not take precedence over protecting the health of the public, we recommend that the "or" in clause 77.9(1)(b) be changed to "and." This would ensure that central directives can allow for appropriate consultation while ensuring that the health of the public is the foremost consideration.

Finally, the draft legislation allows for terminology, including terms like "public health event," to be defined in the regulations of the act. We strongly recommend that the development of regulations in support of Bill 141 include input from public health practitioners and local public health agencies.

Again, I'd like to thank you for the opportunity for this discussion, and we'd be happy to answer your questions.

The Chair (Mr. Shafiq Qaadri): Thank you. About two minutes or so per side.

M^me^ France Gélinas: I want to make sure that I understood you clearly. With central directives, and that goes with the line of questioning that I had before, do you see a potential where the central directive will make sure that the entire province is coordinated but that will come at the expense of good-quality public health, that you could achieve better quality public health if you had local control versus central directives?

Dr. Paul Roumeliotis: We believe that there has to be a balance struck between the two. We believe that in certain situations, if you were to tell me in my area to deliver a memo to my population in English only, I would not. I would have to wait until it's available in French. That's an example of tailoring it to our needs.

1630

Northern populations may not be able to deliver a certain service because they have to fly to deliver it, instead of going there within an hour. I do believe that there has to be a balance, and our point really was that we wanted to discuss it. We believe that we have relationships within public health that can work together to develop consensus in terms of a general direction, allowing local flexibility that will enhance the delivery and the needs locally.

M^me^ France Gélinas: Did you see anything in the report that was done for H1N1 that pointed to, "That was the solution"?

Dr. Paul Roumeliotis: Frankly speaking, I don't think that the solution to the H1N1 issue—we have to look at federal-provincial issues. We have to look at decisions made at the federal level that forced us to use priority populations in populous settings. To blame this solely and say that this is going to resolve the problem is not 100% true. I believe that there were issues beyond everybody's control at the federal level, in terms of decisions of ordering the vaccine and vaccine availability, that put extra pressure on us.

I don't believe this is the only solution, and this is why we wanted to be more involved in the discussion, to be able to look at more robust solutions and comprehensive solutions as well, taking into account the complexity of the multi-jurisdictional issues that also played a role.

M^me^ France Gélinas: Aside from what's going on with the public hearings we're having right now, will there be other means for public health units to bring forward real solutions that would have an impact on quality public health?

The Chair (Mr. Shafiq Qaadri): Thank you, Madame Gélinas. To Ms. Sandals.

Mrs. Liz Sandals: I appreciate you appearing here today. I wonder if we could go back to your comments on the issue around the approval of the acting medical officer of health, because I wasn't really clear about what you were suggesting there.

Dr. Paul Roumeliotis: Yes, sure.

Mrs. Liz Sandals: My understanding was that the way it was currently drafted is that if it is a very short time, then it's up to the local board of health—less than six months. Where it's beyond six months, then it needs to go to the chief medical officer of health, but the chief medical officer of health could include conditions, and that would mesh with the scenario you suggested where somebody is doing educational qualifications.

Dr. Paul Roumeliotis: Yes.

Mrs. Liz Sandals: I wasn't sure—

Dr. Paul Roumeliotis: No, it was a point of clarification. It was a point of agreement, first of all. We agreed in principle. It was just a sort of application; it was more of an application of the amendment. In situations where a medical officer of health signs on and simultaneously gets his or her MPH and becomes fully qualified, that may take a year or a couple of years.

Mrs. Liz Sandals: Exactly.

Dr. Paul Roumeliotis: Just for logistical issues, to re-evaluate that every six months would be a bit redundant and perhaps a waste of time. That's the only thing we're saying.

Mrs. Liz Sandals: So it's just the very narrow frequency of re-evaluation—

Dr. Paul Roumeliotis: Yes, especially for that situation.

Mrs. Liz Sandals: —where you've got the education progressing according to the conditions that have been laid out.

Dr. Paul Roumeliotis: Exactly.

Mrs. Liz Sandals: Okay. Thank you for clarifying that.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Sandals. Ms. Jones.

Ms. Sylvia Jones: Just a point of clarification: Did you mention at the beginning of your presentation that you were not consulted on the need for the amendments?

Dr. Paul Roumeliotis: No, we were not.

Ms. Sylvia Jones: Knowing that, are you not also concerned about being consulted on the regulations? Because my issue—

Dr. Paul Roumeliotis: Yes, we made that point a number of times. We had four months of deliberations trying to make that point specifically.

Ms. Sylvia Jones: Quite frankly, that is my whole problem with regulations. We don't even get this public consultation when we have regulations pass. There is no discussion, no obligation on behalf of the cabinet to discuss regulation changes or additions before they move forward.

Dr. Paul Roumeliotis: All I know is that I was told, as chair of the medical officer of health, that the report would come out the next day, and that was the extent of the consultation.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Jones, and thanks to you, Dr. Roumeliotis and Ms. Stewart, for your deputation on behalf of the Association of Local Public Health Agencies.

REGISTERED NURSES' ASSOCIATION OF ONTARIO

The Chair (Mr. Shafiq Qaadri): I now invite Ms. Doris Grinspun, executive director of the RNAO and not a stranger to that desk. Welcome, and I invite you to please begin now.

Ms. Doris Grinspun: Thank you very much. I'm accompanied today by Sara Clemens from our policy department.

RNAO is the professional organization, as some of you may know, for registered nurses who practise in all roles and sectors across Ontario. We appreciate the opportunity to address the Standing Committee on Social Policy on Bill 141.

Nurses are in a unique position to provide feedback on a pandemic response. We are the health professionals who deal directly with members of the public during a pandemic and help coordinate and provide care. Safeguarding the public by preventing the rapid spread of virulent sickness and disease is, without question, a high priority.

At the outset, we want to extend, on behalf of RNAO, our warmest congratulations to the chief medical officer of health, Dr. Arlene King, on her courageous and expert leadership. It served to galvanize the collaboration of health care providers across this province towards a common goal: overcoming H1N1, a new virus that had the potential to be deadly.

RNAO also wishes to salute the thousands of health care professionals, among them nurses—including those who work in public health—who painstakingly developed and revised their pandemic plans and implemented their roles with the utmost professionalism and care. Also—yes, why not?—a colleague, Allison Stuart, who is here and who actually led a lot of on-the-ground communications with her team.

RNAO supports Bill 141 in general. We have several amendments that, if adopted, will strengthen Ontario's emergency public health response and address serious omissions in the legislation.

The province's goal is to improve the response for the next public health emergency by implementing supportive legislation. Our goal is the same. However, the bill addresses only three areas of concern, while many solid recommendations made in various ministry reports and at meetings of the Ontario health plan for an influenza pandemic have not been adopted in this bill: a lost opportunity, at least at this point, in our view.

It is true that Ontario's response to public health emergencies today, including H1N1, is much more robust than what we experienced during SARS, especially in terms of communication, coordination and in seeking the advice of nurses. For someone like me, who lived through both events in the same role and position, the difference in response is like night and day. And yet, we cannot stop at the halfway mark.

The legislation, as it stands, neglects the need for additional surge capacity and fails to clarify the roles and responsibilities for LHINs and primary care providers under the direction of the chief medical officer of health. An integrated system response, which we urgently need, is still eluding us. In light of these gaps, RNAO offers several recommendations, which are detailed in our submission. I'll speak to four of them.

First, RNAO is pleased to endorse the provisions in Bill 141 that would strengthen local leadership within each public health unit, including those that would standardize the qualifications of each medical officer of health. With nine out of 36 public health units currently operating with an acting MOH, it is hoped that this legislation process will result in more consistent, qualified and knowledgeable officers.

A new provincial requirement to have a chief nursing officer in every public health unit by 2013, a progressive step that the RNAO very strongly supports, further

strengthens the growing leadership capacity in public health at the local community level.

Nursing leadership is absolutely essential during a pandemic response, yet this role is not mentioned in this bill. Chief nursing officers are necessary to ensure clear lines of communication within public health units.

While the chain of command for chief medical officers of health will be extended by this bill, there is an assumption that the chief medical officers of health and the medical officer of health understand the full professional competencies and responsibilities of nurses, and public health nurses in particular. Unfortunately, this assumption is not always the case.

Considering that nurses and public health nurses make up half of the human resources in public health, the chief nursing officer role is a strong and welcome step in the right direction. With this new-found capacity, medical officers of health and the chief medical officer of health should plan to use the CNOs to inform planning, strengthen emergency response and facilitate process and outcome evaluations. Integrating chief nursing officers will not cost the government anything and will lead to much better outcomes.

1640

A chief nursing officer will also be able to clarify for nurses and other professions how nurses may or may not practise within the set scope as set by the College of Nurses of Ontario. This type of clarity is critical in pandemics such as H1N1, when nurses are redeployed out of their usual practice setting. For these reasons, the RNAO urges that the chief nursing officer role be fully integrated in Bill 141.

Our second recommendation relates to planning for the worst-case scenario. It would be nice to think that the world's next pandemic may be similar to H1N1, yet we all know a much more deadly attack looms on the horizon. The question is, are we ready for the worst-case scenario? More powerful directives and better qualifications are not all that is required for coordinating system response. As the chief medical officer of health noted in her report: "The caution is this: Had the pandemic been of a significantly more severe nature, we might not have been as ready. Our acute care system managed, but had many more people swarmed our emergency rooms for much longer, that might very well have tipped the system. In addition, had there been many more deaths early on, the demand for health care services might have overwhelmed an already taxed delivery system."

In developing legislation such as Bill 141 and policies to prepare for the worst-case scenario, the following questions must be asked: How can we strengthen this bill so we can protect the public even if our prevention strategies fail? How will our emergency departments accommodate treatment for thousands more when they're already operating beyond capacity? How will ambulances respond when they are already waiting at hospitals to offload? What surge capacity can you count on when RN positions specifically are being cut and expert nurses are being offered early retirement packages through hospital restructuring processes?

If we address system shortfalls with better surge capacity and stronger coordination of services, we will be able to manage the next emergency. Otherwise, the question mark will remain.

Thus, RNAO recommends the following:

—that the Ontario government build, monitor and strengthen the surge capacity of registered nurses, and public health nurses in particular, by meeting its commitment to increase the nursing workforce by 9,000 additional positions by 2011. Ontario has already added 5,579 nurses during the first two years of the McGuinty government's current mandate. Thus, we are well on our way to achieving the targeted 9,000. We now need to hire 3,421 nurses to meet this target. Given that the Ontario RN-per-population ratio, as compared to the national average, is worrisomely low, requiring in fact 14,000 more RNs in Ontario to catch up to the national average, it is crucial that the remaining more or less 3,500 positions be full-time RNs, specifically registered nurses;

—that the government establish a subcommittee of the Ontario health plan for an influenza pandemic that consists of registered nurses, including public health nurses, ER physicians and ambulance personnel.

The third recommendation we want to address relates to the need for better coordination of LHINs, public health and primary care. All available resources must be mobilized when planning and creating a coordinated system of emergency response. Any local health integration network that is not mandated to include public health services compromises public safety by not being able to respond as effectively to a pandemic threat. It's time that the LHINs were made a formal part of the system by mandating their role and clarifying the direction they receive from the chief medical officer of health, to ensure the most coordinated response when called on.

With the establishment of nurse-practitioner-led clinics across the province—26 are expected to be up and running by September of this year—and the substantial increase in the number of practising primary health care nurse practitioners, RNAO believes that accurate reporting should include nurse practitioners as key primary care providers.

The RNAO recommends the following: create an integrative role and function for LHINs, public health units and primary care providers in their planning, response and evaluation of public health emergencies, while clarifying the chief medical officer of health's chain of command to each; and, include nurse practitioners and NP-led clinics and community health centres within a more integrated, consistent and planned system response to public health emergencies.

Finally, it is crucial that pandemic plans not forget those who are most vulnerable and have difficulty accessing pandemic services. Planning must include drop-ins, shelter-based health services and street outreach services, not just mainstream services such as hospitals and other residential settings. Methods must be found to reliably conduct surveillance and health promotion among vulnerable populations, including the homeless and those who live in shelters.

RNAO has appreciated being involved as a partner in pandemic planning and in the review of the H1N1 response from the outset. That did not happen during SARS; it's happening now.

We offer these recommendations to improve future pandemic responses. Thank you very much for the opportunity to share this with you—

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Grinspun. You have about 30 seconds or so, Ms. Sandals.

Mrs. Liz Sandals: Thank you very much for appearing. You've got a whole array of fascinating suggestions here.

Really quickly, can you talk a little bit more about how you see this knotty problem of primary health care and hospitals, LHINs and public health all being linked together from a primary planning perspective?

Ms. Doris Grinspun: First of all, some of us have never fully understood why public health and primary care, with the exception of community health centres, are actually not part of the LHINs. So that's a question in itself that I think is required to outweigh the pros and cons of that. But at the very least, there needs to be ways of coordination—

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Sandals. Ms. Jones.

Ms. Sylvia Jones: With 30 seconds, I will thank you for your presentation.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Jones. Madame Gélinas.

M^me^ France Gélinas: Does that mean I get her 30?

Thank you very much for your presentation, and I will read your complete report.

The bill really focuses on giving the chief medical officer of health more power. I'd like to have your opinion, in your position, as to: Do you think there are other means to the same end? The law right now will give the chief medical officer of health more power so that we can improve coordination in the hope of improving the quality of public health. Do you figure there are other means?

Ms. Doris Grinspun: We don't believe it's one or the other. We believe that a strengthened role for the chief medical officer of health, the local MOHs and the chief nursing officer, which is a role that by 2013 will be in all units, needs absolutely to play a key role—

The Chair (Mr. Shafiq Qaadri): Thank you, Madame Gélinas, and thanks to you, Ms. Grinspun and Ms. Clemens, for your deputation on behalf of the RNAO.

If there's no further business before the committee, I just remind committee members that amendments will be filed by the deadline, 12 noon, Thursday, March 24, and we will be reconvening here on Monday, March 28, for clause-by-clause consideration.

Is there any further business before the committee? Seeing none, committee is adjourned.

The committee adjourned at 1649.

CONTENTS

Tuesday 22 March 2011

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