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Standing Committee on Social Policy

Comité permanent de la politique sociale

Lung Health Act, 2016

Loi de 2016 sur la santé pulmonaire

Chair: Peter Tabuns
Clerk: Katch Koch

Président : Peter Tabuns
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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Monday 6 June 2016

Lundi 6 juin 2016

The committee met at 1400 in room 151.

LUNG HEALTH ACT, 2016
LOI DE 2016 SUR LA SANTÉ PULMONAIRE

Consideration of the following bill:

Bill 41, An Act to establish the Lung Health Advisory Council and develop a provincial action plan respecting lung disease / Projet de loi 41, Loi créant le Conseil consultatif de la maladie pulmonaire et visant l'élaboration d'un plan d'action provincial à l'égard des maladies pulmonaires.

The Chair (Mr. Peter Tabuns): Good afternoon, committee members. I'm calling this meeting to order to consider Bill 41, An Act to establish the Lung Health Advisory Council and develop a provincial action plan respecting lung disease.

Pursuant to the order of the House dated Wednesday, June 1, 2016, each witness will receive up to 10 minutes for their presentation, followed by nine minutes of questioning from the committee or three minutes from each caucus. I ask committee members to ensure that the questions are relevant to Bill 41 and to keep them brief in order to allow maximum time for the witnesses to respond.

Any questions before we start? Okay, here we go.

ONTARIO LUNG ASSOCIATION

The Chair (Mr. Peter Tabuns): The first witness: Ontario Lung Association, Mr. George Habib. Mr. Habib, if you'll have a seat. If you would identify yourself for Hansard so they get it on transcript. Please proceed.

Mr. George Habib: My name is George Habib. I'm the president and CEO for the Ontario Lung Association. I'm joined by my colleague Andrea Stevens Lavigne, our vice-president of provincial programs. It's a pleasure, I can tell you, to be here today to lend our full support to Bill 41, the Lung Health Act.

We're here today not only representing the Ontario Lung Association and members of our Ontario Lung Health Alliance, but also the more than 2.4 million Ontarians who struggle to breathe every day who live with lung disease. To that point, it's not just the 2.4 million that have been diagnosed with lung disease, but as all of you do and I know I do, we enjoy breathing, so we're also representing all of those who enjoy breathing. Indeed, Ontarians all fully deserve to breathe freely and easily.

It's been a long journey, including two years of working with lung health experts, economists, patients and other stakeholders, to develop a report called Your Lungs, Your Life, which we released five years ago. Since then, we have consulted broadly, engaged with government and other stakeholders and had the pleasure of meeting some incredible, incredible lung health champions, including MPP McGarry, who's here today, who brought this important piece of legislation forward shortly after coming into office.

When the bill passed second reading in November 2014, it was an incredibly emotional time, I know, on the floor of the Legislature. It was demonstrated so beautifully when PC MPP Lisa Thompson actually crossed the floor and hugged MPP McGarry. I remember it well.

Also, those who spoke to the bill at that time: I remember Wayne Gates talking about his experience with family members with lung cancer; and Lisa Thompson, who I mentioned previously, talking about her dad, who passed away with COPD. Of course, Kathryn's motivation was children with asthma. All of us, in some way, shape or form, are affected.

We also met a very brave young lady—13 years old—Kayla Baker, who supported our efforts while waiting for a lung transplant. Although she's no longer with us, unfortunately, her mother continues to be a tremendous champion for lung research.

We also met another amazing mother, someone who lost her child to an asthma attack at school, which you all know led to another significant piece of legislation called Ryan's Law.

Of course, lung disease affects people of all ages, and we have been deeply impressed by the passion and commitment of people like Bev Black, who's here with us today, and you'll hear from her; and two of our COPD ambassadors, Brenda and Bruce, who MPP Gélinas knows very well—they're constituents of Nickel Belt—and who literally toured the province on a motorcycle to increase awareness for COPD.

Throughout our journey, I've been struck with how often people were unaware of the high prevalence of lung disease or the growing burden on our health care system. In fact, many were shocked at the numbers and surprised that the third leading cause of death in this province does not have a dedicated plan, like cancer or diabetes.

Back in 2011, there were 1.6 million people with asthma and 780,000 people with COPD in Ontario. In a few short years, we now have more than two million people with asthma and almost 900,000 people with COPD. Sadly, many of those people are our province's most vulnerable populations.

There are also another 30,000-plus who suffer from lung cancer. Despite medical advances, it's still one of the most deadly cancers, killing more than breast, prostate and colon cancer combined.

Countless others have other lung conditions, such as sleep apnea, pulmonary hypertension, tuberculosis—we're not done with TB—cystic fibrosis and others. For more than 100 years, the lung association has championed their cause.

The beauty of the Lung Health Act and a comprehensive lung health action plan is that it can serve all of those people, as well as the millions more who need protection from risk factors such as poor air quality, radon and second-hand smoke. While we've collectively made significant progress on tobacco, most people don't realize that radon is the second leading cause of lung cancer, and many of those who have it never smoked a day in their lives.

We also know that health care costs have continued to rise. Lung disease is accountable for a high proportion of hospitalizations, readmissions, emergency department visits, home care services and long-term-care services. In 2011 alone, we estimated direct and indirect costs at $4 billion, and projections show that this number will rise to more than $300 billion if it's status quo, if we just continue to do what we're doing now, in the next 30 years.

While we recognize that the Ontario government has taken a leadership role with some of the key prevention initiatives, like ending coal burning in Ontario and renewing the Smoke-Free Ontario Strategy, there's still much work to be done for the more than 2.4 million Ontarians who struggle to breathe.

The good news is that Ontario has some of the best researchers and best clinicians in the world. We didn't want our report to be just another burden report, so we intentionally provided solutions—proven interventions that already existed in specific areas of the province, that could easily be replicated and result in both cost savings and improved lung health.

Bill 41 and the creation of a lung health advisory council and an Ontario lung health action plan will help to ensure that lung health gets the attention it deserves.

I'd like to turn it over to my colleague Andrea Stevens Lavigne at this point.

Ms. Andrea Stevens Lavigne: Good afternoon. Thank you again for hearing us today.

As George mentioned, the Ontario lung health action plan will serve a great benefit to all Ontarians, and the good news is that we don't have to start from scratch. In your package, you'll see that we have in fact drafted a plan already with a number of stakeholders, including the more than 40 members of the Ontario Lung Health Alliance. There's also a letter in there that was sent to Premier Wynne a year ago, which was signed by 20 different organizations, some of them very significant players in the system, like the OMA and the Ontario College of Family Physicians. Others are smaller organizations, like the Pulmonary Hypertension Association and COPD Canada. All of these organizations working together are the ones that can make this plan become a reality.

We also consulted broadly, as George said, with many different stakeholders. We spoke to people at the Registered Nurses' Association of Ontario, which has been a member of our alliance since the inception. They are happy to support this legislation, with the inclusion of nurses—a registered nurse and a nurse practitioner—being part of the lung health council. We're happy to support this inclusion, given the vital role that nurses play in lung health, along with a wide variety of other health care providers: physicians, respiratory therapists, physiotherapists, pharmacists and others.

The draft plan includes a number of evidence-based interventions that were highlighted in the report that George referred to earlier. We released Your Lungs, Your Life five years ago. There were four specific interventions mentioned in that report, and I likely won't have time to go through all of them, so let me just highlight a couple of things.

First was a very successful primary care model. It's based on the Primary Care Asthma Program, which, in fact, was funded and supported by the Ministry of Health and has been in existence for more than 10 years. They supported a pilot project many years ago that demonstrated significant changes in health care delivery; for example, reductions to emergency room hospitalizations. All of these have incredible cost savings.

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We took that model and we put it through an economic model. We were able to demonstrate that by investing $200 per patient, we could actually save $1,000 in health care costs. That was related to a model of an interdisciplinary team that includes certified respiratory educators, who can be a member of any health care profession and who are specially trained. We can speak further about what role they actually play and what they do, but the beauty of this is that these types of health care professionals can be integrated within an existing infrastructure, so we don't have to add new infrastructure to the system. They can be part of hospital-based clinics, community-based clinics, family health teams or CHCs, or be associated with group medicine, family medicine or NP practices.

Another example is pulmonary rehabilitation. This is one of the top recommendations in Health Quality Ontario's own report on quality-based procedures for COPD. There is extensive research to support pulmonary rehab as the most effective treatment for COPD, and yet less than 2% of Ontarians currently have access to these vital services.

Again, we looked at the costing on this, and we could show that if every person who had moderate or severe

COPD had access to pulmonary rehab, the number of COPD-related visits to emergency rooms would be reduced by 24%, hospital admissions by 22% and length of stay by 50%.

The Chair (Mr. Peter Tabuns): I'm sorry. With that, you've come to the end of your time.

Ms. Andrea Stevens Lavigne: Okay.

The Chair (Mr. Peter Tabuns): We go first to the opposition. Ms. Martow?

Mrs. Gila Martow: Hi. Thank you so much for coming in. I think we're all in agreement that we need to have a plan in place for how we deal with all of these different issues. It's not enough to have one bill to address asthma, another bill to address lung cancer and so on and so forth.

My question to you is, do you feel that we have—if maybe you had a couple of points, actually, Andrea, that you wanted to finish, go ahead. But my main question that I wanted to ask is, do you feel that we have enough respirology medical specialists, technicians, nursing teams and equipment in our hospitals? Because it's one thing to have a plan in place, but if we're not training those residents, specialized technicians and nurses, it's very hard to have the best plan possible.

Ms. Andrea Stevens Lavigne: Thank you for that. I would say that, in fact, that relates to what I was talking about: an interdisciplinary care model. While we do have specialists in the province, and we also clearly have primary care practitioners, lung health is dealt with right across the full continuum. I do believe that by providing additional training and resources to the system, we can in fact increase that capacity.

There are definitely people in this province who are champions. Again, I think I'd like to emphasize that the Ontario Lung Association, as well as all of our partners, are very willing to work with government on this, and we do have specialists, some of whom you'll hear from today, who have been part of this. We've done projects that have linked specialty care to primary care. We have many evidence-based interventions that we can use as part of a broader lung health action plan.

Mr. George Habib: I do want to comment about one area, to your question as well—to add the research component. Sadly, lung health research is really underfunded; it got about 2% of CIHR funds. Given the prevalence of the disease and everything else, what we're seeing is that we're losing our best minds around research. We're not inspiring the young researchers coming through the system, because there aren't the dollars to do the appropriate research against the issues of lung health. I think that is one weakness that we do need to address.

Mrs. Gila Martow: Okay. Does my colleague have any questions? No.

I have a minute left?

The Chair (Mr. Peter Tabuns): You have 45 seconds.

Mrs. Gila Martow: I'll just say that my very dear uncle Gerry is in the hospital right now at St. Mike's, getting fantastic care. He's 92, but he's got chronic lung infections. What he was telling me is that he is in a ward with cystic fibrosis patients who are not half his age but a quarter of his age, and dying every day. I said to him that we were going to be discussing this today, and he said to remind everybody about these poor people with cystic fibrosis who are being told, "You have days to live."

The Chair (Mr. Peter Tabuns): Thank you, Ms. Martow. To the third party: Ms. Gélinas?

M^me^ France Gélinas: It's a pleasure to see you, and always nice to talk to you. I think you painted the situation as is pretty clearly. I would ask you, can you dream the future for us? If we do move forward and put a good lung health advisory council in place and they work on this work plan, what will change? What will it look like in two years, in five years, in 10 years?

Mr. George Habib: Well, let me start, and I'm going to ask Andrea to jump in.

We've seen what can be, because there are best-practice areas. The problem is that we're doing it in pockets, in individual situations and so on; we're not looking at it comprehensively. We've seen best practices of what can happen, including a public-private sector initiative along with the lung association called the Value Demonstrating Initiative currently in three LHIN areas. So we are seeing some best practices.

Ideally, what we'd love to see is those living with COPD get, first of all, proper diagnosis; we'd love to see spirometry introduced as a standard for those at risk over the age of 40. Then, with the proper diagnosis, I think the treatment can begin, which can include the appropriate pulmonary rehabilitation to get people back to work, to get those living with COPD and other diseases back to caring for their grandchildren and so on—getting treatment that they can handle, including exercise rehabilitation, and getting them productive again to whatever they want to do and contributing to the Ontario economy in some way, shape or form. That's most ideal.

Secondly, we'd love to see costs related to lung disease decrease, especially use of emergency rooms for care, and take those dollars and redeploy them into other areas of the budget, without increasing the budget, to where they are needed. That's what the model really represents. We'd love to be able to see that.

Bev Black will talk about her journey in a little while and you'll hear more about what she has been able to do as well.

Ms. Andrea Stevens Lavigne: The only other thing I would add is that the goal and the vision of a lung health action plan is, in fact, to address the full continuum. We've already referenced that, unfortunately—well, I guess fortunately—lungs are important to every single one of us because we breathe, but also, lung disease itself can affect babies right up to end of life.

By having a coordinated plan, we can look at the prevention issues for those of us who don't have problems yet and hopefully prevent those from occurring. As George said, with proper early identification and spirometry and other diagnosis, we can have that happen, which in fact would lead to more appropriate diagnosis

and more appropriate treatment. Then, of course, our policy and partnerships and the research that's required, etc., so you have the full continuum for all Ontarians.

The Chair (Mr. Peter Tabuns): I'm sorry to say that, with that, you're out of time with this caucus. We go to the government. Ms. McGarry.

Mrs. Kathryn McGarry: It's an incredible pleasure to have you here today. It's almost two years, I think, since we met at the Kayla Baker Run in Cambridge while I was actually running for election. I was so fully into committing to seeing most of our legislation passing through Ontario through a lung health lens, and it's because of my personal story.

We've talked about my son Rory, who was born with issues and, because of chronic issues happening in his lungs, is now a 36-year-old living with COPD. I remember the time when he spent four years in hospital in the early 1990s. At that point, there was smoking in the hospitals, there was smoking in the restaurants, there was smoking outside, and on the days we had a day pass, we couldn't take him anywhere. So I know that cleaning up our air and making sure that we have prevention in place is just ultimately important.

This is a very important time for me, to see some of the public consultation when it comes to looking at lung health. Because I was a critical care nurse, lung health issues were really my specialty, both from pediatrics, when I spent 10 years at Sick Kids, and through to my conclusion at CCAC as well as the intensive care unit. So I very much recognize lung issues as being a very expensive thing to have to deal with, not only for hospitals and our health care system, but for our families.

If you wouldn't mind just elaborating on why it's important to deal with both the direct costs, such as hospitalization and medication, as well as the indirect costs, meaning mental health issues, depression and those things that families deal with, I would appreciate it.

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Ms. Andrea Stevens Lavigne: Sure, and thank you very much again, MPP McGarry.

As you mentioned, there is such a wide range of lung conditions out there. When we did our report, we only focused on the top three: asthma, COPD and lung cancer. But there is also sleep apnea, cystic fibrosis, bronchiectasis, pulmonary fibrosis—there are many, many of those diseases there.

When we did our costing, again, we were only focusing on the three that we had in our report, and we were able to identify both direct and indirect costs. Most of the indirect costs were in fact related to wage productivity. As you mentioned, you have, unfortunately, people who are dealing with a lung issue themselves, but it also may mean that their parent or their adult child is also having to miss time from work. So the indirect costs were directly related to the wage issue.

In 2011, we were looking at somewhere around $4 billion, most of which was related to COPD, as we mentioned earlier. We did the projections and, in 30 years, we were now over $300 billion. So in terms of your question, that was the most important reason why we need to look at this in a coordinated fashion.

The Chair (Mr. Peter Tabuns): And I'm sorry to say again, with that, we're out of time.

Mr. George Habib: Thank you very much for your time.

The Chair (Mr. Peter Tabuns): Thank you very much. We appreciate it.

Ms. Andrea Stevens Lavigne: Thank you.

MS. BEV BLACK

MS. CAROLE MADELEY

The Chair (Mr. Peter Tabuns): Next, I have Bev Black. Ms. Black? Welcome. If you'd introduce yourself for Hansard, and then we can go from there.

Ms. Bev Black: I'm Bev Black. I'm known as Lois Beverley Black, but I do go by Bev, so that's why the difference in the name tag. I'm going to be sharing my time with Carole Madeley today from the lung association.

I'd like to say hello to the Chair, the Vice-Chair, committee members and the Clerk.

I am the voice of 2.4 million people who suffer lung health issues. I am 74 years old. I'm a widow. I'm still living in my own home. On January 6, 2009, I woke up and I had great difficulty breathing. I couldn't get a breath. I called 911. I ended up in the hospital for almost two months. I was in ICU twice, on life support twice. They told my daughter, "We should just pull the plug. We're concerned about her quality of life." Thank goodness, I had a voice. It's now seven years later.

I am the lung health ambassador for St. Catharines, and this gives me a sense of purpose. I was blessed to have been part of the rehab program at St. Catharines General. It's an outpatient program where they teach you about diet, sleep, exercise, thoughts, your mental health, and that was great. But once I got out of that exercise program, there was nowhere to go to exercise. It was kind of intimidating to have to go a Y and have these studmuffins running flat out on a treadmill beside me, and I'm huffing and puffing and trying to chug along. So I went to a gym, approached the owner, and Zoom-airs was born. We got up to about 27 members going flat-out. It was amazing. None of us were going back to the hospital. We were doing so well. Confidence-building—we cheered each other on.

The gym sold, so I then was able to go to a rehab program at the Firestone Institute. I was a little apprehensive, because it's an in-patient rehab program. But it was amazing. I did know a lot, but there was a Dr. Joe, as we called him, a psychologist. He got into our heads. I've never been one to put myself first. When I sit, I can actually have my oxygen off, but I'm a little nervous; I'm leaving it on low. Because I'm a retainer, my body doesn't get rid of the carbon dioxide. Dr. Joe said, "You know, it's okay to tell people. You may look healthy but you're not. If you don't feel well enough to do some-

thing, you don't." It was just things like that that we are taught.

Once the rehab program was finished, all of a sudden—now, the lung association has maintenance programs, because it's very important to maintain. My lung capacity is 19%, so I'm what they call end stage. It sounds worse than it is. I am not in stage dying. I am a high risk. We have a Fitness for Breath program now at the YMCA in St. Catharines. I'm proud to say that we're up to about 14 members. It's just growing, and it's to maintain our health, the exercise. We have our support group meetings once a month. It is run by a lady from the hospital of St. Catharines, and we have speakers. We continue to talk about our life and our abilities and, here I am, seven-plus years later, playing with my grandchildren and still living alone in my own home.

It's important that this bill be considered and passed. The number of my friends in St. Catharines who have avoided ER visits because we are maintaining, because we are dieting right and because we are doing what we have to do—that's it.

The Chair (Mr. Peter Tabuns): Thank you.

Ms. Carole Madeley: Thank you for providing me the time to share this time with Bev. My name—

The Chair (Mr. Peter Tabuns): Sorry—oh, if you were going to introduce yourself, please go ahead.

Ms. Carole Madeley: Yes. My name is Carole Madeley and I'm a registered respiratory therapist and certified respiratory educator and I work for the Ontario Lung Association. I have first-hand experience in seeing the benefits of pulmonary rehabilitation as, in my past experience, I worked for Lakeridge Health in the pulmonary rehabilitation program for nine years and I saw the benefits of pulmonary rehabilitation: Patients learned to self-manage and improve their quality of life.

These programs have also proven to decrease hospitalization visits, emergency department visits and readmission rates. As Andrea and George told you earlier, we have almost 900,000 people in Ontario suffering with COPD and yet we have less than 2% capacity for pulmonary rehabilitation.

Like Bev, I also understand the importance of maintenance exercise to continue the gains of rehab that have occurred in these programs in the hospitals. In the last couple of years, I have worked with developing community-based maintenance exercise programs across the province of Ontario. We now have 17 community-based programs and we call these programs Fitness for Breath, as Bev mentioned earlier. These programs are a post-pulmonary rehabilitation program available in the community closer to home for patients who have had the experience to go through pulmonary rehab.

I have to say, the biggest challenge with Fitness for Breath is, of course, the low access to pulmonary rehab in the first place; therefore you can't put a maintenance program as a partner everywhere because we're lacking pulmonary rehabilitation.

I'm here to answer questions today that you may have for both Bev and myself related to pulmonary rehabilitation, maintenance exercise programs and COPD. Thank you very much.

The Chair (Mr. Peter Tabuns): We'll start our questions with the third party. Ms. Gélinas.

M^me^ France Gélinas: It's a pleasure to see you again. You are just as good now as you were the first time you presented in my office. It's a pleasure to see you.

Without being dramatic, what would have happened, do you figure, if you did not have access to pulmonary rehab and if you did not have access to maintenance exercise?

Ms. Bev Black: I would definitely have regressed, because there was a time where I was hospitalized during that seven-year span. I went down quite a few pounds. My ability to move, whatever, it's so important. It helps build up your muscle mass where your muscles—they're not drawing all that extra oxygen. I don't have that much to begin with so whatever I can delegate my body to do—that's why that rehab is so important. It truly is.

I must say, my granddaughter was asked to do a thing—she's in grade 4—on body parts. She chose the lung and she talked, and that gives me a sense of purpose because now she's relaying nana's message to these young students: You don't smoke, you do this—blah, blah. It gives you a sense of purpose. I love doing what I do.

M^me^ France Gélinas: Carole, I was happy to hear you say that there are now 17 Fitness for Breath programs. I guess they're all linked to pulmonary rehab?

Ms. Carole Madeley: Yes, most of our Fitness for Breath programs are linked to pulmonary rehabilitation programs. We also have Fitness for Breath programs—for instance, there's one currently in Elliot Lake and the clients who would have accessed that program would have had to originally go to Sudbury, which is way too far away. Just in the last year the Elliot Lake Family Health Team developed a community-based pulmonary rehabilitation program so that the clients can now transition to the Elliot Lake Fitness for Breath program.

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M^me^ France Gélinas: I asked it previously, but I'll ask you the same question: If you were to look two years, five years down the road, how many pulmonary rehabs do you see and how many Fitness for Breaths do you see if we move on with this?

Ms. Carole Madeley: The current situation in Ontario is, we only have 43 pulmonary rehabilitation programs. With Bill 41, the Lung Health Act, we would be able to have access to pulmonary rehabilitation programs across the province. Therefore, they would be available in the communities, in every LHIN so that people with COPD could access these programs, and then, following their pulmonary rehabilitation program, they would have a partnered, community-based program in a fitness facility in their community.

M^me^ France Gélinas: Everywhere throughout Ontario?

Ms. Carole Madeley: Everywhere throughout Ontario, absolutely. We have almost 900,000 people living with COPD, and they live throughout Ontario.

The Chair (Mr. Peter Tabuns): With that, you're out of time.

We go to the government. Ms. McGarry.

Mrs. Kathryn McGarry: Thank you very much, Bev and Carole, for coming in today.

Bev, you're always such an up for all of us and an inspiration for other COPD sufferers to say, "I can do that too." Can you talk briefly about what it took to actually diagnose yourself with COPD?

Ms. Bev Black: I was a smoker. When I went in January—I haven't smoked since January. I needed those two bricks on my head to quit. I had cut down considerably, but I was still smoking. I was diagnosed with COPD probably just before I went in in 2009, but I have regressed because of the severity of it. That's why these programs—I'm able to maintain. I've been at 19% now for four and a half years, and I don't want to go any lower. I just can't afford to. I've got things to do. I've got two beautiful granddaughters I want to play with.

Mrs. Kathryn McGarry: Thank goodness.

Following up on that, Carole, I know that you were answering MPP Gélinas about how many pulmonary rehab programs we need in Ontario. Can you give us another brief outline as to how you would see that? Could one pulmonary rehab centre be partnered with more than the 17 Fitness for Breath programs that you've got?

Ms. Carole Madeley: As I mentioned, right now in Ontario there are 43 pulmonary rehabilitation programs, and that is only allowing access for 4,524 patients. If we have 900,000 patients and we have pulmonary rehabilitation programs available in several communities across the province for these patients to be able to participate in, then it would make perfect sense to partner with a community fitness facility.

As I've developed Fitness for Breath, it is a very cost-effective plan because it's sustainable. The Ontario Lung Association goes in and does the training for the fitness trainers so they learn about COPD and how to look after this population of patients, but the fitness centres themselves own the program. One of the longest models we have here in Ontario is at the Abilities Centre in Whitby. That program has been going strong for almost four years, seeing a group of about 20 for a clients' meeting twice a week. We modelled Fitness for Breath after the successful model we saw at the Abilities Centre.

Mrs. Kathryn McGarry: So in terms of cost, there would be no cost to government, or very little; it's more taken on by the partnership?

Ms. Carole Madeley: Absolutely. The partnership definitely is important with relation to maintenance exercise programs. The cost to the government would be pulmonary rehabilitation, implemented either in hospitals or in communities—

The Chair (Mr. Peter Tabuns): And with that, I'm sorry to say you're out of time.

We have to go to the opposition. Mr. Coe.

Mr. Lorne Coe: As the MPP for Whitby–Oshawa, I appreciate your references to the Abilities Centre.

Thank you both for being here.

Are there any aspects of the legislation that in your estimation could be strengthened beyond what you've read, and if so, what aspects would you like to see included?

Ms. Carole Madeley: When I look at the legislation, I think the importance of the certified respiratory educators—just like if you have diabetes, you see a certified diabetes educator, it's very important to see a certified respiratory educator when you're looking at trying to manage your lung disease, because you need somebody who understands the management of that lung disease and who can teach you to self-manage your lung disease so that you have the skills to go on, and then, of course, down the line, decrease your hospital visits and decrease your primary care visits.

I think the importance is definitely related to certified respiratory educators in our system. That can solve a lot of problems, just like it has helped with managing diabetes in Ontario.

Mr. Lorne Coe: Thank you very much for your answer.

Thank you, Chair. To my colleague, please.

The Chair (Mr. Peter Tabuns): Ms. Martow.

Mrs. Gila Martow: Where are these programs to train to be a certified respiratory educator? Are there enough programs evenly placed throughout the province?

Ms. Carole Madeley: To become a certified respiratory educator in Ontario, the Ontario Lung Association actually offers a program. There's one aspect called asthma TREC and one aspect called COPD TREC. You go on to do these two components, and then you go on to challenge a certification exam that's set out by the Canadian Network for Respiratory Care, and then you become a certified respiratory educator. And, again, you have to recertify every five years. It would be a very similar approach to becoming a certified diabetes educator, as they also have to recertify.

The programs are available through the Ontario Lung Association. We try to get at least 10 to 15 people together to run workshops. We can run workshops throughout the province in different locations.

Mrs. Gila Martow: So is it like St. John Ambulance? How long are these programs?

Ms. Carole Madeley: If you do the asthma TREC and COPD TREC combined, that is a six-day workshop. Then you would go on to write the certification exam.

Mrs. Gila Martow: Okay. That's fantastic. Thank you very much.

The Chair (Mr. Peter Tabuns): Thank you very much for your presentation today.

Ms. Carole Madeley: Thank you very much for your time.

Ms. Bev Black: Thank you.

ONTARIO CHRONIC DISEASE PREVENTION ALLIANCE

The Chair (Mr. Peter Tabuns): Our next presenter, then, is the Ontario Chronic Disease Prevention Alliance:

Sherry Zarins. Ms. Zarins, have a seat. If you'd introduce yourself for Hansard. You have 10 minutes.

Ms. Sherry Zarins: My name is Sherry Zarins, and I'm here in my role as chair of the Ontario Chronic Disease Prevention Alliance. I'm going to be sharing my time with Chris Yaccato.

Chair, Vice-Chair, committee members, and Clerk: Thank you so much for providing the time to give a deputation today on the matter of Bill 41, the Lung Health Act.

Before I get started, I wonder if you could all humour me for just a moment. Take a deep breath and let it out. For me, public speaking makes me very anxious, but I find that if I take a couple of deep breaths, it helps to calm me down a little bit. But I wonder what it's like for the 2.4 million people in Ontario who have difficulty breathing, when the very act of breathing is what's increasing their anxiety. What happens when they need to calm themselves down? For some of them, it's sporadic, like a child with asthma. For some, it's more continuous, like Bev, who depends on oxygen 24/7.

I want to tell you a little bit about the OCDPA, or the Ontario Chronic Disease Prevention Alliance. It's an alliance of 22 health non-governmental organizations committed to integrated action on chronic disease prevention in the province. The purpose is to facilitate partnerships and support collaborative planning, implementation and evaluation of activities that address health promotion and the prevention of chronic disease, all of which are perfectly aligned with the establishment of a lung health action plan.

While the OCDPA is concerned with the prevention of all chronic diseases, we are acutely aware of the high cost of lung disease and the high proportion of costly hospitalizations, re-admittance to hospital, emergency room visits and home care services that are associated with lung disease and, in particular, with chronic obstructive pulmonary disease. As such, we are fully in support of MPP McGarry's private member's public bill to establish the Lung Health Act. We see this as an excellent opportunity to build upon the many initiatives already in place, such as the elimination of coal-fired power plants, the strengthening of a smoke-free Ontario and, more recently, Ryan's Law, and bringing these initiatives all together under one umbrella to eliminate duplication and to provide a coordinated and system-wide approach to lung health. The Lung Health Act would also bring together partners from across the wide continuum of prevention and health promotion.

A couple of examples of OCDPA member activities include:

—Ophea, with their connections throughout the school system and their work on programs for asthma-friendly schools;

—the Ontario Kinesiology Association is increasingly involved in incorporating smoking cessation with physical activity; and

—CAMH, with their extensive work in mental health, addiction and smoking cessation.

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All of these issues are very important to the lung health of Ontarians.

The lung health action plan would also aim to work across ministries, not just with the Ministry of Health and Long-Term Care, but also with the Ministry of the Environment regarding air quality issues, the Ministry of Municipal Affairs and Housing regarding radon and residential testing, and the Ministry of Education regarding asthma-friendly schools.

The plan would also consider the social determinants of health and work to reduce health inequities such as the high rate of lung disease in First Nations and the high rate of smoking with people with mental health issues.

More than half of Ontarians already have one or more chronic diseases. Of the four major chronic diseases—cancers, heart disease, diabetes and lung disease—lung disease is the only one without a coordinated provincial plan that can significantly reduce both the current and future health and economic burdens on Ontario.

The OCDPA was involved a number of years ago when the Lung Association, in partnership with more than 65 stakeholders, developed recommendations for a draft lung health action plan. These recommendations align very well with the Minister of Health's priority of increasing access to care for those who need it most through the Patients First: Action Plan for Health Care.

The proposed legislation will also establish a lung health advisory council for the purpose of considering matters related to lung health and making recommendations to the government of Ontario and the Minister of Health and Long-Term Care. The minister would then be responsible for developing and implementing an Ontario lung health action plan. Important would be the four pillars: health promotion and disease prevention; disease detection and management; policy partnership and community system support; and research, surveillance and knowledge translation.

In the end, the Ontario Chronic Disease Prevention Alliance believes that prevention of costly chronic disease is possible and that, in achieving greater degrees of prevention, Ontarians can live longer with improved quality of life and the provincial government can reduce its health spending.

We believe the Lung Health Act can and will contribute to our vision of making Ontario the healthiest province in Canada. Thank you.

The Chair (Mr. Peter Tabuns): Thank you.

Mr. Christopher Yaccato: Thank you, Chair, Vice-Chair, members and Clerk. I'm not sure how much time I have, but I'll just—

The Chair (Mr. Peter Tabuns): You've got about four and a half minutes.

Mr. Christopher Yaccato: Perfect.

Today you have heard and will hear from many experts on lung health, a diverse group of health care advocates and patients, after which I have no doubt you'll know truly why we need Bill 41, Lung Health Act, to pass.

I, though, would like to focus my words towards yourselves, your colleagues and staff, Minister Hoskins, Deputy Minister Bob Bell, the Ministry of Health and Long-Term Care, Minister Damerla, the Premier and leaders of the opposition; House Leaders Naqvi, Wilson—I appreciate the wonderful letter of support—and Gilles Bisson; countless staff who we have met with over the years: Drew Davidson, Derrick Araneda, Jackie Choquette, Tatum Wilson, Bill Killorn, and the list goes on; our lung health caucus members, MPPs Gélinas and Yurek, and I thank you especially for being such strong supporters and so vocal; and those who spoke to the bill during second reading. It was certainly an emotional day as each and every member who spoke had been affected by lung disease, be it themselves or a family member. I remember MPP Lisa Thompson walking across the floor and giving MPP McGarry a hug; I don't think that has ever happened in this place. Also, Leo Lehman, MPP McGarry's ever-so-diligent and fantastic executive assistant; and, last but not least, MPP McGarry: You made a commitment to us in 2014 when we met at Kayla's run. I say thank you for bringing this bill forward, showing leadership and helping to advance the protection of those who struggle to breathe. Because of your actions we are on path to help all Ontarians better breathe with ease.

To MPP McGarry's constituents and the constituents of all these wonderful elected members who have stood up and spoken on the need for an Ontario lung health action plan, it's a reminder of why we elect officials who say what they will do and do what they say.

Although this bill is not scheduled to become law today, make no mistake: We are well on our way to making your lung health a priority.

As this bill is primarily health-focused, MPP McGarry and Minister Hoskins, you and your staff have been honest in your discussions with us, and I know we will be able to establish an Ontario lung action plan. Its name doesn't matter, but its mandate, content, focus and leadership do.

We understand that this bill may go through changes and revisions; changes should be addressed sooner—today, in my humble opinion. But I say that we are hopeful and willing to work with you and your office to refine the content and come back in September, when the House resumes, to finalize its mandate, which fits very well with government's Patients First focus and can help lower wait times, save health care dollars and keep patients at home and out of hospitals.

I close now and remind each and every one of you how grateful we are for all you are doing to help all Ontarians better breathe with ease, because when you can't breathe, nothing else matters.

The Chair (Mr. Peter Tabuns): Thank you. We go first to the government. Ms. McGarry.

Mrs. Kathryn McGarry: Thank you very much for the shout-out, Chris, but we're here as a team. Certainly, I appreciate the fact that it's not just my own bill. I've had such great support from the co-chairs of the lung health caucus, MPPs Gélinas and Yurek. I very much appreciate their support and, certainly, the recognition that it is very important that we do something for the future, and I think that now is the time. This bill does align very nicely with the transformational changes Patients First is undergoing, the new way we're going to do health care in the future. Thank you very much for that.

Sherry, may I just ask a little bit further about your ideas on prevention strategies across the province of Ontario—I know that you and I have had lots of conversations. How can this kind of strategy be partnered with other strategies, such as the diabetes, heart and stroke, and cancer strategies that we've already got? How can this help partner with and yet focus on lung health issues?

Ms. Sherry Zarins: I think it's important to first establish our plan for lung health. I think we can probably examine the other already existing strategies and pick and take things that are working, and maybe things that didn't work, and put that together and let it influence our plan.

The development of a lung health action plan provides not only the opportunity to coordinate existing initiatives that we have—for example, with smoke-free Ontario and Ryan's Law—but one of the pillars we have in our draft plan relates to policy and partnerships. Ryan's Law is an example of very significant legislation and very important legislation. However, more work can be done on coordinating the implementation, to ensure that the legislation is being adhered to throughout the province. By having an overall plan and a structure, there will be a way to monitor that and support the policy implementation.

Mrs. Kathryn McGarry: In talking about the framework to assist that, that would help to develop some of the partnerships throughout, I use the example of MTO road safety: We have all kinds of campaigns from our road safety partners, from MADD Canada to Arrive Alive Drive Sober. Certainly, the government appreciates having a lot of partners, many of whom are in the room today.

Can you speak to how that framework could help develop those partnerships?

Ms. Sherry Zarins: I think we had a really good start with our national lung health framework, which was put together a number of years ago and on which our draft lung health action plan is based. One of the pillars of that is—

The Chair (Mr. Peter Tabuns): I'm sorry, Ms. Zarins, but you're out of time with this caucus. I have to go to the opposition: Mr. Coe.

Mr. Lorne Coe: Thank you, Chair, and through you, to the delegation: Welcome, Chris and Sherry.

Mr. Christopher Yaccato: Nice to see you.

Mr. Lorne Coe: The bill, when you read it, requires the minister to increase awareness of lung-related diseases, which is a good thing. Yet the minister is not required to report on his or her efforts. A third party, the Ontario Health Quality Council, would be doing that. Do you see that as sufficient?

Ms. Sherry Zarins: I think it's definitely a step in the right direction.

Mr. Lorne Coe: Okay.

Mr. Christopher Yaccato: I think that would probably be a part that needs to be exactly refined: How do you report, what do you report and how do you follow through on its results? That would be one that we would have to look at and refine and go a step further, in my opinion. I think it would be comprehensive work with the ministry to find out exactly what their opinions and thoughts are on that. We'd have to take it to that next step.

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Mr. Lorne Coe: I raise that, through you, Chair, as somewhat of an oblique criticism but, I think, overall with a view to transparency. The effort and thrust that's evident in the legislation right now would be, I think, an added feature that could be considered. Thank you for your comment.

Through you, Chair, to my colleague, please.

The Chair (Mr. Peter Tabuns): Ms. Martow.

Mrs. Gila Martow: He's so formal. It's cute.

I get a lot of complaints about weeds in the park. Obviously, it's not healthy to spray for weeds, but a lot of allergy sufferers tell me that in the spring—especially kids with asthma—they can't go near the parks because of all the pollen. I had spoken to somebody who knew something about what the best practice is, and they had suggested we need to mow more often so that the weeds don't have time to create that sort of pollen. I'm not an expert on it. I'm wondering if you have some comments.

Mr. Christopher Yaccato: Not specifically on weeds. Carole, our respiratory educator, may have a little more.

Rob Oliphant, former chair of the Asthma Society of Canada, talked at a committee regarding the types of trees we are planting. Some are more prone to producing different types of pollen etc. that exacerbate people's lung health. So those types of things that we could maybe work with municipalities on—even something small like that, the types of trees we plant, that would lower those exacerbations in people's lungs.

Sherry.

Ms. Sherry Zarins: I'm certainly not an expert on trees, but to build on your point in terms of those partnerships we were talking about and working with the Ministry of Municipal Affairs and Housing, that would be exactly the type of example.

More important, beyond the pollen, you mentioned—

The Chair (Mr. Peter Tabuns): Ms. Zarins, I'm sorry. With this questioner, we're out of time.

We go to the third party. Ms. Gélinas.

M^me^ France Gélinas: My question is a little bit in line with the first one that was asked.

Basically, if we come back to Ryan's Law, I was really pleased when we passed this law. I think it can do good things. But at the same time, I have a very hard time tracking it on the ground, as to how many schools have implemented it and what it looks like from one school board to the next etc. I want to learn from this for this new bill that we are putting forward.

Have you guys given any thought as to some reporting back that would be mandatory—and put it in the bill rather than in regulation so we don't find ourselves in the situation right now where we all agree that Ryan's Law is good but we have no idea what's going on.

Mr. Christopher Yaccato: You're absolutely right. With Ryan's Law, specifically, we're a little lost in tracking of exactly what's going on, what school board is doing what and so on. It has been a year since everyone in this chamber rose and passed it, so there has got to be a lot more work on that front.

With respect to managing lung health in Ontario, I think the plan could look to address that, and I think we're open to ideas to present. Sherry and I and various other stakeholders would probably need the time to look further into reporting mechanisms to make sure that—not an Ombudsman report or anything that significant. We don't want to burden the ministry with more reporting and keeping their hands clasped. Yet, at the same time, we need to make sure—I think there's an annual Air Quality Health Index report that comes out. Something like that is open and transparent so we can see either progress or areas of weakness—maybe there are areas where we're doing extremely well, but maybe we could focus some attention elsewhere.

M^me^ France Gélinas: I would encourage you to think that through. We are legislators. We look at bills. You can see that we all want to get there. We're all going in the same direction. Nobody's opposed to this. So I want as strong a bill as possible.

We know from experience that some of the bills that were supported by all of the Legislature—I'm going back to Ryan's Law, and I'm thinking, "Darn, I should have put an amendment for reporting back so we don't have to put all of this effort to find out where we're at." So if you could think that through and bring something forward, I think you would do all of us a great service.

I have no doubt we will get there. We will have a council. We will have an action plan. Let's think success and think down the road to what kind of reporting back we would like. And I'm sorry I cut you off.

Ms. Sherry Zarins: That's okay.

The Chair (Mr. Peter Tabuns): With that, we've run out of time, I'm sorry to say.

Mr. Christopher Yaccato: Thank you. Good idea.

M^me^ France Gélinas: I'm doubly sorry.

The Speaker (Hon. Dave Levac): Thank you very much for your presentation today.

TORONTO PUBLIC HEALTH

The Chair (Mr. Peter Tabuns): Our next presenter, then, is Toronto Public Health: Ms. Elizabeth Rea. Ms. Rea, as you've heard, you have up to 10 minutes. If you'd introduce yourself for Hansard, we'll go from there.

Dr. Elizabeth Rea: Thanks for allowing me to speak. I'm Dr. Elizabeth Rea. I'm the associate medical officer

of health for the tuberculosis program at Toronto Public Health, and I'm speaking in support of the bill.

I do want to speak, somewhat predictably after that introduction, about a specific disease that I don't think even the organizers of the bill had front of mind, and that's tuberculosis, which is curable almost all of the time, but that does involve an extended and very involved treatment. It's very severe if it's not treated. About half of people will die within two years if they don't have access to diagnosis and treatment. As a bonus issue, which doesn't apply to most of the broad strokes lung health issues in Ontario, it's infectious. That means there's obviously a huge vested interest for patients, their families and friends affected by TB, but also entire communities.

We don't have anywhere near as much TB in Ontario as we did 50 years ago, but there's still about 600 people a year who get sick with tuberculosis. So it's not a population-wide issue in Ontario as much as it used to be, which puts it in a funny position, because it's definitely one of the big global public health issues, but with only 600 cases a year, it's also heading to the realm of almost a rare disease. The vast majority of family docs and even respirologists and infectious disease physicians haven't dealt with TB. It really is becoming a disease that needs specialized care on both the clinical end and, to a large extent, on the public health end. Yet, in Ontario, as you know, we have a very decentralized system and there's currently no real infrastructure to make sure that a TB diagnosis and care and the public health follow-up are available at a high standard in all of our communities. So my hope is that TB is an example of one of the specific conditions that this committee would be able to look at in some depth and provide practical, concrete advice about how to improve the current situation and get us closer to the elimination of TB in Ontario.

The other specific thing I wanted to bring up about the bill is that currently the way it's worded, the membership of the advisory committee doesn't specify including anybody from public health. Obviously, TB is one part of that, but public health units in Ontario have been involved extensively for many, many years, particularly on air quality, indoor and outdoor air quality, smoking issues, and there's a lot that happens at the local level through those public health coalitions. It would, I think, be very important to make sure that the work of this committee is well coordinated with those other community-level initiatives around air quality, in particular.

The Chair (Mr. Peter Tabuns): Thank you. Our first question, then, goes to the opposition. Mr. Coe.

Mr. Lorne Coe: Thank you, Elizabeth, for being here. As you probably know, I was president of the Association of Local Public Health Agencies for six years prior to getting elected. My question does turn to the composition of the council, and yes, I agree with you that there should be representation from public health. Would you see it being from the association?

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Dr. Elizabeth Rea: That's probably the easiest way to identify somebody. There are many public health units. Referring it to alPHa would allow alPHa to say, "Okay, who is the most involved and available?" It seems like an easy mechanism.

Mr. Lorne Coe: Well, just given the background experience of public health in general in this area, but more specifically the comments that they've provided on this legislation, it would be worthwhile considering. Would you agree?

Dr. Elizabeth Rea: Absolutely.

Mr. Lorne Coe: Would you also think it would be worthwhile considering, as an addition on the council, a clinical researcher?

Dr. Elizabeth Rea: That might be a very useful perspective, yes. I mean, there is a lot of evidence, obviously, and a lot to sift through. I don't think we'll ever get to the point where there's a definitive answer for everything, but having somebody available to the advisory group who can be somewhat of a guide through the evidence might be extremely helpful.

Mr. Lorne Coe: Well, thank you very much for your answer.

Through you, Chair, to my colleague, please.

The Chair (Mr. Peter Tabuns): Ms. Martow.

Mrs. Gila Martow: Thank you very much for coming in today. I think that there are the chronic lung health concerns, preventative and chronic disease, but we also have to address infectious readiness. I was sort of hoping to see somebody on the list today who would be specifically addressing having a plan in place. I think that's where we need to have the public health and that's partly why we need to have the public health. We need to have an emergency plan in place for how to deal with—it's not if, it's when—and I'm wondering if you have any specific comments on that.

Dr. Elizabeth Rea: I think you're absolutely right about the issue. I suppose there are lots of different mechanisms to deal with that issue. I guess I am cognizant that a lot of the lung health issues aren't infectious and that there are already other initiatives around emergency response and public health infection control issues.

So I guess my only real comment about that is, yes, I agree that it's important for the Legislature and the government, broadly, to deal with it, and if this advisory group did take it on, that they would need to make sure they were well connected with other structures that are already in place dealing with those issues.

Mrs. Gila Martow: So I just wanted—if I have one more second?

The Chair (Mr. Peter Tabuns): One more second.

Mrs. Gila Martow: I just wanted to be on the record that Quebec has a very distinct plan in place. I think Marie-France was with me last year when they spoke about that and we were kind of a little bit left in the dust in terms of preparedness.

The Chair (Mr. Peter Tabuns): Thank you. With that, we go to the third party. Ms. Gélinas?

M^{me} France Gélinas: It's a pleasure to meet you, Dr. Rea. I did not know we had an associate medical officer

of health at Toronto Public Health who dealt with tuberculosis. I thought tuberculosis had been handled and there were maybe two or three cases every decade, but 600 a year?

Dr. Elizabeth Rea: Yes, and those are only the people who are ill with TB. I mean, even in Toronto we have 2,000 contacts of TB every year who need medical care to work them up and make sure they're okay and get their follow-up, so it's—

M^me^ France Gélinas: And is most of that care provided in the community or in our hospitals?

Dr. Elizabeth Rea: Not so many people have to be hospitalized for TB anymore, but it is still specialist care, so often those specialists are based out of hospitals.

M^me^ France Gélinas: What's the role of the health unit's tuberculosis program?

Dr. Elizabeth Rea: Right. Most provinces have a unified provincial TB program with the public health and the clinical part of it all integrated under one roof. In Ontario, it's quite separate, which is part of the decentralization tension for TB. So clinical care happens from the physician, but public health is responsible for supplying the drugs, ensuring that the treatment is adequate, providing the nursing care and directly observed therapy for the patients and the supports for families, making sure that people stay in home isolation while they're infectious and that they actually complete treatment, so that involves daily involved therapy. It's public health that does all of the contact follow-up investigations and a bunch of the outreach, education and prevention type of work.

M^me^ France Gélinas: All right. I must say that you were not on my radar when I was thinking about the lung health advisory council, and I'm really sorry about this. You are now. Thank you for coming.

There are lots of big issues with millions of people—maybe not millions, but hundreds of thousands of people—that will tend to take a lot of time, effort and energy from the new council once we start. How do we make sure that you don't fall off?

Dr. Elizabeth Rea: It's a good question. I think it's an issue or a tension for any disease that's potentially high impact but low volume. The people who are involved in TB care are a pretty dedicated bunch. To some extent, you could almost farm out the concerns.

M^me^ France Gélinas: So is there a strategy that exists that—

The Chair (Mr. Peter Tabuns): Ms. Gélinas, I'm sorry to say you're out of time.

M^me^ France Gélinas: I'm really sorry also.

The Chair (Mr. Peter Tabuns): I'm sure you are. We go to the government. Mr. Anderson.

Mr. Granville Anderson: Thank you, Dr. Rea, for coming and thanks for the excellent presentation here this afternoon. It would be remiss of me if I didn't thank MPP McGarry for bringing this bill forward.

TB is not considered chronic in Canada or Ontario anymore, one of the chronic lung diseases. It does affect the spine, I believe, and the brain to some extent, and kidneys as well. Could you elaborate on what's going on in Ontario with respect to TB and—perhaps that's enough for now.

Dr. Elizabeth Rea: Sort of the dimensions of TB in Ontario?

Mr. Granville Anderson: Yes.

Dr. Elizabeth Rea: Okay. There are about 600 cases a year. Most of it is related to people who were born outside of Canada, where there's a lot more TB, became infected, usually years ago, and long after they came to Canada they became ill. So the patterns of it do tend to follow, broadly speaking, the patterns of immigration in Ontario, which is again one of the tensions. Peterborough didn't used to have a lot of people from India, but there are more and more now. About two thirds of people with TB have it in their lungs. You're right; you can also get TB in pretty much any other part of the body as well. If it's in the lungs, it's infectious. Treatment takes about a minimum of six months.

Mr. Granville Anderson: That is what would have been my next question, whether it came in from outside predominantly. I have a friend who is a public health nurse, I guess with your unit. She told me that she's going to homes, I guess, once per week to make sure—

Dr. Elizabeth Rea: Oh, she does directly observed therapy?

Mr. Granville Anderson: Yes. So I said, "Are you not afraid of catching it?" She said they get tested every six months or something like that.

My next question is, specific to the bill, could TB focus be incorporated? How would you focus that? How would you incorporate that, and if so, what would that incorporation look like?

Dr. Elizabeth Rea: I guess, from my end, the big concern that I have about TB is that there's not an infrastructure to ensure specialist care. I really think we're getting to the point in Ontario where there needs to be some centralization, the same way we've kind of centralized oncology care, to some extent, so your family doctor is not treating you for your brain cancer. There needs to be some kind of coordination referral mechanism. That's the piece I think that I'm most hoping a committee like this would be able to provide input on.

Mr. Granville Anderson: Okay. I believe my colleague Ms. Martow touched on this. How would a lung health action plan protect Ontarians and what would that plan look like? What do you think that plan should look like?

The Chair (Mr. Peter Tabuns): Mr. Anderson, I'm sorry to say you've run out of time.

Mr. Granville Anderson: Oh, okay.

The Chair (Mr. Peter Tabuns): Thank you very much for your presentation today.

I've had a request from Ms. Martow for a five-minute recess. Is the committee agreeable? Okay, excellent. Thank you all.

The committee recessed from 1510 to 1518.

The Chair (Mr. Peter Tabuns): Good afternoon, everyone. We have enough members back at the table to resume.

RESPIRATORY THERAPY SOCIETY OF ONTARIO

The Chair (Mr. Peter Tabuns): Our next presentation is from the Respiratory Therapy Society of Ontario: Ms. Nancy Garvey. Ms. Garvey, if you would introduce yourself for Hansard. As you've heard, you have up to 10 minutes.

Ms. Nancy Garvey: Thank you. I am Nancy Garvey, a respiratory therapist. I have a master's degree in applied science. I'm the research committee co-chair for the RTSO.

First, I would like to thank the committee for the opportunity to speak on behalf of the RTSO and to submit this deputation regarding the Lung Health Act, 2016.

As a complement to this presentation, I have the honour of sharing a recent copy of our Airwaves news journal which includes the RTSO's feedback to the Patients First discussion paper forwarded to the minister's office as well as each of the LHIN CEOs. Aiming to "go green," I just have 10 original copies left over from the spring edition that are being distributed. I understand that some additional copies are being printed. It is available on our website also.

There are approximately 3,150 RRTs practising in Ontario. Many are part of transformative, evidence-based, patient-centred programs for infants, children and adults with cardiorespiratory conditions across the province. We believe that the successes, as well as the lessons learned, can be adapted to help address local needs with appropriate local resources and a cost-effective, transparent, responsible approach. We hope you will not hesitate to refer to the feedback document for ideas related to improving lung health, in addition to the advocacy documents and presentations provided by our colleagues here today.

During this presentation, I aim to address the complexities of lung health related to the complexities of the health care system and transformation in particular and the need for a well-thought-out, comprehensive, coordinated approach to address these complex issues that is patient-centred, transformative, effective and efficient—namely, the need for the Lung Health Act.

To provide an insight into the complexities of lung health, I'd like to begin with a personal reflective story. When I was in high school, I loved and did well in science and math, and am still intrigued by the challenges they present. When I was looking at career choices I took that into consideration, as well as my desire to work with people and ideally do something that would make a difference in their lives—a complex challenge. Health care was the easy choice.

When I first heard about respiratory therapy, I almost readily discounted it, thinking it wouldn't provide enough of a challenge and there wouldn't be too much to do. "Really: The air goes in; the air goes out. How complex is that? That is what most people think of in terms of breathing and lung health. Will that really keep me challenged and engaged in making a significant difference in people's lives for the rest of my career?" Well, I quickly learned otherwise. At times the complexities were almost overwhelming. To begin, lung health is important for everyone, from birth to the end of life.

The respiratory system, including the nose and mouth, warms air to body temperature, filters particles that may cause harm, adds humidity to keep the lung environment healthy, and transfers oxygen to blood as it flows through the lungs for delivery to cells throughout the body, as well as dumping carbon dioxide, a waste product from the cells throughout our body. Lungs have a large but limited capacity to enable vigorous exercise as well as quiet breathing. That capacity is adversely affected by the slow onset of chronic lung diseases, as the respiratory system can be overburdened by air pollution and other harmful exposures where people live, learn, work and play.

We're all familiar with examples like off-gassing in home building materials, mould in schools, dust in work settings and what used to be tobacco smoke in public places. Additionally, the lung's ability to respond quickly to sudden onsets of infectious disease or other harmful exposures can become compromised. Poor lung function contributes to other chronic conditions, resulting in multi-morbid complex conditions, visits to health care providers, emergency department visits, hospitalizations and increased needs for home and long-term care.

Increases in our middle-aged and elderly population will lead to an increased incidence of respiratory conditions such as COPD and pneumonia. Respiratory disorders can permanently damage the lungs and restrict lung functions.

Over 40 years later, I can testify that the chemistry of acid-base balance, the physics of airflow, opportunities to interact with interdisciplinary colleagues, and the privilege of providing respiratory care to babies, children and adults, contributing to them living better lives where they live, learn, work and play, as well as the complexities associated with lung health that I've just described, have kept me well challenged, as are all of us working with and caring for people who have or are at risk of having respiratory-related conditions. We are all faced with, and our bodies have to deal with, the complexities of lung health every day of our lives, which is directly related to the complexities involved in addressing changes in the health care system and the need for a comprehensive, coordinated plan.

As the ministry's Externally-Informed Annual Health Systems Trends Report from 2014 reports, "Canadian health care systems have their foundation in acute care, and perform their best when addressing urgent needs."

It also reiterates a message that the World Health Organization documented years ago, and that has been mentioned here today, that chronic respiratory disease is one of the top four chronic diseases affecting populations around the world.

The Trends Report also observes, "The most prevalent chronic diseases ... require regular and extended care, and are therefore mismatched with the episodic model of care."

We know that part of our health system includes regular and extended care and we know that that part is changing to meet the needs of people who are living longer and often with multiple chronic conditions.

We also know that a lot can and needs to be done upstream in the health care system to promote lung health and prevent both the onset and progression of chronic conditions as well as uncontrolled and avoidable exacerbations.

I'd like to call your attention to the National Lung Health Framework continuum of care schematic on which the draft of the Ontario lung health action plan is based. Across the middle, it identifies stages of health, from the healthy at-risk populations to end-of-life palliative care, and related characteristics, at the bottom, as the determinants of health. It identifies health promotion and disease prevention, disease detection and management, policy, partnerships, community support, research, surveillance and knowledge translation as key elements needed to address the physiological and health care system complexities that affect lung health.

What policies, programs and resources are put in place to address each of these elements of care? How do we change the focus of health care from episodic acute care to include a stronger focus on health promotion and disease prevention while supporting infants, children and adults along each step of the continuum? How will eHealth and mobile health apps fit into the picture?

There's no magic bullet, no easy answer to the complexities affecting lung health. We need to ensure that the complex changes that are made provide the best value for patients and their caregivers as well as being cost-effective for the system.

Health system transformation in Ontario recognizes the need for change. A lung health advisory can bring together a variety of expertise, including LHIN-based informants, to provide advice and identify opportunities for system improvements. A lung health advisory will make responsible recommendations that have maximum impact on the burden of chronic and infectious respiratory disease, taking lung health and health-care-system complexities into consideration.

Our province is a recognized leader for our smoke-free Ontario legislation, commitment to air quality and other public health programs that promote and support lung health. We have marked significant inroads in the provision of asthma, COPD and other lung health programs and services as part of interdisciplinary teams in primary care. We're looking at another very realistic opportunity to lead the nation and the world in the development of a comprehensive, coordinated plan for lung health that will have significant positive health outcomes for infants, children and adults in Ontario, as well as the system.

Working together, we can help Ontarians have better lung health and so have better lives, be engaged, happier members of their communities—Ms. Black—contributing to a stronger Ontario. So I ask you today, just as the Lung Health Alliance partners strive to do what they do well for patients on a daily basis, to do what you do well: Make a difference in the lives of Ontarians and move Bill 41, the Lung Health Act, forward to third reading as soon as possible.

The Chair (Mr. Peter Tabuns): Thank you very much for your presentation. We go first to Ms. Gélinas.

M^me^ France Gélinas: Thank you. I've talked to some of the previous presenters—I'm not sure if you were here or not—about what would be some indicators that the council did its work, that the plan has worked. I'm into the future, where the council is there, they've done a plan, the plan is being implemented. What are some of the indicators that would prove to us that we have done good work—"we" as in the collective; I'm not going to be the one carrying out the plans—and who should be the one who reports on that?

1530

Ms. Nancy Garvey: I would propose—particularly with the changes occurring at the LHIN level, where they're going to be coordinating care for their LHINs—that there be some accountability for the LHINs to report back to the ministry on the indicators that are decided upon. I would defer to the advisory council to define those indicators in particular. I can project that some essential ones will be reductions in emergency department visits and hospitalizations.

The primary care asthma program was referred to earlier. It was a pilot project for four years from the beginning of 2002 to 2006 in 17 sites. Now, with the lung association's leadership, it has expanded to 150 primary care sites across the province and has resulted in significant decreases in emergency department visits.

M^me^ France Gélinas: I'll just ask you a quick one. I have no problem with having the LHINs report back on indicators that, I take it, the council would have identified to report. Reporting to the minister versus reporting to Ontarians: Should those reports be for all to see or for the minister?

Ms. Nancy Garvey: For all to see.

M^me^ France Gélinas: For all to see.

Ms. Nancy Garvey: Yes.

M^me^ France Gélinas: You would be confident with leaving the identification of indicators to the lung health advisory council?

Ms. Nancy Garvey: Assuming that there will be someone from, say, Health Quality Ontario who would be part of the council. I think there is a framework being developed or, if it's not already developed, I know that the lung association has worked with HQO on the development of indicators. Dr. Teresa To from SickKids and ICES has been a leader in the development of indicators for COPD and asthma. I have confidence that there could be a reporting system recommended through the interaction of the council when it comes together.

M^me^ France Gélinas: With the help of all of the partners you have named and the LHINs putting all those indicators together to report back to the public.

Ms. Nancy Garvey: Yes.

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

The Chair (Mr. Peter Tabuns): We go to the government: Madame Lalonde.

Mrs. Marie-France Lalonde: Thank you for being here with us this afternoon, and thank you for your support of Bill 41.

I had the great pleasure of actually being part of a multi-disciplinary team a few years ago, as a social worker working in a hospital, and I certainly value the role that respiratory therapists provided to us while we were trying to discharge some of our patients and some of the health care issues we were facing then.

But there has also been an evolution in our health care system, and I have not been a part of that system, but maybe I can ask you. We know that technology has been playing a more impactful role in our health care system. What equipment do you see as often used in the home and the community right now?

Ms. Nancy Garvey: I think we're sitting on the edge of a huge explosion in the use of mobile health apps. A friend of mine, a 77-year-old grandma, had open heart surgery six months ago, and she has a Fitbit to track her 5,000-steps-a-day goal. I think we're going to see more of that. Colleagues we worked with from the lung association are leading the development of a mobile health app for asthma and COPD, where people can monitor their asthma and get two-way directional messages about their asthma going out of control etc. It's really remarkable. I think all of that is going to be integrated into the electronic medical record.

I have been doing some work with eHealth Ontario in the Connecting South West Ontario strategy. There is a Rhapsody integration application that, just over the last couple of years, has created a tunnel to integrate mobile health app information into EMRs. There's all kinds of technology, along with point-of-service systems that can monitor oxygen saturation etc. in the primary care office versus having to go to the hospital to have some tests done. Spirometry in primary care has been mentioned.

I think there are some huge advances that we're just on the edge of moving forward with, as we move things upstream.

Mrs. Marie-France Lalonde: Thank you very much. I think you've sort of answered a little bit of my next question. I guess I see this as a huge impact, in terms of having access for people in the community, being a part of their health care, giving them empowerment in their own health system. How are seniors responding to this new technology?

Ms. Nancy Garvey: I think very positively. I mean, Bev was talking about texting her granddaughter and, as I said, the 77-year-old has her Fitbit. I mean, I'm looking at 70 and I'm right into it too—

The Chair (Mr. Peter Tabuns): I'm sorry to say that with that, you're out of time for this question. Someone else may follow up.

To the opposition: Mr. Coe.

Mr. Lorne Coe: Through you, to our delegation: Nancy, thanks for the presentation. It was excellent.

You were in the audience when I asked my question of Elizabeth about the composition of the lung health advisory committee, so you'll appreciate this as the research co-chair.

Given the focus of the work of the lung health advisory council—as I read it, a part of that, probably a large part of it, is going to be focusing on critical evaluation of basic and clinical data. Do you think it would be helpful to have a clinical researcher as part of the composition?

Ms. Nancy Garvey: Absolutely. I think that we have, again, some amazing respiratory researchers in Ontario. ICES has some excellent researchers who have been working with programs. I'll leave it at that.

Mr. Lorne Coe: I just want to take you now to the part of the legislation that talks about reports. The legislation at the present time speaks to an interim report being published by the minister within two years relative to the progress in developing the Ontario lung health action plan. Do you think that's too short, too long or just right?

Ms. Nancy Garvey: I think it depends on how the advisory is organized, funded and project managed, and what type of change management processes are in place.

Mr. Lorne Coe: Well, my question is more based in the research component again because, typically, it would be a longer horizon than two years to do the critical evaluative research of the model that's reflected here.

Ms. Nancy Garvey: Yes. I agree with you completely on that. I guess what is expected in two years in terms of the interim report—it could be a status update and it might be the plan as it's laid out.

With a lot of ministry programs that I'm familiar with, there is about a five-year time frame for implementation and evaluation because, again, you have to be able to measure the changes pre and post program implementation and you have that rolling cycle. So, yes, you need the time.

Mr. Lorne Coe: Thank you very much for your answer. Thank you, Chair.

The Chair (Mr. Peter Tabuns): We'll go on to our next presenter then. Thanks for your presentation.

Ms. Nancy Garvey: Do I have time for one other comment?

Mrs. Gila Martow: Sure. Can you please give us one more comment?

Ms. Nancy Garvey: Just when you were talking about representation, to include somebody from primary care and the different points along the health care system: When you asked previously about public health, maybe Public Health Ontario would be a good person to represent.

You made reference, with your research question, to including a clinical researcher, but to make sure that the whole program clearly reflects development, implementation and evaluation—

The Chair (Mr. Peter Tabuns): And with that, you are out of time. Thank you very much.

UNIVERSITY HEALTH NETWORK

The Chair (Mr. Peter Tabuns): Our next presenter, then, is University Health Network, Mr. John Granton. Mr. Granton? Good afternoon. When you have a seat,

could you identify yourself for Hansard? Then you have up to 10 minutes.

Dr. John Granton: Sure. Thank you very much. My name is Dr. John Granton. I'm the head of respirology at University Health Network, Women's College Hospital and Mount Sinai Health System. I'm also current chair of the Ontario Lung Association board and past president of the Ontario Thoracic Society and the Canadian Critical Care Society.

On behalf of my colleagues across Ontario—and I speak to the broad sense of colleagues, both as it relates to my physician colleagues as well as nurses and respiratory therapists and those interested in preserving lung health—I'd like to thank you for this opportunity. In fact, I'm very excited about the opportunity to speak with you today and hopefully address some of your questions moving forward.

I also wanted to thank Kathryn McGarry for her hard work in bringing this bill forward and your hard work in bringing it into law, hopefully; and as well, the lung health caucus and the Ontario Lung Association for working collaboratively with the government to make this happen.

1540

I'm really here on behalf of my patients. I think, for a long time now—I guess it's a sense of frustration as a physician, and certainly as a patient, at really not being able to realize the benefits, which are so close at hand, in consolidating how we manage patients with lung disease.

You've heard a little bit about the importance of lungs, and Dr. Gershon will give you the statistics on it, but on a personal level lungs are extremely important. They're exposed to the entire environment. They receive the full cardiac output, unlike any organ in the body. They can have a primary disease associated, things like asthma, emphysema, obstructive lung disease, that you're familiar with, or pulmonary fibrosis. But, because of how they're uniquely positioned in the body and what they are exposed to, they're often the casualty of so many other conditions. Think of pneumonia, severe acute lung injury, people having to go on heart-lung machines and lung transplantation, people with rheumatic diseases or people with cancer, like lung cancer. Also, the complications of cancer care commonly affect the lung.

Lung disease is one of the most common reasons we admit patients to hospital, and it is one of the most common reasons why we readmit patients to hospital. Singularly, it is one of the largest diseases which influences our health care expenditures.

So it has been frustrating for so long to see this group of conditions so badly orphaned. We recognize that lung cancer is the most common cause of death in patients with cancer, more than colon cancer and breast cancer combined. We're seeing a change in demographic. This is not a men's health issue now; this is a women's health issue, with more women smoking and being exposed to the side effects of cigarette smoke. We're seeing much more lung cancer in women. This disease does not respect gender; it does not respect age. We see children with lung disease. We see adults with lung disease. It is a burgeoning health problem. Until this point we really, as a group, have not paid enough attention to lung disease in general. So this is a fantastic opportunity.

I want to convey to you that this bill is vital, really, to move forward, as a group, to improve health outcomes for our citizens. I'm really here to urge you to help move this bill forward. I think that by utilizing the collective expertise of the council, and with the minister, to develop a lung health action plan, and using the lung health caucus as a group of expertise—and it does need to bring in a broad group of experts, both from the ministry as well as from NGOs, from research—to really develop a very fulsome strategy to not only develop a fulsome lung health management plan, but also to develop those metrics, which are so crucially important to ensure that those programs are accountable to the population, accountable to the patients and accountable to the government for its investment, that can be easily done.

We also recognize that there are many silo programs across the province, which are currently up and running through the generous support of this government and previous governments, as well as from private funding organizations, through the lung associations and other associations, which are working. We know they're working. I think this is an excellent opportunity to kind of shepherd the kittens and bring them together to develop a fulsome strategy which reaches all Ontarians.

I want to help you understand that much of what we need to do, we already know. It's simply capitalizing on those programs and harmonizing them across the province that will make a huge difference. We heard some things around technology. You've probably heard about pulmonary rehabilitation and the importance, really, of simple diagnosis to properly identify patients with lung disease early on to make sure they receive appropriate treatments, but equally—and it is a common problem—to make sure that patients who have been mislabelled as having lung disease are no longer treated with these expensive pharmacotherapies and achieve appropriate treatments for the underlying heart disease, which might be masquerading as lung disease or mislabelled. All of these things, I think, can be brought to bear with the passage of this bill.

The final thing I would say is that the chances to improve productivity, the chances to reduce hospitalizations and the chances to improve the outcomes and the well-being of Ontarians with lung disease rely heavily on the passage of this bill. And so I am, along with my colleagues, tremendously supportive of this initiative and will back you 100% to make sure it succeeds.

I'll take your questions.

The Chair (Mr. Peter Tabuns): Thank you very much. We go to the government: Ms. McGarry.

Mrs. Kathryn McGarry: Thank you very much, Dr. Granton, for coming this afternoon. I'm absolutely delighted to have you here. I know we have had a lot of conversation regarding a lung health action plan and why it's so important in Ontario. I know that lung disease,

including COPD, lung cancer and chronic conditions, takes up a high percentage of our hospital budgets and our health care spending because of hospital admissions, readmissions and home and community care. I know that research is a component of what it takes to ensure that we can have early diagnosis and that we have a gold standard of care across the province for certain conditions such as COPD.

Why is it necessary, though, to initiate a full lung health action plan in Ontario rather than the piecemeal approach that we've had so far?

Dr. John Granton: It's a very good question. Like most chronic diseases, it requires a very fulsome strategy which is all-encompassing. I think, because of the complex nature of lung disease and the fact that patients also have many comorbidities, it requires a strategy which can deal with early diagnosis, early treatment, education, prompt therapy, follow-up, and also patient and provider education to make sure that the learning sinks home and that patients can adapt their lifestyle and, importantly, improve their outcomes.

That can only happen through a comprehensive strategy. I don't think you can piecemeal them because they overlap so much and are so—they're integral to each other. You can't do one, essentially, without the other. The common thread through all of this is an iterative process, which is essentially research: trying to measure it and improve upon it and learn from it as we move forward. That could be on any level. Within Ontario, there are many talented researchers—you'll hear from one right after me—who are capable of conducting the very important research as it relates to the impact of different programs and the impact of the condition on Ontarians.

Mrs. Kathryn McGarry: One of the things that I have been interested in is the simple spirometry test. Actually, you administered mine—

Dr. John Granton: That's right. You do not have COPD.

Mrs. Kathryn McGarry: —to prove that I do not have COPD. Yes, it was there in black and white. Can you talk about how it would be, in order to get that early diagnosis with COPD in particular, and how you would roll out the gold standard of care to all providers in Ontario?

Dr. John Granton: The elements are there. Ensuring that labs are properly funded to carry out those investigations—I can speak to Ottawa, which actually closed one of its pulmonary function testing—

The Chair (Mr. Peter Tabuns): Dr. Granton, I'm sorry to say that you've run out of time with the government. We go to the official opposition: Ms. Martow.

Mrs. Gila Martow: Thank you very much for coming in and presenting. One of the discussions that I have with my family—I was an optometrist, my husband is an ophthalmologist and my stepson is doing cardiology training. We have this discussion about the models of health care. One of the concerns is bureaucracy: that bureaucracy is eating up too many health care dollars and that when we create a new type of bureaucracy we don't necessarily get rid of other layers of bureaucracy or programs or things like that.

The other is that doctors used to be the driving force of organizing health care and how it was delivered, and running hospitals. Fifty years ago, really, the hospitals were run by the physicians. Now it's a much more co-operative thing. Actually, it's the whole field of hospital administrators running hospitals. As a physician—you are a physician—

Dr. John Granton: Yes.

Mrs. Gila Martow: Yes, you're a respirologist. Just wanted to be sure. What is your feeling about doctors organizing the administration of health care delivery and prioritizing how that delivery is done and organizing it more? Do you feel that doctors have kind of lost control over some of that? I'm not trying to put you on the spot.

Dr. John Granton: No, no. We've matured as physicians, hopefully. I think the days of physicians being the pinnacle of how care is provided have changed appropriately. Most of us have realized that this is a team contact sport and that we rely heavily on our front-line providers—home care workers, respiratory therapists, educators, nurses and physicians—to provide comprehensive care. It speaks to Kathryn's point about developing a very fulsome model of how we actually treat patients with a chronic condition.

1550

Lung disease is no different than heart disease or kidney disease. I think, up until this point, we really have not paid attention to a condition which is incredibly common. So I don't think it's any one group of individuals; it's going to be a collaborative group of individuals focused on providing this strategy.

Mrs. Gila Martow: Would you like to see more effort being made to facilitate physicians to have it less formal? Right now, a physician refers to another physician. There's so much back and forth until these letters get read, faxed, emailed and things like that—more of a casual, monthly video conference to review with the nurses, with the doctors, with the respirology team, and to have that co-operative fitness discussion—even the patients themselves—to have more of that "use the technology" to have those discussions?

Dr. John Granton: Yes.

Mrs. Gila Martow: Okay.

Dr. John Granton: Because I see we're running out of time.

The Chair (Mr. Peter Tabuns): Ms. Martow, that was a very good question, but you ate up your time.

Madame Gélinas.

M^me^ France Gélinas: Just to allow you to finish your thought, when the last question came to you, you were talking about the importance of having a lab properly funded. You talked about, specifically in Ottawa, where one of the pulmonary function labs closed. Was it a pulmonary function lab?

Dr. John Granton: Yes.

M^me^ France Gélinas: How many do we have right now?

Dr. John Granton: I don't know the answer to that question. There are many independent labs and there are many within hospitals.

Clearly, I think the fact that the Ottawa one closed was, again, a lack of recognition of the importance of that diagnosis and some ignorance on the part of the administrators on the importance of diagnosis. I think it speaks to a general lack of understanding as to the importance of diagnosing, in a timely way and accurately, lung disease.

You would never do surgery or prescribe medication for a condition that you haven't diagnosed, and yet for lung disease, I can tell you, we routinely prescribe medications for something we haven't proven. So I think it behooves us, as health care professionals, to properly diagnose our patients and make sure we have the right disease and the right patient so that they can get the right treatment at the right time. And we're not doing that.

M^me^ France Gélinas: You also started by saying that we are not able to realize the full benefits of—and then you went on to a different track. What were you talking about?

Dr. John Granton: Sorry; I do that once in a while. The full benefits of many programs: If you look at nurse educators, if you look at smoking cessation, of which there is a clear health benefit, there's a clear cost savings with this and a clear effect on hospitalizations, readmissions and a mortality benefit—rolling that out for every Ontarian to have access to, and pulmonary rehabilitation. That's not unique to respiratory disease.

This isn't siloed. People with lung disease, people who have kidney disease: All of these people can benefit from rehabilitation. It's not necessarily any different. I think a comprehensive rehab strategy that addresses the needs of Ontarians could embrace, in part, lung health needs as well. It's not too siloed.

M^me^ France Gélinas: No. My last part was that you talked about accountabilities and metrics.

Dr. John Granton: Yes.

M^me^ France Gélinas: Do you have something in mind or will you really leave it to the advisory council to decide?

Dr. John Granton: I think I would leave that. I don't want to get too granular, but I think I would leave it to the experts to decide what is measurable and what is meaningful.

M^me^ France Gélinas: As long as we make sure that we do get metrics to measure and report.

Dr. John Granton: Yes.

M^me^ France Gélinas: You support reporting to the public?

Dr. John Granton: Definitely. Public accountability is so important these days.

M^me^ France Gélinas: Thank you.

The Chair (Mr. Peter Tabuns): Thank you for your presentation.

Dr. John Granton: Thank you for the opportunity, once again.

CHILDREN'S HOSPITAL OF EASTERN ONTARIO

The Chair (Mr. Peter Tabuns): Colleagues, we have Tom Kovesi on the line from the Children's Hospital of Eastern Ontario. Mr. Kovesi, I'm Peter Tabuns. I'm the Chair of the committee. All three parties are represented around the table. You have up to 10 minutes to present. If you'd just introduce yourself for Hansard, we can proceed.

Dr. Tom Kovesi: Good afternoon. Thank you so much for having me. My name is Dr. Tom Kovesi. I'm a pediatric respirologist at the Children's Hospital of Eastern Ontario—CHEO. I'm going to take you on a little bit of a different tack because I deal with children's lung disease, and most of the day you've been hearing about adult lung disease. I'm the past chair of the Ontario Thoracic Society and I'm also past chair of the Pediatric Assembly of the Canadian Thoracic Society.

I'd like you to keep in mind that respiratory diseases are the commonest conditions in children. Constant colds are the commonest reason for a child to visit a doctor. Asthma is the commonest chronic disease in children and the commonest reason for hospitalization in the province of Ontario. Rates of sleep apnea are rapidly rising in kids in parallel with the obesity epidemic. Respiratory health among indigenous people in Ontario remains a significant area of concern and is actually my own personal area of research.

Here in Ontario, I think we're doing a lot of things right. Asthma hospitalizations have fallen and asthma death is exceedingly rare. Key asthma medications are covered by ODB, and ADP covers much, if not all, of the cost of many of the respiratory devices and advanced treatments that children with advanced lung disease need, including home oxygen and breathing machines.

But there is still a lot more we can do. Modern asthma treatments are incredibly effective and nearly all hospitalizations for asthma are preventable, but to do that we need to help physicians adhere more consistently to national asthma guidelines. This is going to require more asthma education and possibly incentive programs analogous to what currently exists for diabetic care. We need to provide better access to diagnostic facilities, including spirometry, as you've just heard from Dr. Granton, and sleep studies.

We need to provide better patient education as well and better access for kids to have their asthma inhalers actually work and reach deep into their airways. This requires subsidization of devices called spacer devices, which kids can use to coordinate their breathing so that they when use the puffer the medication actually gets deep into their airways.

Public education continues to be needed to encourage people, including children, to avoid getting respiratory infections partly by remembering to always wash your hands before you touch your face; to optimize vaccination rates, including influenza, whooping cough and polio; and we continue to need education to encourage

youth not to take up smoking and to help smokers either quit or, as a bare minimum, smoke entirely outside so smoke doesn't recirculate within houses.

The lung health advisory council that Bill 41 would establish would help achieve these tasks by reviewing, refining and prioritizing recommendations developed in consultation with the lung health stakeholder community as part of the Ontario lung health action plan in terms of research, prevention, diagnosis and therapy for pediatric as well as adult lung disease. The council would develop a timeline for the implementation of priority recommendations to improve lung health and reduce lung costs. To me, it would function analogously to other system-specific advisory councils providing recommendations for key health care issues that affect Ontarians.

In my mind, one of the key urgent priorities that this type of council could address is the need for more certified respiratory educators. These educators could provide education to community physicians, provide better access to diagnostic tools such as spirometry, and provide more direct and in-depth patient education. Better access to spirometry would also facilitate early diagnosis of chronic obstructive pulmonary disease, or COPD, as you just heard from Dr. Granton.

The Patients First initiative, to me, provides an important opportunity to integrate certified respiratory educators at a sub-LHIN level, which is similar to a system that has been very effective and has been functioning for a number of years in the province of Alberta. The council could also stress the importance of having the Ministry of Health cover the cost of spacer devices to young children with asthma whose parents have a reduced income and also improve access to respiratory rehab, once again, as you just heard.

In summary, a lung health advisory council would fill a key gap in Ontario's long-term planning in improving the health of Ontarians: the need to address the urgent and expanding issues of lung disease not only in adults but also in babies, children and youth.

Thank you for giving me the opportunity to speak to you. Please bring forth your questions.

The Chair (Mr. Peter Tabuns): Thank you very much for your presentation. We go first to the official opposition. Ms. Martow?

1600

Mrs. Gila Martow: Thank you very much. When you're talking about pediatrics, I'm reminded of when my son, my oldest one, was in kindergarten. Some kids started laughing as he was eating his lunch and he didn't know what the joke was until finally they told him that one of the kids sprayed his puffer on his sandwich, so immediately he stopped eating. I had to leave work as an optometrist in the middle of the day with a waiting room full of patients to go because the school was concerned because he'd ingested medication. That meant that the child was told he wasn't allowed to have his puffer in his little fanny pack that he used to carry with him. I said, "I think the boys understand. They're all friends and I think they understand the severity." I really fought hard for him to be able to carry that. The school wouldn't allow him, and it made me nervous from then on.

What is your feeling in getting kids to really understand and in educating the classmates of the children? I think that's what it comes down to: that this isn't a toy and there are serious consequences.

Dr. Tom Kovesi: I completely agree with you. I think asthma education in schools is one of the areas that, as a province, we really need to work hard to improve. That involves not just the friends of patients with asthma but of course the kids themselves, the teachers and the educational system.

As the committee is aware, I'm ecstatic that we've now passed Ryan's Law, which helps kids with asthma who are responsible to carry their inhalers wherever they go to deal with asthma emergencies as rapidly as possible.

Mrs. Gila Martow: Thank you very much. I think my concern is that the kids who have asthma seem to understand because they've had an asthma attack so they're pretty scared. My worry is that the other children—I would like to see the schools having the tools. Maybe there's a children's book, colouring book or something that we can work on together. I just wanted to have that on the record. Thank you very much. I'll pass it on.

The Chair (Mr. Peter Tabuns): Okay. Thank you very much. Madame Gélinas.

M^me^ France Gélinas: Thank you so much for your presentation, Dr. Kovesi. My first line of questions has to do with your ideas—and many others have brought it forward—that we need certified respiratory educators to do the education, to make sure people have access to spirometry.

My first question is, how come we're not there yet? Is there something you can see or explain as to why, although everybody agrees, and everybody who has come here today has agreed and pretty well said the same thing you said, we haven't done it yet?

Dr. Tom Kovesi: It's a fantastic question and certainly a complicated one. Part of it, I think, involves silos: that respiratory educators have traditionally in Ontario partly lived in hospitals. Specialists have had access to them, and not necessarily community practitioners. Some of the respiratory educators have been provided at lung association offices. Some communities have these offices. They're relatively small programs, and again there are barriers because the educators aren't necessarily where the physicians for the patients are.

To me, now that we're moving into a new era in terms of having LHINs divided into sub-LHINs, if we could get one certified respiratory educator into every sub-LHIN so they would be directly connected with patients and community professionals, I think we could enormously enhance respiratory care in Ontario.

As a past chair of the Ontario Thoracic Society, wearing an adult hat and a pediatric hat, there's a really interesting study in one of the British journals where they looked at patients who were over the age of 40 who were

smokers who had any respiratory symptom—a cough, bronchitis or pneumonia—and if you did a spirometry on them, you find a significant rate of COPD and you diagnose it early. But to do that, you need to have really immediate access to high-quality spirometry.

M^me^ France Gélinas: Agreed. My next question has to do with—we're setting up this Lung Health Advisory Council. Everybody around the table is all in support. Do you feel that it is wise, safe and advisable to have children's health dealt with by the same advisory council that deals with adults?

Dr. Tom Kovesi: Yes, I do. I think it's important to have experts in both adult and pediatric respiratory medicine contributing to the discussion, but some of the issues are really very similar. Spirometry is an issue in kids and adults. Sleep apnea is increasingly an issue in kids and adults. The need for education, for implementation and guidelines, really crosses those borders.

The Chair (Mr. Peter Tabuns): I'm sorry to say, with that, we've run out of time. We will now go to the government: Ms. McGarry.

Mrs. Kathryn McGarry: Thank you very much, Dr. Kovesi, for your time this afternoon. I started my nursing career at SickKids many years ago, when there were smoking units for parents on every single floor and in the cafeteria. In those days, we were managing to count the evening census, as well as the census of asthmatics with young children and how many were staying overnight.

At that time, there was a lot of research done and a gold standard of care for asthma developed, including medications etc. It really cut down significantly on the number of hospital admissions. We're not there yet. We still have kids with asthma. How would a lung health action plan help improve the management and diagnosis of asthma and other respiratory diseases in children?

Dr. Tom Kovesi: I think it really cuts through all of the areas that are important. Working with the Ministry of Health to establish clear targets for decreasing asthma emergency department visits and hospitalizations, and working with the LHINs and the new LHIN structure to achieve that, is one piece. As we've been talking on multiple topics, the issue of education at every level is something with which the advisory council could help. It could also help coordinate research. There are so many areas, including First Nations children's health, where we really need more research and more guidance in how to prevent and manage these issues better.

Mrs. Kathryn McGarry: Thank you. I know that around the council there will be components of research built in, just simply by who would be present at a council table. I also understand that you have done a lot of work in our aboriginal populations in Ontario. Can you give us an overview of lung health of aboriginal populations and what we need to do, going forward, to improve it?

Dr. Tom Kovesi: The issues of indigenous kids are a little bit different from in the GTA, where asthma is an issue and access to asthma management is definitely an issue. But probably for kids, the bigger issues are respiratory infections. We recently finished a study in the Sioux Lookout zone north of Thunder Bay where we showed that respiratory infections in the first couple of years of life are three to four times higher than in the rest of the province. Much of that relates to the social determinants of health. Access to good-quality housing, indoor air quality, access to potable water so you can wash your hands frequently and reducing levels of cigarette smoking are all really crucial issues that need to be dealt with to help the respiratory health of these kids.

Mrs. Kathryn McGarry: Do you think a lung health action plan could help to incorporate some of those things?

Dr. Tom Kovesi: Absolutely, in every one of those aspects. In fact, I leave tomorrow morning back to Sioux Lookout to start the next phase of our research program.

The Chair (Mr. Peter Tabuns): I'm sorry to say, with that, Dr. Kovesi, we've run out of time. Thank you very much for attending us this afternoon.

Dr. Tom Kovesi: Thank you so much.

DR. ANDREA GERSHON

The Chair (Mr. Peter Tabuns): Our next presenter: Andrea Gershon. Ms. Gershon, as you've seen, once you have a seat, if you'd introduce yourself for Hansard. You have up to 10 minutes to present.

Dr. Andrea Gershon: Chair, Vice-Chair, committee members and Clerk, thank you for providing me the time to give a deputation today on the matter of Bill 41, the Lung Health Act. I am a respirologist, a lung doctor at Sunnybrook Health Sciences Centre, a scientist at Sunnybrook Research Institute in clinical evaluative sciences, and an associate professor at the University of Toronto. As a respirologist, I take care of people with respiratory disease. I'm a general respirologist, which means I tend to see things that are more common, things like COPD and asthma. That's what my research is in and that's what I'm mostly going to be talking about today.

COPD stands for chronic obstructive pulmonary disease. Previously, it was known as emphysema or chronic bronchitis. It is mostly caused by smoking, but non-smokers also get COPD—it's not uncommon—and it's more common in older adults.

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Asthma is a common disease that we can manage but we cannot cure. It is a serious disease. Although some people can have very mild forms of it, people still die of asthma. I'm sure you all have a parent, a family member, a friend or a co-worker who has asthma or COPD.

I'm going to start by giving you some facts, some evidence. I'm a scientist; I work off evidence. This is from my own research that my colleagues on my research team and I have done. It was done right here in Ontario on our Ontario population. These describe the burden of COPD and asthma in Ontario. I'm only able to touch on each of these briefly, but I'm happy to answer questions or provide more information or the actual publications from the journals that these are published in.

I'll first talk about COPD. Did you know that about one in four individuals are likely to be diagnosed and receive medical attention for COPD during their lifetime? This is known as lifetime risk, and it looks at the likelihood of somebody having a disease over their lifetime. The lifetime risk of COPD is about double that of heart failure and three times that of heart attacks, breast cancer and prostate cancer—each, not put together. Did you know that at any one time, about one in 10 adults 35 years and older has physician-diagnosed COPD in Ontario? This is a likely an underestimate because we know that under-diagnosis of COPD is a big problem.

Did you know that the prevalence of COPD has increased by more than 60% since 1996 in Ontario? Our models project that it will increase by another 14% by 2024, despite improvements in care and decreases in smoking rates.

COPD is the third leading cause of death. A lot of people don't know that. All-cause mortality in COPD—this is a good thing—is going down, but it's decreasing in men, not in women.

COPD is a leading cause of hospitalizations and emergency department visits. I'll try to say this carefully: Individuals with physician-diagnosed COPD were responsible for about a quarter or more of all hospitalizations, emergency department visits and ambulatory care visits in the province. They also take up about one third of long-term-care resident places and use about a third of home care resources. You have to understand that these visits are not for COPD, but COPD has a lot of comorbidities that the COPD contributes to, so it's because of their COPD that these people are ending up in hospital.

The volume of COPD hospitalizations and emergency department visits is increasing. Our models forecast that they will continue to increase so that Ontario should expect 10,000 more COPD hospitalizations and 10,000 more COPD ED visits in 2024 compared to 2014. Our data forecasts that the direct costs of COPD—just the costs of the hospitalizations and the physician visits—will be $10 billion in 2024, a $2.3-billion increase from 2014. This does not take into account patient expenses or lost productivity—all of those indirect factors.

I alluded to comorbidity in people with COPD. Did you know that over half of lung cancer, a third of all pneumonias and cardiovascular disease, and a fifth of all psychiatric health services in Ontario were used by people with COPD? This is because COPD predisposes to those conditions.

Social and economic disadvantage appears to have a significant, consistent, negative impact on COPD morbidity. We have done studies and we have shown that the gaps in outcomes in people with COPD between people of the highest and the lowest socioeconomic status are getting bigger. Over time, they're getting worse.

Finally, Métis people living in Ontario had a higher prevalence of physician-diagnosed asthma and COPD than the rest of the Ontario population. I'm happy to share the exact numbers with you.

Let me tell you some facts about asthma. In 2015, there were over two million people living with asthma in Ontario. One in four children in Ontario are affected by asthma. The prevalence of asthma increased by 55% between 1996 and 2005. This is likely accounted for by a 30% increase in the incidence of asthma in children—children who are going to have this disease for the rest of their lives. That's another point I'm going to come to.

One of every three individuals in Ontario will be diagnosed with asthma in their lifetime—that's the lifetime risk that I referred to before. It's higher in women and people of lower socioeconomic status.

Once someone has asthma, they have it for life. People might go into remission—they might be in remission for years and years—but we have shown that most people will come back to the health care system.

People can be diagnosed with asthma at any age. It's not a disease of children.

I talked about comorbidity with COPD. Comorbidity among individuals with asthma is substantial. People with asthma are twice as likely to have many other types of diseases, such as respiratory diseases, including COPD, psychiatric disorders, metabolic and immunity disorders, and hematologic disorders.

Finally—I'm sorry I don't have this figure for Ontario, but the annual economic burden of asthma across Canada is estimated to be $52 billion. This does not include the costs of school absenteeism, decreases in school performance, lost productivity and those other, indirect costs.

This is some of our research. COPD and asthma exert a huge burden on Ontario. Despite the burden of these diseases, as other people have alluded to, they have received relatively little attention. Resources and funding for respiratory disease—I know from the research side—have historically been less than for other diseases of much lesser burden.

Part of the reason for this, I believe, is a tendency to blame the patient. People with COPD and lung cancer are often smokers. These are two of the most common and concerning respiratory diseases, and people blame them. But people with heart disease smoke, and people with cancer smoke and some people with lung cancer don't smoke. I think this is one of the things that has stood in the way.

If you look at the quality of care for asthma and COPD in the community, there are lots of gaps, things that can be done better. For example, a lot of people have referred to pulmonary function testing—spirometry—but I'm going to put some numbers on it. Pulmonary function testing is used to diagnose COPD and asthma, but in our research we found that only one third of people with COPD get pulmonary function testing and less than half the people with asthma get pulmonary function testing to diagnose their disease.

Would you start a blood pressure medication without taking blood pressure? Would you treat heart disease before doing a heart tracing and an ECG? Yet that's what is happening all the time. No wonder underdiagnosis is a problem.

These are just statistics. They're just numbers. As a respirologist, I have the privilege of taking care of many people with COPD and asthma—the people these numbers represent. They're my patients. To tell you about all my experience would take hours—days—and I don't have that much time left. I could tell you stories of hardship, strength, resilience, failure, pain, suffering and death.

I could tell you about Mr. S, who had a heart attack and stroke as a result of a COPD exacerbation and spent months in the ICU and is now back living independently today.

I could tell you about Ms. D, who has bad COPD, with many exacerbations. Each time she has to go on prednisone, it causes her to get anxious and depressed, and she just can't handle it.

I can tell you about Mrs. S, who's a young woman—37 years old—who has been diagnosed with COPD. That's very young for this disease—a progressive disease.

I believe that there are many things—many simple things—that we could do to help people, these people that I know, with respiratory disease in Ontario, things that would improve their care, their health outcomes and their lives.

The Chair (Mr. Peter Tabuns): I'm sorry to say, you've run out of time.

Dr. Andrea Gershon: I'm done. Thank you.

The Chair (Mr. Peter Tabuns): With that, I go to the third party: Ms. Gélinas.

M^me^ France Gélinas: Thank you so much for coming. I think there is support from all parties to move ahead with the lung health advisory council. My question to you is, what are your expectations from this council?

Dr. Andrea Gershon: As I said, I think there are some very simple things that we could do, so my expectations are low. I don't think we have to do that much to get some attention for these patients. They need some very simple things, like a diagnostic test to know whether they have a disease, and maybe put some people at ease because they don't have a disease—to be able to help them out. I think these very simple things can have long-term outcomes.

There's a lot of talk about quality indicators and measuring success, and that's something that I do in my research. I really think that would have an impact.

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M^me^ France Gélinas: The second question is, if we know that this test exists—it's cheap, easy to learn and easy to administer—why aren't we doing this?

Dr. Andrea Gershon: It's an excellent, excellent question. I think this is where research, and going about it systematically to find out exactly what's going on, is very, very important. That's where a bill or a committee, or an approach like this, is important.

We've done studies. We've found that there are certain characteristics that are associated with not getting pulmonary function tests—certain comorbidities, certain types of physicians that aren't ordering them—and we can take the time. We can target these areas, and we can address these problems and get this done.

M^me^ France Gélinas: You seem very hopeful.

Dr. Andrea Gershon: Definitely. Like I said, I think there are a lot of very simple things that we can do that can make a huge difference, because they haven't been done before.

M^me^ France Gélinas: When it comes to reporting back—I've asked this of other presenters—is this something that you would like to see in the bill, to make sure that we do put in a component that is developing indicators or metrics, so that we report back and so that we can track progress?

Dr. Andrea Gershon: Absolutely. This is actually research that I do. We are developing—and it has been a struggle, because it's hard to get funding agencies to fund this type of thing. We are developing evidence-based COPD quality indicators, using a Delphi panel, who will have the quality indicators ready.

I've already worked a little bit with HQO and the Ministry of Health to start implementing some of these indicators. I'm working with ICES to find out how we measure these in the health admin data, looking at ways where we can measure things outside of the health admin data. I think it's all possible. It's all there. It's going to need a little work, but we can do it.

We've talked a lot about outcome indicators, but I think just as important is measuring process-of-care indicators.

You ask what we can do in two years. We may not be able to see the decrease in hospitalizations, but we can see if more pulmonary function tests are being ordered. We can see if the right medications are being prescribed. We can see—

The Chair (Mr. Peter Tabuns): And with that, I'm sorry to say, you're out of time.

We'll go to the government. Ms. McGarry.

Mrs. Kathryn McGarry: Thank you, Dr. Gershon, for coming in today. It's incredible to hear you speak.

I know that years ago, asthma was tackled by a province-wide strategy, whereby new medications were tried and best practices were tested. I worked at SickKids at the time, so I saw an incredible difference over the years on how we tackled that.

So when you're talking about COPD, one thing that comes to mind is the fact that you're talking about the blaming-the-victim part of it, which doesn't necessarily mean that people are supportive of doing this. I know that to be true, so it's interesting to hear you say that.

Do you think, and why do you think, that it's very important to initiate a lung health action plan as a provincial strategy, as a framework to roll out things like COPD best practices?

Dr. Andrea Gershon: Oh, my goodness. I think it's so big. There are so many moving parts. There are so many exciting things going on across the province in so many different areas. There are so many things going on with other chronic diseases. I think there are just so many opportunities, and it just needs somebody to bring them all together—and add a little more; I still think there's

more work to be done. I just think it could be very powerful and very impactful and make a big difference in people's lives.

I think that having that kind of overview, the bird's-eye view, of what's going on and understanding is very, very important, as opposed to just siloed—people working side by side on two different things that might be similar, and not knowing what's going on.

Mrs. Kathryn McGarry: With the comorbidities, I know that we've got other strategies across Ontario to combat some of the other chronic diseases. Do you think that this strategy could be rolled into an overall strategy to prevent chronic disease and then also have a focus on lung health?

Dr. Andrea Gershon: Absolutely. I think that not to work with other—at ICES, I work with other researchers: cardiovascular disease, cancer. I think it's very, very important.

However, I do think that people with lung disease have very unique needs, very unique medications, very unique challenges, and to not recognize those is doing them and society a great disservice, because they're not getting the help they need, they're ending up back in the emergency department and they're ending up back in hospital. It's not an efficient use of resources.

Mrs. Kathryn McGarry: Research seems to be a focus of yours, which helps us to determine on how to roll out best practices. I know that research would be a component of anybody on an advisory council because that's part of the council's work. How important is research in establishing a lung health action plan?

Dr. Andrea Gershon: I think research is huge. I think research is huge in understanding what's going on on the ground, to know what we need to do to develop those strategies—not just to develop strategies but strategies to develop—

The Chair (Mr. Peter Tabuns): I'm sorry to say you're out of time with this questioner and it's time for us to go to the official opposition: Mr. Coe.

Mr. Lorne Coe: Thank you, Chair, and, through you, thank you so much for your presentation. It was very interesting to have you take us through your presentation.

Dr. Andrea Gershon: Thank you.

Mr. Lorne Coe: At the end of the day, you believe that the passage of the bill before us is going to lead to enhanced strategies for managing asthma. Is that correct?

Dr. Andrea Gershon: Asthma and COPD and other respiratory diseases—absolutely. I think it has that potential, anyway.

Mr. Lorne Coe: Okay. On page 2 of the legislation that we're considering today, it talks about undertakings that the minister can commit to. It highlights several activities. It talks about partnerships across health care sectors, facilitating the creation of training and professional development opportunities, and it goes on to talk about improving access to early diagnosis. It ends with improving access to community and home support.

You're fine with all of what's listed there? Are there any aspects that you would think need to be added to that list?

Dr. Andrea Gershon: Oh, goodness, that's a big question. I'm sorry, I don't feel like I'm quite equipped to say. Absolutely, I do not think that's a complete list. I think there are other things that we can do. I think maybe we have to focus on some things. We can't do everything at once. I like the idea of a committee of experts getting together, and patients, and figuring out what course we should take. I really hope that research is part of that, as well.

Mr. Lorne Coe: Very well; thank you for your answer. To my colleague, please, Chair. Thank you.

The Chair (Mr. Peter Tabuns): Thank you. Ms. Martow.

Mrs. Gila Martow: I just want to say very quickly, and I think Ms. McGarry would probably agree, that patients, when they tend to have one health problem under one disciplinary group, also require the attention of other specialists. Do you have any comments in terms of your experience dealing with patients who have multiple health problems? We mentioned diabetes, we mentioned other aspects, and how to get that coordination, because we've become so specialized in health care that it's the sub and the sub and the subspecialty groups, and that makes it even more difficult.

Dr. Andrea Gershon: I couldn't agree with you more and I think that we need a holistic approach that puts the patient first and takes into account their needs. But it's interesting because you get diabetes and heart disease and a stroke and they're all put together, and then there's COPD. So you do get people with an expertise so they go to a clinic where they're getting attention for all these things, and then there's COPD. Yet we know that COPD interacts with each one of these comorbidities, exacerbates each one of these comorbidities, and is exacerbated by each of these comorbidities, so we have to start thinking of the whole patient—by the way, people with asthma as well.

This is where I think that people with respiratory disease have very unique needs and we have to think about them in the context of their overall health. I appreciate your comments.

The Chair (Mr. Peter Tabuns): And with that, I'm sorry to say we've run out of time.

Dr. Andrea Gershon: Thank you.

The Chair (Mr. Peter Tabuns): Thank you for your presentation today.

McMASTER UNIVERSITY

The Chair (Mr. Peter Tabuns): Our next presenters, then, are McMaster University. Dawn Bowdish? As you've seen, if you could introduce yourself for Hansard. You have up to 10 minutes to present and then we go to questions from the caucuses.

Dr. Dawn Bowdish: Wonderful. Thank you, Chair, Vice-Chair, committee members and Clerk for providing me the time to give this deputation on the matter of Bill 41, the Lung Health Act. My name is Dr. Dawn Bowdish. I'm the Canada Research Chair in aging and

immunity, and I'm an associate professor at McMaster University.

As your Canada Research Chair in aging and immunity, I want to point out why Bill 41 is of particular importance to an age group who I care deeply about, older adults. As I'm sure that you're aware, the percentage of those who are over 65 in our province is at the highest it has ever been, and that number will continue to rise.

Personally, I don't think of this as a negative. Older adults contribute more volunteer hours, they contribute more unpaid caregiving than any other demographic, and I personally value their contributions to our community and our province.

However, I do often hear them blamed for increasing health care costs. I'd like to point out that aging in good health costs very little. Not needing to go to a doctor when you're 70 costs just as much as not needing to go to a doctor when you're 20. However, aging with chronic diseases—and lung diseases are a major component of those chronic diseases—those are what complicate care and drive up health care costs.

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I'd like to give you some examples of how having a Lung Health Act and a dedicated lung health action plan would improve the lives of older adults and those of us who care for them.

As you've already heard, the leading cause of hospitalization in older adults is chronic obstructive pulmonary disease. We have ample data demonstrating that community-based care by respiratory therapists or respiratory health personnel, tailored apps that patients can use on their phones, and self-management strategies that can be taught to both the patients and also their caregivers reduce the frequency of emergency room visits, and yet so many of our older adults receive their primary care in the emergency room. This is not a sustainable strategy and it's not something any of us want for the older adults in our lives. Ontario needs Bill 41 in order to implement quality, evidence-based, community-based care that will decrease these hospital visits.

Another example I'd like to give you is that of lung cancer. Lung cancer kills more Ontarians every year than prostate cancer, breast cancer and colon cancer combined. Yet the percentage of research dollars specifically dedicated to lung cancer, as opposed to all the other cancers, is optimistically estimated at less than 5%. Lung health advocates consistently rank reducing the stigma of lung disease as an important component in lung health. The perception that lung cancer or other chronic lung conditions, like pulmonary fibrosis or COPD, are a smoker's disease or somehow the patient's fault means that there are fewer donations that go to non-profit organizations that do patient advocacy or patient care. There are fewer advocacy groups that lobby our major funding agencies. As a consequence, there are less research dollars specifically dedicated to lung cancer and other lung diseases.

This means that not only is there less research, but then there are fewer training opportunities for our young people, our young scientists and clinicians. At the end of the day, this ends up meaning less capacity and contributes to these unacceptable mortality rates. Let me assure you, there is no scientific reason why lung cancer should be so fatal. It's merely a training, research and opportunity based mortality. Eliminating stigma through community-led education initiatives will affect more than just the patient; it will change the research and clinical care landscape. Ontario needs Bill 41 in order to increase education, awareness and patient advocacy.

Another example and one that is certainly dear to me as I study aging is that the foundations of lung health are truly laid down in youth. Asthmatics who don't actively manage their asthma when they're young become very challenging to treat as they grow older because their medications are now less effective. My respirologist colleagues find that caring for older asthmatics who have comorbidities like we've heard about—cardiovascular disease, depression, obesity—is particularly challenging, because we don't understand how those diseases work together to complicate asthma and we don't understand how the medications work together to complicate or reduce the efficacy.

So one important investment in lung health in old age is never smoking or smoking cessation. Smoking cessation at any age will improve complications down the road. However, the earlier you begin smoking cessation, the greater the impact is going to be. A recent study has demonstrated that smoking cessation programs that begin during unrelated hospital stays are particularly effective. Others have found that strategies that are tailored to specific groups, like youth or aboriginal populations, and are delivered by members of those same groups are also particularly effective.

Many, many studies have shown that community-based respiratory health professionals are more effective and less expensive avenues for helping patients manage their asthma. If we had a lung health advisory council that could draw on the expertise of the greater than 40 members of the Ontario Lung Health Alliance, we would get good advice on the best practices to prevent costs now and in the future. Ontario needs Bill 41 to draw on the expertise of stakeholders, from patients to professionals, to implement the most effective strategies in patient care.

My own research is on respiratory infections such as pneumonia in older adults. You're probably not aware that getting pneumonia in mid to late life can actually accelerate or exacerbate other seemingly unrelated conditions, especially dementia and cardiovascular disease. In fact, physicians often think of pneumonia as the slippery slope that's the beginning of the loss of independence and reduced quality of life. Diagnosing respiratory infections like pneumonia is particularly challenging with people who have pre-existing lung disease or other comorbidities. This contributes to antibiotic misuse and antibiotic resistance.

Preventing lung infections by better vaccination programs and better diagnosis will provide more years of

healthy, independent living. This is completely consistent with Ontario's Action Plan for Seniors.

Although I can, if pressed or if writing a grant, provide you with ample statistics about the economic benefits of preventing lung infections in older adults, my guess is that this is something that we—because we are not burdened with anyone who is too young at this table—are collectively and intuitively aware of. We all know the challenges of dealing with the older adults in our lives. Many baby boomers are unpaid caregivers. They are caring both for their parents, who are in their twilight years, but also their grandchildren. This unpaid care is a major contribution to Ontario families and our province's economy. Keeping the over-50 crowd healthy—which is my mandate—with a directed lung health action plan will mean that many Ontario families, including my own, can breathe a little easier.

I'd like to bring up one more point for you to consider. Ontario is a major research hub for lung research, despite the fact that this is a chronically underfunded disease. Our university hospitals in Toronto, Ottawa, London and, of course, Hamilton, where I'm from, have actually led the world in the treatment of asthma, diagnosis of rare diseases and creating evidence-based practices for improving clinical care. In fact, there are a number of very exciting new initiatives at our university hospitals that have the potential to make Ontario the premier centre for clinical trials in lung health.

As you know, health care is a major economic growth industry. The creation of a lung health action plan and coordinated, directed research that brings together the incredible intellectual resources we already have in this province would put us on the map as the best place to do research and help us retain the highly skilled young scientists, clinicians and health care workers who we invest so much in.

Ontario needs Bill 41 to make Ontario the world leader in respiratory health and respiratory care. As your Canada Research Chair in Aging and Immunity, as a researcher, a scientist and someone who has older adults in my life whom I care deeply for, I am in full support of Bill 41. I look forward to having a plan on the table that addresses some of the cracks that older adults fall through, and I look forward to continuing to work with the Ontario Lung Health Alliance and dedicated politicians and stakeholders to improve the lives of Ontarians today and tomorrow.

Thank you very much for your time and your consideration.

The Chair (Mr. Peter Tabuns): Thank you very much. We go first to the government. Mr. Dhillon.

Mr. Vic Dhillon: Thank you, Ms. Bowdish, for your presentation to the committee this afternoon. We know people are living much longer and therefore they'll need more health care, and that the people who are using our health care system the most have chronic conditions. Can you explain how research in immunology can help the top users of our health care system and how we can keep people out of the hospitals?

Dr. Dawn Bowdish: Absolutely. As someone who studies infectious disease, I have a strong mandate to keep people out of the hospitals. That's one of the best things we can do to reduce infectious disease in older adults.

Aging in good health costs as little as being young and in good health, but it is, in fact, chronic diseases. What tends to happen—and we've heard from Dr. Gershon—is that these chronic diseases tend to travel in pairs. You don't just get asthma, you get asthma and depression; you don't just get COPD, you get COPD and heart disease. It's those users who have an unfortunate number of these comorbidities that tend to be the most challenging to deal with, because, again, we don't understand medication interactions and we don't understand how they compound each other.

There are a few things we need to do: prevention, and there are simple preventive strategies we can use; management, so people who are taught to manage their asthma or their COPD stay out of hospital for longer and they have fewer of these complications; and there is a certain degree of research. We seem to see that there are some individuals who, despite best efforts, seem to be on a poor aging trajectory. Some of the research that is coming out of my lab and others has shown that we may be able to intervene once we identify those people. That's a long-term research goal, to keep older adults healthier for longer. What we all want for all of the older adults in our lives is a long, healthy life and very little time living unwell.

Mr. Vic Dhillon: Thank you for your answer. Can you explain briefly how pathogenic microorganisms affect us so much, especially when we're talking about our lungs?

Dr. Dawn Bowdish: One of the things that people are often most surprised about is that one of the major things you can do to keep yourself healthy as an older adult is to stay away from small children. And yet, one of the best things you can do for your cognition and keeping active is to be involved in your grandchildren's lives.

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One of the things that people don't understand is that having good vaccination programs for children for influenza and pneumonia is actually more efficacious sometimes than vaccinating older adults. Having targeted vaccination strategies for children and health care workers and those who care for older adults is oftentimes more efficacious than vaccinating the older adults themselves.

These are the sorts of coordinated, thoughtful, intelligent, evidence-based strategies that we need to rely on our respiratory health alliances to develop for us.

Mr. Vic Dhillon: Thank you very much for your answers.

The Chair (Mr. Peter Tabuns): We go to the official opposition. Ms. Martow?

Mrs. Gila Martow: Thank you very much for coming in. I want to address a couple of the things you said. One is, my late mother, who never could light a match, never

did light a match, never lived or worked with anybody who smoked, died of lung cancer. I think that people have a hard time understanding that. A lot of times, in fact, people don't believe me when I tell them that. I think we definitely need a lot more public awareness in that regard. I'm fairly certain you'll agree with me on that.

Dr. Dawn Bowdish: Absolutely.

Mrs. Gila Martow: In terms of vaccinations—and I'm so glad that the member opposite got you to bring that up. That is a real challenge for us, as members of provincial Parliament, when people come to us to notarize those forms saying that they don't want to vaccinate their children. There are some of my colleagues who refuse to notarize those forms, even though it doesn't mean you're agreeing with them, but they just don't want to be a party to that. Then there are colleagues who just sign it and don't discuss it.

My compromise has been to spend 10 minutes—I'll sign it for you; you don't have to pay a lawyer, but you need to give me 10 minutes. Part of those 10 minutes is that there are people who are elderly and immunocompromised individuals who are ill or elderly as well. There are people who can't be vaccinated and children, for all kinds of challenging reasons, who can't be vaccinated. You're not vaccinating your child just to protect your child. It is a community that we live in together and sometimes we do things to protect other people. I think it's a big, big challenge for health care providers to educate people. We're hearing in BC this week that there's been an outbreak of mumps.

What would you advise, in terms of the task force having people on there who have expertise in these kinds of challenges? What would you see?

Dr. Dawn Bowdish: There's actually very interesting literature on how to approach people who are antivaccine. One of the first things you ask is, "What are your particular concerns?" and not making assumptions about what their concerns are. I agree with you completely that sometimes the most evocative argument is that you're not doing it for yourself; you're not even doing it for your children. You're doing it for someone who's on cancer therapy and essentially has no immune system.

My own children were forbidden to see their uncle when he was on cancer immunotherapy because it's known that they carry infectious disease that he would have been particularly prone to.

You're doing it to protect the older adults in your life. You're doing it to protect those who don't. So I think having that conversation is one that tends to be particularly evocative.

And then there's having really skilled health care providers who can answer whatever the particular concerns are that are stopping it. One of the examples I always give is that I've been in many a research study and I have had influenza many years where I wasn't obviously sick. So even though I wasn't sick, I was still transmitting, and that's an important argument people need to know.

The Chair (Mr. Peter Tabuns): I'm sorry to say, with that, you're out of time. We go to Madame Gélinas.

M^me^ France Gélinas: I loved your presentation. Thank you so much for coming. I think putting a lens on older adults was something very worthwhile this afternoon. You did say something that piqued my interest to no end here, that there is no reason for lung cancer to be so deadly. Could you repeat that and explain it to me?

Dr. Dawn Bowdish: Yes. One of the reasons we have a hard time diagnosing lung cancer is that we don't have pain receptors in our lungs, so you can have a huge tumour and you won't feel it. That is a major issue. Diagnosis is absolutely an issue.

Having said that, though, the lung is actually a fairly easy place to access. If we inject a therapeutic, it goes to the lung first. We should be able to do surgery in the lungs. Many of the novel immunotherapeutics that are in trials at my own university, at McMaster, and other places are actually predicted to be particularly efficacious on lung cancer. However, they can't find the research dollars to actually get a cohort of lung cancer patients.

Scientifically, lung cancer in some ways, one would predict, would be less challenging than breast cancer, colon cancer or prostate cancer, and yet without the research dollars just to try some of these therapies or target them—those trials aren't happening. I would predict that if we had a concerted research focus to really tackle this, I bet we would make pretty spectacular progress pretty quickly.

M^me^ France Gélinas: I get it. My second one is that you went on to say that people with COPD often receive their primary care in emergency rooms because education in the community and the whole bunch does not happen. I take it that you brought this forward because you are hopeful that once we have the lung health advisory council, things will change for the better. I agree with you that it has to change for the better. How did we get there? Why is it that we don't do this already?

Dr. Dawn Bowdish: In my city, Hamilton, we have major economic disparities. It has been shown again and again that people of higher socioeconomic status will access health care in a way that people of lower socioeconomic status won't. Unfortunately, especially for people who have complicated care, maybe don't have a good primary physician—maybe they have got a diagnosis, maybe they haven't—they go to the emergency room again and again, and without good follow-through and without good community care, they come back to the emergency room.

Getting educators into the community has been shown again and again to be an efficacious way of especially dealing with people with challenges to accessing health care. Unfortunately, socioeconomic status is one of those challenges. I am extremely hopeful that increasing community-based care, respiratory therapists will help, especially those who are the most vulnerable.

M^me^ France Gélinas: A previous deputant was talking about having one in every sub-LHIN. Would that work for the area that you come from?

The Chair (Mr. Peter Tabuns): I'm sorry to say that you're out of time. Thank you.

Dr. Dawn Bowdish: Thank you very much.

The Chair (Mr. Peter Tabuns): Thank you for your presentation today.

CANADIAN ASSOCIATION OF RADON SCIENTISTS AND TECHNOLOGISTS

The Chair (Mr. Peter Tabuns): We go on then to the Canadian Association of Radon Scientists and Technologists, Mr. Bob Wood.

Mr. Wood, as you've seen, I'm sure, please introduce yourself for Hansard when you have a seat, and then you have up to 10 minutes to present.

Mr. Bob Wood: Hi. For those of you who don't know me already, I'm Bob Wood. I'm past president of the Canadian Association of Radon Scientists and Technologists.

To the Chair, Vice-Chair, committee members and Clerk, I thank you for providing me the time to give a deputation today on the matter of Bill 41, the Lung Health Act.

I'd also like to recognize a member of the committee, my own MPP, Granville Anderson.

Simply, I urge you to bring forward Bill 41 for third reading and royal assent. I'm obviously in support of this. I'd really like to talk about three things—why Bill 41 is essential, my own story, and a few statistics—before I get to a conclusion.

Of the four chronic diseases responsible for 79% of deaths—cancers, cardiovascular diseases, lung disease and diabetes—lung disease is the only one without a dedicated plan in the province.

I sit before you as a plumber who worked in construction all over the city, all over this province. I can't imagine building a building without a plan, without specific details of how things were going to go together, and then having inspections along the way. How are we running lung health care without a plan? It's just mindboggling to me. Maybe I'm looking at this from too simple a perspective, but it's mindboggling to me that you can do health care without a plan that looks at all of these parts.

I have just been so impressed with other deputants and the detail they've been able to bring forward. I hope I can bring it back to maybe a more general level.

Bill 41 proposes establishing a lung health advisory council to make recommendations to the Minister of Health and Long-Term Care on lung health issues and requiring the minister to develop and implement a lung health action plan respecting research, prevention, diagnosis and treatment of lung disease.

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As a business owner, this is just simply good planning and strategic implementation. Nine out of 10 Ontario voters in the 2014 provincial election said that lung health should be a priority. You guys are all politicians sitting around the table. I think you need to pay attention, and your parties need to pay attention. It sounds like they have been.

One in five Ontarians—2.4 million people—are living with serious lung disease. This number is projected to rise to 3.6 million over the next 30 years. This statistic jumps out at me as simply being a huge part of the population that is living with the stigma. I'm going to talk more about stigma in a few minutes.

My story: I stand before you—or I sit before you; I said "stand," but I'm sitting before you—as a well-controlled asthmatic and as someone who lost their mom to cancer. Hers was breast cancer that ended up metastasizing to her lung. Thanks to the medical community, we got six great years with my mom. She got to see me married, and she got to see her grandsons—Andrew and my nephew Alex. Unfortunately, she never got to meet Kyle, my youngest son, who passed away this year.

We spent that last year with Mom, helplessly watching a vibrant, beautiful woman deteriorate into someone who was bedridden and could hardly breathe before we lost her.

You may not realize this, sitting in this room, but lung issues come with a stigma from the general populace. When a kid is having an asthma attack, the parents didn't do something right: There's a cat in the house, or they live with a maple tree out front. For some weird reason, with a lung issue, people blame people who are closest to that person or that person themselves. That person must have been a smoker. If you have a heart attack, does anybody blame you? But if you have COPD, it's your fault. I don't know how to change that stigma. There's a whole bunch of brighter minds than me that have come up and sat in front of you and talked today.

The stigma of self-blame does not go well with the fighter spirit that is required—in my opinion, it's the number one cause of survival from a significant major disease, that fighter spirit. I saw my mom fight that cancer, and boy, she won it for a number of years.

The way I lost my mom was why I ended up in the radon industry. Some of you know me as Mr. Radon. I swore that if there was anything I could do to stop another family going through the loss of a loved one, I would do it. Then radon came into my life.

Radon is only one part of this lung issue, but it's a really ignored part from my perspective. I may be a one-trick pony—that's okay. That's the pony I know. Radon is the number one environmental cause of cancer death. I'm going to say that again: Radon is the number one environmental cause of cancer death. Public Health Ontario has estimated that 3.6% of lung cancer deaths—sorry, 13.6%; let me get my numbers right—in Ontario are attributable to radon. That represents 847 people every year. They die of radon-caused lung cancer.

The part that really gets me about this is that we know how to test for radon and we know how to economically fix it. Radon is never an issue within a house or within a building that we don't know how to fix. Yet it doesn't seem to get—800 people a year? Come on!

I bet you if you went into health and long-term care and asked them how they tested for radon, they wouldn't

know. I know that many of you people do because many of you people have received a kit.

The Ontario Lung Association, who has been my greatest partner in the last two years, has recognized radon awareness and testing as the number one priority in the health promotion pillar of Ontario's Health Action Plan. They have been an awesome partner. We have gotten some incredible things done.

Radon gas exposure touches many ministries other than just the health industry. Ontario Lung Association and CARST working together have made inroads into getting things changed under the Ministry of Municipal Affairs and Housing.

I am so sorry today to hear that we have lost Ted McMeekin as a partner, but I'm sure that it has moved far enough ahead that we will continue to gain ground in those areas.

We've gained ground at looking at ground contact apartments—there's a Residential Tenancies Act position out there for public review—and in the Ontario Building Code under the Ministry of Municipal Affairs. The Ministry of Labour is under review right now for looking at radon in the workplace. It has been a great year, but there is so much more to do.

Let me compare quickly another couple of statistics: If we look at the annual report for 2014 for road safety, there were 481 people killed. Have you seen an awareness campaign from the MTO? I have.

Let me go quickly to some other statistics—

The Chair (Mr. Peter Tabuns): Mr. Wood, I'm sorry to say that we have to move on.

Mr. Bob Wood: Questions. I apologize.

The Chair (Mr. Peter Tabuns): No, nothing to apologize for.

We'll go first to the official opposition: Ms. Martow.

Mrs. Gila Martow: If you could just wrap up, because they got you quite in the middle there.

Mr. Bob Wood: Okay. There is a number of other things that are really small numbers, like carbon monoxide—11 deaths per year.

Mrs. Gila Martow: Basically, what you're saying—and I understand—is that small numbers of deaths seem to get the press. What I would say to you is that the problem, as many of us here see it all the time, is that you have your sexy diseases and your sexy causes. It's just like fashion and it's just like what toy is in. It doesn't always make sense.

But sometimes we all have to collectively put our heads together, and I think that's what this bill is trying to address: to get the teamwork together, but to also get the public awareness and to put people who are aware together. Hopefully, we're going to see some people with some good skills in marketing and PR work.

We saw that with Lou Gehrig's disease, which I would say probably was the least sexy disease on people's radar, it went to number one, from one of the bottom to one of the top. Why? Because somebody came up with the Ice Bucket Challenge. It was funny and it was entertaining. It wasn't just about supporting a great cause; it was about the entertainment aspect of it.

It's hard to see anything entertaining about any disease, but unfortunately, that's the world we live in. People are very aware of heartbreak and almost everybody has a story of heartbreak to tell. I apologize. I'm on committee with people, and they have to hear my same stories every time. But we all have those stories and we all have that heartbreak, but at the end of the day, we know that we're here for a good time, not a long time—and to try to focus on that.

I really think that's what you came in to say, and maybe you have a few more words you want to add on that regard.

Mr. Bob Wood: I think that this bill will solve part of that awareness problem.

Mrs. Gila Martow: Great. I really appreciate your passion and I'm so glad that you came in, because we've had a lot of very serious researchers with heavy stuff and you explained why they're so passionate about their work. Thank you so much.

Mr. Bob Wood: Thank you.

The Chair (Mr. Peter Tabuns): Madame Gélinas.

M^me^ France Gélinas: Nice to see you, Mr. Wood.

Mr. Bob Wood: A pleasure.

M^me^ France Gélinas: I will start by telling you that in my basement, on a little shelf about six or seven feet from the floor, there's this little wee thing with a tab on it with a date. I decided to keep it for a year, so it won't be until December until I mail it. I have my little envelope, and it's ready to go. Just so you know: You convinced me.

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That being said, I represent the riding of Nickel Belt, and the member from Sudbury will tell you the same thing: There are lots of older houses in Sudbury and Nickel Belt that are built on rock. We are the foundation of the Canadian Shield, and lots of people have rock in their basement. I'm one of them. We know full well that the risk of radon increases because it's a natural gas and all of this that goes with it, plus we live on top of big, big mines that shake up our city on a regular basis, which increases the risk.

Then we start to look at why Sudbury's lung cancer rate is so high. Nobody ever talked about, sure, we have a 28% smoking rate—we know that half of those people will die because they smoke—but we also have a perfect storm for a lot of people to be exposed to radon.

Our health unit has done a bit of very good work within the measly resources we allocate to health units to do great work. We've had part of our community—the community of Copper Cliff, if anybody knows Sudbury—where there have been quite a few homes where people went door to door and gave them radon kits so we could see if there was radon in their basements. Even the ones that came back with radon were so easy to fix. It was like, "How come we did not do this way before?"

The question to you—and if you're not comfortable, you don't have to answer it—is, how come we're not doing this now? When we know there is such a high risk of such a deadly disease—the last presenter gave me

hope, but at this point it is still a very deadly disease—how come we're not doing more?

Mr. Bob Wood: I'm not sure why there's not more being done, other than the focus. Again, we seem to get this focus thing that goes this way and goes that way. Radon is unfortunate, in that you can't see it, you can't smell it and you can't taste it. I don't know about your life, but my life is probably a little simpler, and I forget to pick up the milk and bread on the way home, because it's not sitting there right on my forehead.

M^me^ France Gélinas: And our house, garbage is Tuesday morning. We have a tough time with that.

Mr. Bob Wood: I can only say that I believe this bill will drive that ability for us to get more awareness, more people testing and more people out of that loop because they've tested. Hopefully, most of them test low, like I hope you test low. But if they test high, then they can do something about it.

The Chair (Mr. Peter Tabuns): With that, we're out of time. We go to the government. Mr. Thibeault.

Mr. Glenn Thibeault: Thank you for being here today, Mr. Wood. The Canadian Association of Radon Scientists and Technologists sounds very Star Trekky and very cool, but when you actually start hearing about radon—I know, as my colleague from Nickel Belt mentioned, that more and more people have started talking about it. You've been doing a good job of making sure that people are aware of radon and the effects of it.

I also want to thank you for sharing your story. It's important for us, as politicians, to be able to take that and understand the personal effects.

I lost my dad last summer. He was 101; 56 when I was born. He had lung cancer and had his upper lobe taken out when he was 72. He almost made it 30 years—29½—before it got to him. But it really emphasizes some of the things you were talking about and our support of the goals and intentions of our Lung Health Action Plan.

I think we've done that through our investments in the asthma program, the Smoke-Free Ontario Strategy, the Telehomecare expansion program for COPD, My CancerIQ and other assistive devices programs. So there's a lot going on; there's a lot that we're doing. Some of the things you highlighted—there is always more to do.

I was interested in what you were saying about how Bill 41 can address radon, but how this bill can be used to coordinate activities across ministries. You talked about that and said there's more to do. Maybe with that, I'll give you my time to follow up.

Mr. Bob Wood: We have very much felt siloed in trying to bring out the radon message. The radon message has moved from us, through the lung association, to those people where we could, generally, find a way to get into their office to talk about it. I think that partnership has been really great for us to drive that message into government, but there are other areas we get a larger resistance from in getting that message out. Having a council that is created, it is an issue that we will drive easier into those other governments and other departments, and then be able to reasonably make those appointments and get those things done in different ministries to make it a priority within those.

Mr. Glenn Thibeault: Great. How much time do I have, Chair?

The Chair (Mr. Peter Tabuns): Ten seconds.

Mr. Glenn Thibeault: Thank you for your time.

Mr. Bob Wood: Thank you very much for your time.

The Chair (Mr. Peter Tabuns): Well put. Thank you very much, Mr. Wood.

ONTARIO THORACIC SOCIETY

The Chair (Mr. Peter Tabuns): Our next presenter is on the line from the Ontario Thoracic Society: George Chandy. Mr. Chandy, I'm Peter Tabuns. I'm the Chair of the committee. With us are Lorne Coe and Gila Martow from the opposition; France Gélinas from the third party; and from the government, Marie-France Lalonde, Glenn Thibeault, Vic Dhillon and Granville Anderson.

You have up to 10 minutes to present, and at the end of that time we'll go to questions. If you would introduce yourself for Hansard.

Dr. George Chandy: Hello. Thank you very much for the opportunity to present a few points here. It's an honour to have these 10 minutes. I fully recognize that the members of the committee have probably been sitting there for the last three hours listening to many people, so I'll try to make my talk, which is closer to the end of your time period, more succinct and focused on a few points.

I thought I'd first introduce myself. My name is George Chandy. I'm the chair of the Ontario Thoracic Society, which is the professional society for both adult and pediatric respirologists in Ontario. I'm an assistant professor at the University of Ottawa, focusing on pulmonary disease or lung medicine.

My clinical practice—I'm primarily what is known as a clinician teacher. My responsibilities involve taking care of patients primarily, as well as the education and mentorship of trainees, from the medical student to the subspecialty fellow level. My areas of practice primarily involve subspecialty areas in pulmonary hypertension, which is a very rare and deadly illness, as well as sleep medicine, which is also deadly but far more common, which I'll speak about again in a second. In addition, I take care of general respirology patients.

My practice is primarily based out of Ottawa, Ontario. However, along with a colleague of mine, I help coordinate sleep medicine care—that's the care of patients with sleep problems such as narcolepsy, obstructive sleep apnea and insomnia—in an area of northern Ontario. We're focused out of Timmins, Ontario, but we take care of patients all the way north via Telehealth. So we take care of patients directly in Timmins with on-site visits, but through Telehealth for most of northern Ontario, outside of North Bay and Sudbury. So that's just a bit of background in terms of myself.

I just wanted to focus on three or four different points. First of all, the act that is being brought before you today,

the Lung Health Act, is very important to give due consideration to. I have to reflect upon the fact that we do invest in both lung health and medicine in Ontario reasonably well. However, there are deficits in certain areas that could be improved upon—deficits with respect to a focus on death prevention, diagnosis and treatment, as well as the coordination of care, as many of the needs of patients do not always fall under one silo, and therefore improved coordination will benefit patients and could certainly be improved upon by this act.

In terms of prevention, if we just reflect upon the factors which contribute to lung problems generally all over the world, but particularly in Ontario, these include smoke exposure, both first- and second-hand, air quality, radon exposure, and, interestingly, weight as well. Weight is the primary contributor to obstructive sleep apnea, which is a very prevalent disease.

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What is interesting is that it's always a tragedy when someone develops a disease, has personal and professional costs associated with this disease and may well have a death associated with the disease. But it's a double tragedy when that disease could have been prevented by factors that are within society's control. If we just reflect back, we have done very well in Canada on improving exposure to asbestos, although even now a lot more work needs to be done there. We've done very well in terms of decreasing smoking rates, although there is still work to be done. So prevention is really key in lung disease.

Secondly, diagnosis: Many lung diseases are actually underdiagnosed. These particularly include COPD and obstructive sleep apnea. It is thought that the majority of patients with these diagnoses are actually out there undiagnosed, suffering from symptoms that limit their quality of life and will eventually limit how long they live.

Thirdly, treatment: Patients with all of these diseases can have access to excellent therapies, which are already out there. Most of these therapies improve one's quality of life tremendously and may help one live longer or save a life if caught early enough.

These are the main factors I wanted to elaborate on in my conversation here, because I feel that one thing that is missing in lung health is coordinated action.

Lung health does not have the sexy appeal of certain other areas of medicine like, let's say, cancer in general or cardiac care. I feel that the Lung Health Act will help enforce a coordinated view on lung health and help well-meaning individuals working in the bureaucracy change the way patients flow through the system, and allow them to access needed care in areas that are not necessarily in one silo—for example, rehabilitation, access to assisted care in the community, etc.—as well as bring an awareness and, hopefully, funding to improve both diagnosis and prevention of these diseases.

Those were the main points I wanted to elaborate. I want to leave time for questions from the committee.

The Chair (Mr. Peter Tabuns): Thank you, Mr. Chandy. I'll go first to France Gélinas.

M^me^ France Gélinas: Thank you so much for your presentation, Dr. Chandy, and for focusing on key points.

I will go back on some of your key points, the first one being that you really put the emphasis on coordinated action on lung health. I just wanted you to drill down a little bit: Do we already have good action out there, but we need coordination, or is it because it's geographically located and not available to all? From where you see the health care system, where are we?

Dr. George Chandy: This is a difficult question to answer directly in a place like Ontario, because we're geographically very diverse, unlike smaller places like Holland, where you could give a simple answer. In Ontario, there are several issues to address.

First of all, for sure there are geographical issues. Let me give you an example. In Ottawa, where I live, if I had a patient eight years ago with a lung nodule—concern for lung cancer—what I would have done, as a lung specialist who might not take care of a lot of patients with lung cancers, is figure out a way to coordinate the care of that patient, obtain a lung biopsy, obtain referrals to specialists and filter them through the system. Today in Ottawa, what happens is that all patients with lung nodules, such as I mentioned, go into a centralized system where they're immediately triaged by a group of specialists who focus on evaluation of lung nodules. The advantage of this is that patients have access to the people they really need to see faster, they have access to tests faster. One of the advantages of such a system is that you have people with specific expertise who can sort out who really needs to be investigated or not, you have fewer unnecessary tests, and the tests that you do carry out need to be repeated less often and patients just get to the end quicker.

Let's contrast that to a patient who might cross my path when I'm in northern Ontario. That access is simply not there. So I guess the first point to make is that we clearly have an inequity of access to care across Ontario, and that is in large part geographically based. I don't want to sound naïve: When you're in a small town in an isolated part of northern Ontario, one is never going to have as good access as in downtown Toronto and Ottawa. But my point is that through coordination of this, our system could be far better for those patients.

But it's not just the coordination of care. Access to testing for those patients when they get referred is often delayed, and there are often longer waiting times than what we would consider acceptable. At the end of the day, unfortunately, health costs money and funding is important to focus upon in order to improve access to care. It's not simply an issue of coordination, and I didn't mean it to sound like it was simply that, but that's an important factor to consider in the implementation of this lung health care act.

The Chair (Mr. Peter Tabuns): I'm sorry to say that, with that we've run out of time for this questioner. We go to the government party. Mr. Thibeault.

Mr. Glenn Thibeault: Dr. Chandy, thanks again for your presentation and the information. It's very informa-

tive, I know, for all of the members sitting around this table.

There are a couple of things that I'd like your comment on. I think through the efforts of the Ontario Lung Association, many organizations are coming together to share resources, expertise and knowledge. I know that the ministry has engaged with these organizations as we've moved on a number of initiatives, but I think what you're saying is that there's always more to do. I'm looking first for some comment on that.

The second thing, as a doctor in Ottawa and the hospitals in Ottawa, maybe some further information on what you're seeing in our hospitals in respect to the types of lung disease that people are coming in with, how it affects their overall health and some of the costs associated with dealing with people who have lung disease.

I know our time is short so I'll leave it with that for your comments, sir. Thank you.

Dr. George Chandy: Sure. Can I just ask you to repeat the first question there?

Mr. Glenn Thibeault: Pardon?

Dr. George Chandy: The phone line just faded out. What was the first question there?

Mr. Glenn Thibeault: Oh, I was just talking about how the ministry has been working in conjunction with the Ontario Lung Association to come together on sharing resources, expertise and knowledge. I know you've been saying that you'd like to see some more coordinated action, so just a comment on some of that, and then the second piece as well, if we have time for that.

Dr. George Chandy: Absolutely. Firstly, you had mentioned that work is being done but more needs to be done—absolutely. Let me just illustrate that in terms of diagnosis: For example, it is estimated that 90% of patients with obstructive sleep apnea—which is a significant cause for cardiovascular complications like heart attack and stroke as well as motor vehicle accidents, as it can potentially make one sleepy when driving—are undiagnosed. Access to expert assessment as well as testing is important. A similar pattern is noted for other diseases, such as COPD.

To address your second question—and it's a very important point—what do we see in our hospitals these days? Well, the problem is that when someone has already had exposure to cigarette smoke, there are irreversible changes, as you know, for example, when one develops emphysema. The best of our medications help improve lung function a bit, help improve quality of life quite a bit more, but one can often nonetheless be left with a significant disability, which leads to increased hospitalization. So we end up seeing, as time is progressing—even in my very brief career—a bigger and bigger cohort of sicker and sicker patients who often need more assistance in the communities. And this is not just in lung medicine, of course; it's in other areas of medicine as well. We see—

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The Chair (Mr. Peter Tabuns): I'm sorry to say that with that, we've come to the end of your time with this questioner. We go to the official opposition: Mr. Coe.

Mr. Lorne Coe: Thank you, sir, for your commentary and narrative thus far. My question centres on the provincial action plan, which is part of the legislation, as you know. I'd be interested in your comments about what components you think should form the evaluative section of that plan.

Dr. George Chandy: By evaluative, do you mean diagnostic assessment of patients?

Mr. Lorne Coe: I didn't quite hear you; I'm sorry.

Dr. George Chandy: By evaluative, did you mean for diagnosis of patients?

Mr. Lorne Coe: Yes.

Dr. George Chandy: Very good. You can't treat the disease, obviously, until you've diagnosed it. Most of the diseases I've discussed have very cheap diagnostic methods. The problem is that these methods are available in abundance in big cities, but they're not in smaller communities. This needs to be improved upon.

Ironically, unfortunately, smoking rates are often even higher in these cities as well. So the burden of disease is greater, and we just do not have access as one would in Toronto or Ottawa.

Mr. Lorne Coe: Thank you for your answer.

Chair, to my colleague, please. Thank you.

The Chair (Mr. Peter Tabuns): Ms. Martow.

Mrs. Gila Martow: Hi. I just want to repeat what you said: "Health costs money." I think that's kind of the challenge that we see here. We have new treatments all the time and patients live longer and all of that eats up valuable health care dollars, so it's so important that we prioritize those health care dollars.

Do you have any comments on how to better prioritize health care spending in terms of greater health for lung patients?

Dr. George Chandy: That's a very good question. I mean, this is almost the main question in our era right now. What I would say is that prevention is the best place where we can put our dollars. However, when we have sick people—the patients I see in clinic already have disease. We need to have the ability to diagnose them and treat them with modern therapies. Often, one can do this most appropriately, most effectively and for the least cost if such care is coordinated in a system where people are relatively specialized in taking care of that area, or if a community has a specialized plan for taking care of those patients—a system in which tests are not duplicated.

Ultimately, it is true that medications and treatments cost money, but this, in my view, should be a focus for a society that has a willingness and interest in taking care of those of us who have the greatest need.

The Chair (Mr. Peter Tabuns): And with that, I'm sorry to say that we've run out of time. Thank you very much for your presentation today and answering questions.

CAMBRIDGE MEMORIAL HOSPITAL

The Chair (Mr. Peter Tabuns): We'll go on to our next witness. From Cambridge Memorial Hospital:

Loretta McCormick. Ms. McCormick, thank you for your patience. As you're well aware, it would be very useful if you'd introduce yourself for Hansard. You have up to 10 minutes and then we'll go to questions.

Ms. Loretta McCormick: Great. Thank you. Chair, Vice-Chair, committee members, Clerk, thank you for providing me time to give a deputation today on the matter of Bill 41, Lung Health Act.

My name is Loretta McCormick and I'm a primary health care nurse practitioner and a doctoral student at University of Western Ontario. I work in a specialized, hospital-based outpatient clinic at Cambridge Memorial Hospital with individuals with COPD. I work with respirologists Dr. Christine Macie, Dr. George Mathai and Dr. Ali Rashad.

I support Bill 41 because of its passion for helping Ontarians with lung health concerns specifically related to individuals similar to the ones I see every day in clinic.

In 1994, Dr. Barry Make wrote that collaborative self-management as a framework for the delivery of care to individuals with respiratory illness would require four components. These four components are provider and patient partnership, mutual goals, instruction and monitoring.

Dr. Make's components have become the foundation of my doctoral work in COPD. Each day in clinic, I see patients for consultation to partner and develop goals, provide education and monitor their progress. I teach patients about the mechanics of respiration. I show patients their breathing test results and sometimes review through drawings what that means. I explain the trajectory of the illness and how that path can be altered through lifestyle choices, medications and awareness. I explain the medications and demonstrate their use. I applaud the efforts of my patients to adopt self-management strategies and encourage patients to continue.

I ask patients if this information is helpful and I ask them what their goal of care is. One person might tell me that they would like to be able to go shopping again with their daughter, ride a bicycle with a grandson, travel to see family, return to work, cover the cost of medication or simply ride a bus. I arrange transit, accessible parking permits, and compassionate-grounds medication coverage, refer patients to specialists and kinesiology colleagues, and educate, educate, educate.

I have learned that COPD is a complex respiratory disease that looks like so many other things. COPD can be mixed up with heart failure, cancer, anemia and advancing age. COPD also has comorbid illnesses, including depression and osteoporosis, to name two.

When patients come to see me for the first time, they bring their medications, including all of their inhalers, to clinic. Some bring prescriptions that have not been filled; others bring medications—many medications. They describe how they don't know how to use the medication or how the medication works, and either do not take them or, in some cases, take whichever inhaler they happen to reach for when they're breathless. Patients do want to self-manage. They just need the tools to support them. Each patient is an individual with a story and each patient wants to not be breathless.

Bill 41 sets the stage for a much-needed structure on which to build a coordinated approach to the delivery of care for individuals with COPD. COPD is debilitating and insidious. It is a thief. It robs individuals of function, slowly limits their social activity and, in doing so, reduces their quality of life. COPD increases their dependence on others and affects their self-concept.

Hospitals are in the acute care business but also, and simultaneously in fact, hospitals are in the chronic care business. Chronic conditions flare and require emergent medical care and, as we've heard, COPD ranks top in hospitalization and readmission rates. Literature supports how many times COPD is actually diagnosed in the emergency department or ICU when the individual patient presents in acute distress. Bedside hospital nurses provide education, support, reassurance and health care.

Bill 41 provides for a top-down and bottom-up approach to the delivery of health care for individuals with lung health issues through educating the professionals providing the care. Bill 41 has many strengths. It aligns nicely with the National Lung Health Framework. It contains encouraging recommendations such as 5(c) and 5(d), the facilitation of training and professional development for health care professionals, and improved access to maintenance services for individuals.

I find this particularly helpful to my work with my hospital colleagues. I will host educational formats for hospital staff, open houses on World COPD Day, and lunch-and-learn sessions. I also host students from family practice and nurse practitioner programs, internationally educated nurses, registered nurses, and registered practical nurse programs.

I started my doctoral journey because I wanted to know how individuals with COPD understand the concept of partnership and I wanted to know who was educating the educators. I was naive enough to think I had an original thought: co-management and real partnership. Individuals with lung disease need co-managed care from educated, specialized care providers. The need is for education: Educate the patient and educate the provider to provide this co-managed care.

I support Bill 41 because it provides for the establishment of an advisory council to make recommendations. I love what I do, but I do see the human and economic burden of COPD and I know that Bill 41 is a very important first step to helping Ontarians living with lung disease. Thank you.

The Chair (Mr. Peter Tabuns): Thank you very much. Our first question goes to the government: Ms. McGarry.

1730

Mrs. Kathryn McGarry: Thank you very much, Loretta, for coming in. It was an absolute pleasure to have somebody here from my home riding of Cambridge in an institution I spent many years as a critical care nurse in, and that included a lot of time spent with Drs. Macie and Mathai. So I very much appreciate you

coming in. I had the opportunity of actually touring the COPD clinic fairly recently. I really appreciate the support.

Can you talk more about the clinic in terms of assisting in diagnosing, which is key, prevention, delaying worsening COPD symptoms and how you educate your patients?

Ms. Loretta McCormick: The COPD clinic is me and three respirologists who work with me closely, who also do ICU coverage and sleep study coverage. What happens in the COPD clinic is that as a nurse practitioner, I can order tests, I can write prescriptions and I can refer to specialists. So I can cover them on that kind of scale. I sometimes get patients referred by family physicians for optimum COPD education and management, and I sometimes get patients from the emergency room. I've changed the referral basis from the emergency room so that they can be referred directly to me if they come in with a COPD exacerbation, because I think that's a really great idea.

I keep patients for a little while. Sometimes I'll keep them for two years, where they come back and see me. It's the monitoring that's so important. You cannot teach everything all at once, so what I try to do is teach as I can and offer support as I can.

If patients are struggling at home, they call me. If they need to come in to see me, they come in to see me. I tell them sometimes to get their picture taken on the way in—and I'm referring to a chest X-ray—so I can see if they have pneumonia or something else going on.

It's a very approachable type of clinic. I go out to see patients who are on the wards in the hospital. I will meet them so that they're not afraid to come down and meet me when they get referred, because you never know. I think that's extremely helpful.

We have a patient-centred approach in everything we do. We ask patients if they're okay with what we're doing or what they can do for us or with us. So it's very patient-centred.

Mrs. Kathryn McGarry: In terms of the collaborative self-management program, that's music to my ears, because I think that's really what it's all about. Can you expand on that?

Ms. Loretta McCormick: It's funny, because collaborative self-management seems to be a rather simple concept, but it's a bit of a struggle because people have to—

The Chair (Mr. Peter Tabuns): I'm sorry to say, but you're out of time. I'm going to go to the next questioner: Ms. Martow.

Mrs. Gila Martow: Thank you. It's Loretta, right?

Ms. Loretta McCormick: Yes.

Mrs. Gila Martow: Like Loretta Lynn. I love that movie, Coal Miner's Daughter.

I wanted to bring up, because I think we're all in agreement—it's such an easy committee, this, because basically everybody is in agreement, just with different perspectives. Everybody is in a very collaborative spirit in terms of all the different specialties and advocacy groups and politicians.

What I wanted to mention is this: Do you ever feel frustrated about a lack of coordination between hospitals or between different regions? One of your patients will be up at a cottage somewhere, have a crisis and go to the hospital there and not be able to access the information that they need, sometimes, from your hospital. Has that been a problem?

Ms. Loretta McCormick: I haven't come across that on that level. A lot of times, what may happen is, if my patients are going up north, I may prepare them for what to do, what could happen if something were to happen.

A lot of patients want to be able to manage without having to go to the emergency department. There isn't a lot of evidence to support things like action plans and medications that they'll take, so I don't generally do that. But a lot of times, patients who aren't smoking anymore, who are taking their medications right, who are moving around a little bit—the evidence to have exacerbations is a little bit lower for those folks, so that has been kind of helpful. And if they do, when they come back to see me in the follow-up they'll generally tell me if they've had an exacerbation and they've been treated with antibiotics and prednisone. There hasn't been a lot of that so far.

Mrs. Gila Martow: That's what I would like to see: better coordination between all the regions and the hospitals, because I think there are a lot of wasted health care dollars when people—not necessarily with lung health challenges—go to one emergency room and then, because of where they're travelling for work or vacation or whatever, all of a sudden they have to have all of the tests repeated because it's impossible to get access to that kind of thing.

The other thing, if I have another second or two to mention it, is that it's not all about medication. I think a lot of us understand that there are now all kinds of treatments—even vibrating chairs and things like that—to help if people have mucus that's there, and exercises; it could just mean lifting your arms. Now we understand that the worst thing is not to move.

Ms. Loretta McCormick: Yes. Speaking about that earlier question, there was an occasion when a physician called from the emergency department of a Toronto-based hospital and was telling me what they were going to do with the patient and then sending the patient back. That was kind of helpful. My patient told the physician that maybe letting Loretta know might be helpful.

Mrs. Gila Martow: So the patients have your cell?

Ms. Loretta McCormick: No, my office number on my card, and my email.

Mrs. Gila Martow: Oh, okay. Excellent.

The Chair (Mr. Peter Tabuns): And with that, I'm sorry to say that we're out of time.

Mrs. Gila Martow: Thank you. Perfect timing.

The Chair (Mr. Peter Tabuns): We go to Madame Gélinas.

M^me^ France Gélinas: This is wonderful. Your hospital managed to get enough resources to have an

outpatient clinic specifically for COPD, and hired you through hospital funding?

Ms. Loretta McCormick: Yes.

M^me^ France Gélinas: Wow. We need more of you in the 154 hospitals throughout our province.

Ms. Loretta McCormick: That's what they tell me.

M^me^ France Gélinas: My question number two is, do you have pulmonary rehab in Cambridge?

Ms. Loretta McCormick: When I first started there, I had this lovely gym at the end of the hall, and had a kinesiologist. I would refer my patients there, and she would do a six-minute walk test, which was an evaluation metric. That was wonderful.

Then I understood that there were some changes going on, so I partnered with the community. I found a kinesiologist in the community and partnered with her. I said, "Could I get the same form of support?" There's a small cost involved for the people whom I send there. It's not a disclosure confidentiality-wise, so we've covered all of that, and patients will still get their rehab, but they get it off-site. So far, that has worked out very well. If there's anything that comes up, the patients let me know as well.

The other thing that I've found in what I do is that I agree with Ms. Martow: Just moving is a good idea. So I send my patients to the mall before the stores open. I have a one-pound weight on my table. Just for fun, I get them to be doing that while we're talking, just to give an idea of what small pieces of things we can do. We talk about rehabilitation studies that say that the body in motion tends to stay in motion, so we do a lot of those kinds of things.

M^me^ France Gélinas: But you don't become their primary care provider. They have to have primary care. What do you do if they don't have a primary care provider?

Ms. Loretta McCormick: Cambridge has a city hall, I understand, that sends people notes on which physicians are taking patients—

M^me^ France Gélinas: There's no shortage of primary care physicians in your area?

Ms. Loretta McCormick: Yes. And there's a nurse practitioner clinic.

M^me^ France Gélinas: So you would never run into a position where you need to prescribe drugs that are not what you're allowed to prescribe, simply because everybody has a primary care provider?

Ms. Loretta McCormick: Yes. That's kind of helpful, plus it gives you someone to partner with as well. I can call up the primary care provider and say, "I was thinking about this. What do you think about this?" There was a presenter earlier who talked about all of the other little things that can creep up and flare up to COPD.

M^me^ France Gélinas: Has paying for pulmonary rehab been an issue for any of the clients that you've dealt with?

Ms. Loretta McCormick: Not so far, because I compare it to parking charges. Parking there is free.

M^me^ France Gélinas: It's cheaper to go there because they don't have to pay parking?

The Chair (Mr. Peter Tabuns): With that, we've run out of time. Ms. McCormick, thank you very much for coming and presenting today.

Ms. Loretta McCormick: Thank you.

The Chair (Mr. Peter Tabuns): Members of the committee, thank you for your diligent approach and your co-operative nature. The committee stands adjourned.

The committee adjourned at 1740.

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