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**Official Report
of Debates
(Hansard)**

SP-11

**Journal
des débats
(Hansard)**

SP-11

**Standing Committee on
Social Policy**

The People's Health Care
Act, 2019

1st Session
42nd Parliament
Monday 1 April 2019

**Comité permanent de
la politique sociale**

Loi de 2019 sur les soins
de santé pour la population

1^{re} session
42^e législature
Lundi 1^{er} avril 2019

Chair: Nina Tangri
Clerk: Eric Rennie

Présidente : Nina Tangri
Greffier : Eric Rennie

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

**STANDING COMMITTEE ON
SOCIAL POLICY**

**COMITÉ PERMANENT DE
LA POLITIQUE SOCIALE**

Monday 1 April 2019

Lundi 1^{er} avril 2019

The committee met at 0900 in room 151.

**THE PEOPLE'S HEALTH CARE
ACT, 2019**

**LOI DE 2019 SUR LES SOINS DE SANTÉ
POUR LA POPULATION**

Consideration of the following bill:

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

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

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

Are there any questions before we begin?

**OFFICE OF THE FRENCH LANGUAGE
SERVICES COMMISSIONER
COMMISSARIAT AUX SERVICES
EN FRANÇAIS**

The Chair (Mrs. Nina Tangri): Seeing none, I'd like to call upon the Office of the French Language Services Commissioner. Please state your name for the record.

M. François Boileau: Good morning. Bon matin. My name is François Boileau. I'm the French Language Services Commissioner for the province of Ontario. I'm with Joseph Morin, our legal counsel at the office.

Thank you very much for this unique opportunity to present on Bill 74. My presentation will be in both French and English but mainly in English.

Le projet de loi 74, si adopté, aura un impact sur la façon dont les services de santé sont planifiés, coordonnés, financés et fournis et aura aussi des implications majeures en matière de services de santé en français.

Le projet de loi 74 crée Santé Ontario, un organisme unique qui gèrera et coordonnera les services offerts dans

l'ensemble de la province, tout en éliminant les 14 réseaux locaux d'intégration des services de santé.

Ontario Health will designate Ontario health teams at the local level. These teams will be responsible for coordinating and providing care to specific populations and geographic areas. These teams will include, for example, hospitals, long-term-care homes, community care agencies and community health centres. They will be clinically and fiscally accountable for delivering a co-ordinated continuum of care.

Several proposed initiatives may have a positive impact on accessing French-language health services. First, the government will introduce new tools to improve how patients and their families navigate the health system. This is promising for francophones who face access barriers.

Secondly, the government wants to optimize the use of digital resources to increase access to specialists. This is also a promising initiative for francophones living in smaller, more isolated communities.

The Minister of Health and Long-Term Care, the Honourable Christine Elliott, insisted on improving access to online health records. It is going to be critical to ensure that these tools are fully accessible in French. We know from past experience how difficult and costly administrative and program revisions are. The minister reiterated numerous times that this new system would let patients have a say in their health care journey. For francophones, this ability to influence the provision of health care services in French will be established by maintaining the French Language Health Services Advisory Council and French-language health planning entities.

In its preamble, Bill 74 outlines the obligation to respect the requirements of the French Language Services Act but provides little language on how this will be done. We would like to see this part of the bill amended to clarify that this requirement applies to the planning, design, delivery and evaluation of French-language health services. We propose detailed wording to that effect in our first recommendation, which would require, as I understand it, unanimous consent from this committee.

What is not clear at this stage is the scope of responsibility of the entities and to whom they will be able to provide advice. Their voice must be equally heard at the local and provincial levels. Their role in the planning, design, delivery and evaluation stages is crucial. Section 44 of Bill 74 seems promising in terms of the relations between entities and Ontario Health, but their role goes deeper, as they need to be able to interact daily with the

newly created Ontario health teams across the province. Our recommendation number 6 proposes a wording that would reiterate the importance of a solid regulation scheme to that effect.

Bien que nous soyons d'accord que la centralisation de la planification et de la coordination des services peut être bénéfique afin d'établir des directives plus fortes et systémiques au regard des services de santé en français, il reviendra à la haute direction de Santé Ontario d'établir et de mettre en oeuvre de telles directives.

When Ontario health teams are established and the integration of community health service providers within these teams takes place, the government will have to ensure that health service providers that are fully or partially designated under the French Language Services Act maintain the designation of these services. This obligation should be clearly specified in Bill 74 so that no French-language services are eliminated. This is crucial. Our recommendations number 4 and 5 address these important issues.

Comme dans toute transition, le processus retenu pour la désignation des équipes Santé Ontario et l'intégration des fournisseurs de services peut créer une occasion d'évaluer et de vérifier la capacité de ces fournisseurs de services de livrer des services en français. Au travers de ce processus, les fournisseurs de services qui ont une certaine capacité d'offrir des services de santé en français devraient être encouragés à demander la désignation sous la Loi sur les services en français, une belle occasion pour tester le nouveau processus de désignation, ce que j'ai recommandé auprès de la ministre des Affaires francophones, l'honorable Caroline Mulroney, depuis son entrée en fonction.

The proposed legislation creates mechanisms for collaboration between the new health agency and the existing French-language health planning entities. I applaud the fact that Bill 74, The People's Health Care Act, 2019, recognizes the important role that entities can play in advising Ontario Health. But before everything gels, much time will pass. Time can lead to uncertainty and uncertainty to paralysis or worse. Therefore, we recommend a precise wording in our recommendation number 10, in part V on transfers. Our proposal calls for a clear regulation to set out the duties of the agency, the integrated care delivery systems and health service providers for consulting with the French-language health planning entities. While the bill confirms that their voices will be heard at the provincial level, we strongly recommend that provisions be added to confirm the role of entities at the local level as well as their ability to guide the integration and coordination of services by Ontario health teams.

Alors que la réforme prend forme, notre bureau continuera de fournir des avis constructifs en collaborant avec le ministère afin de s'assurer des meilleurs résultats possible pour améliorer la prestation de services de santé en français.

I'd like to point out, in a final word, that the co-operation of the Ministry of Health and Long-Term Care has been so far very good and we're hopeful that it will continue in the days to come. Thank you very much.

The Chair (Mrs. Nina Tangri): Thank you. We'll begin with the official opposition: Madame Gélinas?

M^{me} France Gélinas: Merci beaucoup, maître Boileau, d'être venu ce matin. Ma première question est assez simple : est-ce que vous avez été consulté, vous ou votre bureau, avant que le projet de loi 74 ne soit déposé?

M. François Boileau: Avant que le projet de loi 74 ne soit déposé? Non.

M^{me} France Gélinas: Est-ce que c'est typique qu'un projet de loi qui aura une importance pour tous les Franco-Ontariens et Franco-Ontariennes soit déposé sans que votre bureau le sache?

M. François Boileau: Nous avons tenté à plusieurs reprises de consulter et d'aller voir le gouvernement, mais nous ne travaillions que sur des rumeurs sur un projet de loi qui avaient été coulées dans les médias. Donc aussitôt que nous avons pris note de ce projet de loi, nous avons contacté le ministère. Bien sûr, ces rencontres et ces discussions-là étaient informelles, puisque ce n'était pas en rapport à un projet de loi véritable qui avait été déposé.

M^{me} France Gélinas: On a vécu et vous avez fait un rapport sur ce qui est arrivé à Penetang, lorsqu'on a vu une amalgamation forcée de deux hôpitaux, un étant désigné et l'autre ne l'étant pas, et les grosses pertes que la communauté francophone a eues. Est-ce qu'il y a, dans le projet de loi 74, des garanties que ce qu'on a vu à Penetang ne se reproduira pas si le gouvernement utilise ses nouveaux pouvoirs pour mettre des hôpitaux ou des services de santé ensemble, quelques-uns étant désignés, les autres ne l'étant pas?

0910

M. François Boileau: Nous n'avons pas vu de telles garanties. Voilà pourquoi nous avons proposé des modifications au projet de loi 74, des recommandations très claires—numéros 4 et 5—qui visent justement les pouvoirs de la ministre en matière de discrétion et en matière d'intégration. Donc, pour nous, ce sont des recommandations qui sont essentielles pour le projet de loi 74 afin de, justement, prévenir que d'autres Penetangs n'arrivent pas.

M^{me} France Gélinas: Et puis, pourquoi c'est important?

M. François Boileau: C'est important parce que lorsque c'est consacré dans une loi, ça envoie le message à tout le monde que les droits linguistiques, notamment ceux qui sont inscrits dans la Loi sur les services en français, sont importants et qu'on ne doit pas les sacrifier pour le bénéfice d'une intégration, qui peut être forcée ou voulue, mais qui pourrait se faire selon des termes purement administratifs. Souvent on oublie—il n'y a personne qui est là pour rappeler avec des drapeaux rouges—les obligations en matière de respect de la Loi sur les services en français.

M^{me} France Gélinas: Si on parle des tierces parties—donc on sait que si on regarde le système de soins à domicile, souvent ce n'est pas un organisme du gouvernement qui offre les soins à domicile, mais c'est une tierce partie, un contrat d'embauche, souvent, avec un organisme privé qui offre les services. Avec le projet de

loi 74, est-ce qu'on a des garanties que les services en français seront offerts si c'est une tierce partie qui offre les services de santé?

M. François Boileau: Il n'y a pas de telles—

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

M. François Boileau: Il n'y a pas de telles garanties dans le projet de loi 74, mais la relation entre les fournisseurs de services et les entités de planification des services de santé en français est extrêmement importante. Cette relation-là n'est pas explicitée dans le projet de loi 74, qui vise davantage Santé Ontario. Donc, c'est pour ça qu'il faut descendre un peu plus et non pas revivre ce qu'on a déjà vécu à l'époque où le gouvernement laissait les tierces parties un peu libre, parce que les réseaux locaux d'intégration du système de santé ne permettaient pas d'avoir de bons outils légaux pour faire face au manque de services en français de la part d'organismes qui étaient identifiés par le système de santé.

M^{me} France Gélinas: Mais on est dans la même situation maintenant avec le projet de loi 74?

M. François Boileau: Nous sommes dans la même situation.

M^{me} France Gélinas: OK. Si on ne prend pas les—

M. François Boileau: Les recommandations qu'on met de l'avant.

M^{me} France Gélinas: —recommandations que vous avez faites.

M. François Boileau: Oui.

M^{me} France Gélinas: OK. Je vous remercie.

The Chair (Mrs. Nina Tangri): My apologies. You do have two more minutes. It's six minutes on each side. So go ahead.

M^{me} France Gélinas: Apparemment, il nous reste deux minutes. Si tu regardes toutes les recommandations que tu as faites, est-ce qu'elles sont toutes d'importance égale?

M. François Boileau: Oui, mais en même temps, on a mis l'emphase sur les recommandations numéros 4 et 5. Pour la recommandation 1 qui vise le préambule également, ça, je pense que si le préambule—le projet de loi ne comporte pas d'objets. Il y a une section sur les objets de l'agence, mais pas des objets de la loi comme telle. Alors, c'est important d'avoir le meilleur préambule possible pour nous permettre d'avoir une meilleure interprétation, à l'avenir, de la loi sur la—the people's care act.

Mais on a aussi des recommandations—donc, 1, 4 et 5, et puis recommandation 6, qui concerne bien sûr les entités, et la recommandation concernant le transfert aussi qui est très importante, qui est le numéro 10.

The Chair (Mrs. Nina Tangri): This time, it's one minute.

M^{me} France Gélinas: Si c'était toi qui décidait, les entités de planification, elles se rapporteraient à qui au niveau local? Comment est-ce que ce processus d'entités peut servir au maximum les francophones?

M. François Boileau: Je pense que la relation entre Santé Ontario et les entités va être extrêmement importante, mais si les entités au niveau local dépendent seulement des équipes de Santé Ontario et que leur

financement dépend d'eux autres, là ça risque d'être plus problématique.

Je pense qu'il devrait y avoir une imputabilité qui soit dirigée vers Santé Ontario et aussi vers le ministère. Plus on se rapproche du centre, plus on s'assure que les services en région pour les communautés minoritaires, comme les francophones, vont être assurés. Si leur financement dépend seulement du local et que leur évaluation dépend seulement du local, là on risque d'avoir un problème.

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

Mrs. Robin Martin: Merci beaucoup pour votre présentation et aussi votre travail et vos efforts.

The ministry really appreciates all of the recommendations that you've made and the fact that you've been working together. I understand that your commission was consulted during the drafting of the legislation—perhaps you didn't know.

M. François Boileau: Well, I'm the commissioner, so I would know.

Mrs. Robin Martin: Okay. And we had a great deal of conversation since then with the ministry—

M. François Boileau: Since Bill 74 was tabled, yes, we've had a good deal of contact, and it was all very positive.

Mrs. Robin Martin: Good. Thank you very much.

We know that Bill 74 has specific provisions in it that would recognize respective rules for Indigenous and francophone-speaking populations in the planning and delivery of health care in their communities. Our preamble highlights some of those things, and I think you mentioned some proposed changes to the preamble.

M. François Boileau: That's correct.

Mrs. Robin Martin: Thank you for those specific suggestions. I understand why you would want to put those in there.

In addition, the six French-language health planning entities would continue.

So we feel like we're working together with you in a positive way to make sure that French-language services continue to be provided under the new regime.

One of the things I would want to talk about is how you feel French-language services are currently being provided in Ontario. Certainly, at my mental health round tables I've heard that there are some difficulties with the way things are on the ground right now.

M. François Boileau: I'll have the opportunity to table a final annual report on April 25. But to answer that very large question would take lots of time.

In regard to mental health, later on this afternoon you will receive a representation from entities, and they might be in a better position to give you insight.

On mental health issues, if you don't start on the right foot with consulting the proper organizations and those who actually deliver French-language services or have the capacity to deliver them, then it's problematic. The way it has been set out under the previous government was not the best way of dealing with these issues, and we haven't

seen too much improvement in regard to dealing with mental health issues with this current government.

Again, I'm not here to provide feedback based on facts—I would have to think it over a little bit more, but from what I've gathered, it seems that it's still problematic.

Mrs. Robin Martin: One of the things I heard from people at the mental health round tables was that francophones have to self-identify as requiring francophone services, even when in some cases it's very obvious that it's a francophone, and they're not necessarily being offered services in their first language, which is a problem.

M. François Boileau: Yes. One of the key measures that the government could propose is to have an indicator on the health card—not on the health card, but when you apply for your health card, if you indicate that you prefer receiving French-language services, then it will help service providers to know in advance what you prefer. Then it may be a useful tool to coordinate efforts in regard to French-language service delivery, especially to a vulnerable population such as people who have mental health issues. They are not the ones who will actually ask for French-language services—thus, the importance of the concept of active offer. The concept of active offer is of crucial importance, especially for vulnerable populations, including patients who have mental health issues. The concept of active offer is that you create an environment that is conducive for francophones to receive French-language services and to ask for French-language services. Too often, we've seen that you have bilingual signs but when you go to the office and you specifically ask for French-language services, you get the impression that you're disturbing and that you're asking for special privileges. That's not an environment that would be conducive for francophones to ask for French-language services.

Mrs. Robin Martin: You mentioned that there were certainly elements in the act, Bill 74, that you think are promising for francophones and how francophone services can be delivered. Can you just elaborate a bit on what those—

M. François Boileau: Actually—

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

M. François Boileau: One minute?

What is more promising is what Minister Elliott was saying when she tabled Bill 74, which is not really in Bill 74. What she was saying was that digital resources, online services for communities in the north and elsewhere, is already a reality. We need to have access to digital resources and to have access to online services via Skype or whatever technology is available over there.

0920

So this is promising, because it creates an environment in which—we cannot raise doctors or even nurses, but specifically doctors, just because we have a lack of doctors, period, no matter what language they are speaking.

The Chair (Mrs. Nina Tangri): Thank you very much. Time is up. Thank you for joining us here today and presenting to us.

M. François Boileau: Time is up, period?

The Chair (Mrs. Nina Tangri): Time is up.

M. François Boileau: Oh. Thank you.

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

ONTARIO HEALTH COALITION

The Chair (Mrs. Nina Tangri): If I could call upon the Ontario Health Coalition, please, to join us. If you can please introduce yourselves, and state your name for the record. You have eight minutes to present, followed by six minutes each from each of the recognized parties. Thank you very much.

Ms. Natalie Mehra: Thank you. My name is Natalie Mehra. I'm the executive director of the Ontario Health Coalition. This is Devorah Goldberg. She's our campaign and research director.

The process with which this legislation has been developed, and is being rushed through the Legislature and these hearings, requires us to put on the formal record our protest and our formal complaint.

Legislation that covers 18 million Ontarians and 1,800 health service providers, that profoundly changes the way that our local health care providers deliver services, and that gives unprecedented powers to the Minister of Health and to a new super-agency to order mergers, mega-mergers, amalgamations, service reductions, transfers of service, closures of service and closures of entire service providers, should be subject to a robust public process.

The health system is understood in Ontario to be a public system. It's understood to belong to the people of Ontario. Most of our communities have spent the last 100 years or more building their local health service providers and supporting them. They do not belong to the government. The government was elected as a steward for that system, and has no mandate whatsoever to do this. It was never mentioned during the election.

More than 1,500 people and organizations that have asked for standing before this committee will not be heard in these two part-days of public hearings in Toronto.

I have to say that I looked at the former pieces of major health care restructuring legislation, and this process is unprecedented. In the LHIN legislation, there were five days of hearings. There were 1.5 months of notice for standing before the standing committee. Even in the Mike-Harris-era omnibus-bill health restructuring commission, there was public notice. There were 15 days of hearings across Ontario. Both of those pieces of legislation were subject to amendments.

That said, I'll move on—because we only have eight minutes, which is also the shortest time ever—to what the legislation actually says.

This legislation gives extraordinary powers to the Minister of Health and to the government's appointees in the super-agency to order, direct, coerce through funding powers, and otherwise force the restructuring of the health system.

What has been said publicly really only is that it will create a super-agency and some health care teams. Teams are voluntary. What this legislation actually does, the

majority of the legislation, is give new, unprecedented powers to the minister, and extraordinary powers to the minister, service providers and the super-agency to restructure our entire health care system, including 1,800 service providers, in the minister's own words, covering 15 million Ontarians.

Section 20 gives unfettered powers to the minister to direct any health service provider to do anything.

Sections 20, 31, 32, 33 and 40 all give extraordinary powers to the minister and to the super-agency to facilitate by negotiation, to make orders, to make directives and to make a whole variety of different types of orders, to force mergers, amalgamations, mega-mergers, service transfers, service reductions, service closures and closures of entire providers.

A number of those provisions are extraordinary. In particular, section 20 has never existed in any form in Ontario law before. In all of these sections, there is no protection against the transfer of public, non-profit services to private, for-profit providers. In fact, section 20 explicitly gives the minister the power to do that.

In the leaked documents from February, the government's hand was tipped a little bit. The leaked documents show that the intention there was to order the contracting out of support services and procurement, and those were undefined and therefore unlimited. That could easily include hospital diagnostics, a whole range of support services, and so on.

There is nothing in this legislation that protects rural hospitals from being taken over and amalgamated—in fact, that's the intention—and closed down. There is nothing that would protect against any local non-profit or public service from being reduced unilaterally.

In most of the legislation, there are no procedural protections. Even under the Harris restructuring commission, there was a publicly written plan. The commission travelled the province and did hearings. There was the right to access documents. There was the right to appeal. There was a timeline. There was public notice. There were clear decisions. None of those procedural protections or democratic protections exist in this legislation.

We are the most deeply concerned about this legislation as we've been about any legislation in my 25 years at the leadership of the Ontario Health Coalition. This government has no mandate to force privatization, mega-mergers, amalgamations, transfers, closures or reductions of health care services. We must be clear that we see this legislation as damaging and dangerous.

The Harris-era health restructuring was just over 300 hospitals brought down to what is now 141 hospitals in approximately 260 hospital corporations. This is 1,800 health service providers that the minister intends to bring down to 30 to 50 conglomerates of various different sorts in health care. This is restructuring on a scale that this province has never seen. The Harris-era hospital restructuring commission cost \$3.9 billion to lay off staff, build a building over here and move the service over here, rehire staff over here, transfer services, close down local services, and so on.

We fear that this bill will cost billions of dollars, taking money away from care, and cause upheaval and instability to a workforce that has already been stretched for decades. It will cause the loss of local services and the inability for the public to have any meaningful input. This bill takes away any last vestiges of local control over our health care—for-profit privatization, and profound risks to the quality and accessibility of our health care.

What Ontario needed was an amelioration of health care services, not another grand experiment in health care restructuring.

We are asking you to repeal this legislation. If not, we are asking you to fundamentally amend it to protect the public against privatization, the loss of local services, and the closure of small, rural and local hospitals, and to insert procedural protections to ensure that the public has the right to have a say over our health care system that we fund and that we rely on from birth to death.

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

Ms. Effie J. Triantafilopoulos: Good morning, and thank you very much for taking the time to present to us.

You've spoken about the lack of public consultation. You may be aware that the minister; our parliamentary assistant, Robin Martin; and myself, as parliamentary assistant for long-term care have spent the last several months doing extensive consultations with stakeholders, with people who are on the front line. I find it very surprising for you to say that you feel there has been a lack of public consultation in this respect.

0930

One of the comments I also noticed on your website was that you said that the previous legislation was “not perfect—in fact, far from it.” So why don't you highlight for us today what aspects of the previous legislation are flawed, and what you feel we should do differently?

Ms. Natalie Mehra: We believe that lobby meetings, backdoor meetings and off-the-record meetings are not proper public consultation. Normally, a piece of legislation like this would be initially put out in a white paper. There would be questions on key provisions. There would be wide public consultation on that discussion paper. There would be proper notice for that, before the legislation was even written. That would be the normal process. Then, that input would go into the drafting of the legislation and then that legislation would spend a few months going through the Legislature. There would be proper public notice for hearings. The public would be allowed to hear. Hearings would be held in every geographic region of the province. This is parliamentary tradition which has been broken in this process today. None of that has happened.

We represent more than half a million Ontarians and 400 member organizations, and our members have not been consulted on this legislation. I've just travelled the province doing town hall meetings. Nobody in the town hall meetings has been consulted on this legislation. As I say, more than 1,500 people have applied for standing

before this committee who will not be heard because of the process that you've chosen. I think that is indefensible, frankly.

On the previous legislation: Frankly, parts of the previous legislation that we had problems with have been brought forward into this legislation. There were extraordinary powers for the local integration networks to restructure health care. However, those powers were much more limited than these powers, and they were subject to at least some process and some democracy. There were appeals; there were public board meetings. None of that exists in this legislation. It was faulty, however, in that the appeals were not meaningful.

The provision that you have in this legislation in section 48 that cabinet can expand the purview of the legislation so it can expand it to even more providers without ever going back to the Legislature is profoundly undemocratic and really not justifiable. Section 35, which allows providers to integrate themselves without proper process, without appeals and so on, is also not correct, but part of that was taken from the LHINs legislation. But all of the public interest provisions, faulty as they were in the LHINs legislation, have been stripped in this legislation—all the community engagement ones, the democratic board and so on and so forth.

Ms. Effie J. Triantafilopoulos: I think you'll find that many, many stakeholders who in fact were consulted would be very disappointed to hear that you think there wasn't in fact a very public, transparent consultation process.

But let me ask you another question: You've obviously read Bill 74, and I'd like to ask you how many times you found the words "privatization" or "privatizing health care" actually appearing in this bill.

Ms. Natalie Mehra: I couldn't name off the top of my head how many times privatization is in the bill, but I can say that there are more than five separate sections of the legislation that give extraordinary powers to the minister and the super-agency to order or coerce the transfer of public and non-profit services to private and for-profit providers and that there are no provisions that actually prohibit that from happening.

Ms. Effie J. Triantafilopoulos: And I would suggest to you, having also read the bill very carefully, that privatized health care come up actually zero times in this bill. Zero times. Not once is it reflected in this legislation. Perhaps I would just suggest that you might want to take a second look at that.

Ms. Natalie Mehra: If there is no problem, if there is no intent to privatize our health care services, then respectfully, through the Chair, the government should pass amendments under each of those five sections explicitly saying that you will not transfer any public and not-for-profit service to a private for-profit provider or any part of that service to a for-profit provider.

As I say, we have asked for the bill to be repealed. We think it's so ill-conceived and badly written that it should be repealed and rethought. However, if you pass it, we ask you to make those amendments.

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

Mrs. Robin Martin: I heard you say that a lot of the powers that are in this legislation were in the previous legislation.

Ms. Natalie Mehra: And there are extraordinary powers in this legislation that have never before appeared in Ontario legislation.

Mrs. Robin Martin: And you referred to section 20, which is a section about directives from the minister.

Ms. Natalie Mehra: The minister can issue a directive to any health service provider to do anything, unfettered.

Mrs. Robin Martin: But the other parts of the legislation about integration and all those things: That all has been done before. It was in the predecessor legislation which you sort of—

Ms. Natalie Mehra: To answer the member's question, parts of those sections were in previous legislation. This legislation reaches further in terms of grabbing power and certainly reaches further in terms of grabbing power with no accountability, no process, no public interest protections and no principles to guide the restructuring.

The Chair (Mrs. Nina Tangri): Thank you very much. We'll move on to the official opposition: Madame Gélinas.

Mme France Gélinas: Thank you so much for being here, Ms. Mehra. My first question is that you have 400 agencies—

Ms. Natalie Mehra: Member organizations.

Mme France Gélinas: —member organizations and you have over half a million members. How sure are you that not one of them has been consulted?

Ms. Natalie Mehra: I'm positive. We have had several emergency meetings with our members, our board of directors and our local coalitions, and none of them were consulted on this legislation. In fact, the first time we saw anything about it was when the documents were leaked in February.

Mme France Gélinas: Is this typical of new legislation, that organizations that have such broad membership throughout the province would not be consulted?

Ms. Natalie Mehra: No, it is not typical. I think it's unprecedented. As I say, I looked at the process. I remember the process from the last two major rounds of restructuring. Even though, at the time, they dropped the bar in terms of public consultation and public process and, in fact, they were the subject of books and university theses and so on about how poor the process was, this is worse than even those were.

Mme France Gélinas: Okay. You talked a lot about the bill not specifying not-for-profit, and if it doesn't say not-for-profit, then it's not a big stretch to assume that it's because there's going to be for-profit delivery of our health care system. Why would it matter? People would still gain access with their health card. What difference does it make if it's a for-profit provider or a not-for-profit provider?

Ms. Natalie Mehra: This is the concern. The majority of long-term care is for-profit, and chain companies have taken over the majority of that. We know that the for-

profits are lobbying to take over the chronic care hospital beds, the convalescent care beds and other services that they want, to expand their market share. This committee is going to hear from a whole array of providers over the next two part-days of hearings, and those providers will talk about how they want more unfettered market access in order to expand their market share, in a lot of cases—the for-profit home care companies that now control the majority of home care, and the for-profit long-term-care companies.

But our public hospitals are still not-for-profit in this province. There are still a whole array of non-profit long-term-care homes, home care services, community service providers and so on. When you foresee what happens when the providers, in the minister's words, are "unfettered" to form their own conglomerates, who is going to come to the top of the heap? It's going to be the large hospital CEOs who see themselves at the top of that heap and the chain companies that are poised, that are in the position, to take over more services and to expand their market share using the tools in this legislation.

Whether it's the current minister's intent or not—who knows what that is—what is in the legislation is unheard-of powers to order these things to happen and almost no conflict-of-interest protections for the super-agency or for anyone else. Then the conglomerates are left, with no public governance, to run themselves.

I think the risk of privatization in this legislation is the highest that it has ever been, and when you have a government that is extremely close to the for-profit long-term-care industry and other for-profit providers, when you have for-profit surgical clinics already bidding to take over our public hospital services, the risk just continues to go up.

I take issue with the notion that the health minister has said that you will still use your OHIP card. The evidence from Ontario and across the country is that when for-profit clinics take over the surgical and diagnostic services from hospitals, they extra-bill patients. We've called every private clinic in the country and the province three times over the last decade and caught the vast majority of them extra-billing patients hundreds or thousands of dollars for medically necessary health services.

Lest anyone believe that you could just regulate them, in British Columbia the government has a regulation to stop them from charging user fees. The clinics have taken the government to court and sought and won an injunction against the government, prohibiting them from enforcing their own protection for patients against extra billing and user fees in the private clinics—and a number of the private clinics are double-billing as well.

Similarly, in long-term care, the for-profit long-term-care homes have led the opposition to improving minimum care standards. The for-profits have lobbied intensively for deregulation and often won it, and currently are lobbying for deregulation of the inspections process.

These things are not in the public interest. They raise costs for families, who have to hire in extra care in long-term care in order to get enough care for their loved ones.

They do mean that you have to pay for health care with your credit card, as opposed to your OHIP card, and they do undermine single-tier public medicare in this country.

0940

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

Ms. Natalie Mehra: Sorry. That was long.

M^{me} France Gélinas: No, that was very informative. Would you see that one of those Ontario health teams would be led by a big existing—I'll say "extended care," or name one—that an existing private provider in Ontario could become the lead agency for one of those Ontario health teams?

Ms. Natalie Mehra: I won't call them teams, because a team is voluntary. These are conglomerates that will be made up of a mixture of mergers, transfers, takeovers etc. And yes, absolutely, the for-profits will be the most organized. The chain companies are the most organized to take over a new array of services, which is why they're very positive about this legislation. It gives them access to whole new markets.

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

Ms. Natalie Mehra: Thank you.

HOME CARE ONTARIO

The Chair (Mrs. Nina Tangri): I'd like to call upon Home Care Ontario. If I could ask you to please introduce yourself and state your name for the record. You have eight minutes to present, followed by six minutes each from the official recognized parties.

Ms. Sue VanderBent: Thank you. Good morning, everyone, and thank you very much for the invitation to be here with you today. My name is Sue VanderBent, and I'm the CEO of Home Care Ontario. We are the voice of home care in Ontario.

Home care has become a cornerstone of the province's health care system in the last several years, driven, basically, by demographics. Last year, more than 750,000 Ontarians received more than 39 million hours of publicly funded home care in Ontario, and an estimated 150,000 people have privately retained an additional 20 million hours of care directly. These numbers will continue to grow as our population ages.

On behalf of my members, I'm very pleased—thank you very much, Madam Chair, for asking me to speak to Bill 74, The People's Health Care Act. Simply put, the current health care system is not working as well as it could or should. It's fragmented, it's siloed and it has left our hospitals vulnerable and operating at full capacity or over for many, many years now. This is critical.

We have all seen what this means for patients. It means that 1,200 people are waiting daily in closets and common spaces and hallways, and we also know that they are waiting in ERs. Unfortunately, this hallway health care, as it has been named, is something that's not just a scary headline; it's really a reality. Many of you might have done that with a family member.

Patients don't really want to be in the hospital anymore once they've had their treatment. In fact, they are at risk for infections like VRE and MRSA. They do generally want to go home, and they want to go home safely. However, we have created some very highly prescriptive rules in the last several years that have resulted in less patient care, and I would say that this is because of silo thinking, silo acting, silo funding, which is really what this bill is meant to correct.

We have now over the last decade seen shorter and shorter home care visits, the rationing of care, growing wait-lists for home care and a very confusing assessment system for patients and caregivers. With these issues in mind, Home Care Ontario has been working very closely over the last year with the Ontario Hospital Association and the Ontario Community Support Association to explore ways to break down these silos and to begin to streamline health care.

In pockets across Ontario, there is some great work being done in the new bundled care integrated models. For orthopedic post-surgical patients, we are proving the concept of a continuum of care. It's a short, little part of the continuum, but it is nevertheless a continuum. We know that we can get better and improved wait times and admissions through better data sharing and the use of virtual care and remote monitoring.

While these advances are occurring in isolated areas, it is time we think to embrace these innovations. Bill 74 will help us build an innovative and integrated system around the patient by decreasing some of the silos that currently exist for us to talk to one another through an IT platform where we can share records to have a seamless health human resource pool where we can cross-train people and move them across the system, and where we can integrate care and help everyone, patients and caregivers, to know that somebody is actually in charge and somebody does not have to go to the ER because their mom is breathless in the middle of the night and they don't know what to do. The only safe thing to do is to go to the only place that's open 24/7, which is your local ER.

Specifically, we hope and we think that, as Bill 74 is enacted, we will start to see more continuum of care and less siloed thinking and acting. This will end 15-minute visits, rationing of care and wait-listing. We also hope it will help us address some of the really serious health human resource problems that we have with retention.

Home Care Ontario recommends that, for the stability of the patients we serve and as the system is transforming to its final end state, this standing committee consider the current approved health service providers maintaining responsibility in Ontario health teams for volumes of care: the 750,000 people. We really have to maintain a stable system as we move into something as profound and as big as the creation of an integrated care delivery system in Ontario.

The Ontario health teams, especially the early adopters, must partner with service providers to improve care pathways and the patient experience. These are the two things we need to do. We need to better understand care

pathways and we need to better understand the patient experience. This, then, starts to improve continuity of care for patients, and it allows the operational changes that this Ontario health team needs to make to eliminate the siloed thinking, which has really been what the LHIN has represented. That's not being offensive to those organizations; it is just a silo that we have to address.

The government needs to proceed with an orderly transformative process of change that makes sure that patients and caregivers know where they're going and know who will be looking after them. Ultimately, the biggest continuum should not just be home care and hospitals and community agencies; it should be family doctors and mental health teams. It should be all of the other services that are part of the health care system in Ontario. We must knit them together. There are as many people sitting in the ER who have mental health problems as there may be someone who has orthopedic problems or an infectious problem.

We really do need to start thinking about: How do we create a network of health care providers that is providing a continuum of health care services in a defined geographic area? That's the way we get a hold of understanding how patients in a defined geographic area use all the health care services. We can use a connected IT system to map patient movement. What we call in the literature "whole-system patient mapping" is about basically understanding how your patients move and use the system, and then very much design the system to help them get the care they need.

We recommend that Ontario health teams really move quickly into new medical devices and models of care, that are going to promote remote care, virtual wards, patient-reported data and self-management. We're seeing some good examples of that.

The Chair (Mrs. Nina Tangri): Thank you very much. Your time is up.

I'll begin with Ms. Armstrong. Go ahead.

0950

Ms. Teresa J. Armstrong: Thank you very much for being here today and giving us your presentation.

I wanted to ask you: Did you have the opportunity to be consulted on Bill 74 prior to drafting? If so, when were you consulted?

Ms. Sue VanderBent: Yes, we had an opportunity to talk in generalities about the need for a system that is a continuum of care for people. That is what Home Care Ontario has been talking about for a decade now: that knitting together all of the parts of the system is important to control and get a hold of now.

Ms. Teresa J. Armstrong: So you met prior to the drafting of the bill? How many meetings was that, and when were they held? Do you recall if it was before the bill, during the bill or prior to the release of the draft?

Ms. Sue VanderBent: I think Home Care Ontario has been heard loud and clear, talking about the need for a continuum. Certainly, in all of our pre-budget submissions and even last year's pre-budget submission, we picked up

on the same issues that disconnect us as a system. Certainly, the fact that we don't have an ER system that can talk across all of the system of Ontario's health providers is a huge issue.

Ms. Teresa J. Armstrong: Is it fair to say, then, that it wasn't a formal consultation before the drafting of the bill, that they've looked at the information you provided in the past and just thought they would be connecting the dots to the bill? Or did they actually have a formal meeting to say, "We're going to be drafting a restructuring of Ontario's health care system. As Home Care Ontario, what are your suggestions? What are your solutions to these problems?"

Ms. Sue VanderBent: Our suggestions have been the same for many, many years in terms of connectivity and increasing the role and expanding the role of home care for the betterment of patients. That's something that has been an ongoing and continuing process for this association.

Ms. Teresa J. Armstrong: Do you see some of the solutions in the wording of the bill that your organization has been talking about over the years? Do you actually see them put into practice here and described, how they're going to work?

Ms. Sue VanderBent: A bill is very big, and it's a legislative tool. I see all of the elements that are a potential for being enacted in this bill. It does create connectivity. If we're going to be looking at designing an integrated health system that does provide connectivity, I think Bill 74 supports that.

Ms. Teresa J. Armstrong: Based on your expertise, you talked about human resources in the home care field. Can you tell us whether Bill 74 addresses the human resources and the challenges that we see in home care and whether you believe that front-line health care workers, like the PSWs and nurses, are going to actually be better supported by the massive health care structure bill that we have now?

Ms. Sue VanderBent: Our surveying of our members tells us that the reason people are leaving our sector is mostly because of scheduling, the fact that we are rationing visits, that we are only giving PSWs, in particular, early-morning hours or late-afternoon hours—very little opportunity for them to work during the day. This creates a situation where, even though I have great respect for PSWs, they could probably find different work that was less taxing, less unstable, than it is today. It really is unstable because of the scheduling processes that we have right now.

We are very successful in recruiting PSWs. We're working on a very large campaign with the government right now called Work for Life. We are recruiting people to come to work with patients, but we are losing them because of a rationing of care—short visits—that makes it difficult.

Ms. Teresa J. Armstrong: I find those same complaints in my office. I'll be kind of honest with you: They come from a lot of for-profit carriers, when it comes to home care.

You talked about accountability. I just wondered if you could explain whether or not you believe Bill 74 is going

to improve patient care in the home care sector, and when there is no information on governments or accountability—as we heard from the health coalition, about the ability for patients to complain to home care services—how do you think that's going to actually help home care recipients of that service when it comes to Bill 74, when there is no accountability built in there and there's no avenue for them to actually complain?

The Chair (Mrs. Nina Tangri): There's one minute, please, to conclude.

Ms. Sue VanderBent: The patient is everything in terms of this bill. This is very patient-centred. How does a patient move in this system? Their complaints, telling just home care, don't help the patient. This Ontario health team has got to be responsible for how patients move. The patients who are sitting in hallways are complaining because they are in the hallway. They're complaining because they're sitting in a bed waiting to go home. We see that that is the problem with the system. They shouldn't have to be doing that.

I don't know the exact complaint mechanics in this bill, but I can tell you that if there's an Ontario health team that's responsible for the better innovation and integration of care, we should be making sure people have every ability to get back home and get as much care as they need in the home and only have to go to the hospital or the ER for something that is really an acute need.

The Chair (Mrs. Nina Tangri): Thank you very much. We'll move to the government side: Mrs. Fee.

Mrs. Amy Fee: Thank you for being here this morning. You were talking quite a bit about how the recommendations that you've been making for quite some time are seen in this bill and also about how important it is to have those decreased silos and to have partners and making sure that we have integration throughout the system. So what I'm wondering from you is if you could talk a little bit about how you think home care can successfully be integrated into this new system and what that needs to look like and some examples of what you've seen that needing to be.

Ms. Sue VanderBent: All right. I could talk about specific patient populations, for instance. Let's say we have a part of the province where we have a large number of COPD patients—congestive obstructive lung disease. In Hamilton, we have that because we have big steel firms, so we do have a lot of that. We attract a lot of patients and we attract specialists—respirologists—who work in that area. Right now, we could do a lot better to interface and align our home care system with the care of those patients.

Because COPD is a chronic disease, it has also multiple comorbidities. People can be depressed, people can be frail, and people can live in very disadvantaged circumstances with COPD. What we really need, then, is to say, "Okay, here's our patient, Mr. Smith. Mr. Smith is going to use the services of the Firestone regional chest and allergy clinic. He's going to need a clinical nurse specialist. He's going to need housing. He may need help for mental health, with depression, because he's an isolated person."

How do we help Mr. Smith not fail in his own health and end up in the ER one night? And then, because he has

been functioning out in the community at a fairly frail rate, the hospital might say, “Maybe Mr. Smith really needs a long-term-care facility.” And there we have our ALC days that start.

That’s a really simple example of what happens when the whole system does not pick out the individuals who really need to have some additional help. Anybody who is elderly with a chronic comorbid condition like COPD, like congestive heart failure, like renal disease, like end-stage cancer, like palliative care—all of those illnesses can lead us down a very quick path to ALC beds, which is why we have the highest rates right now in Ontario of ALC beds. We have approaching 16% of our acute care beds that are currently being used by someone who a system that is integrated and preventive and anticipatory could have averted.

That’s not to say that we can avert everybody, because there are people who have a big stroke and it’s unexpected and they come to the ER and they do need to be in a long-term-care facility because they’ve had serious brain damage. That’s going to happen.

But I can tell you that in my many years in health care, this is a shocking level of ALC beds in Ontario—just shocking—and we should all be concerned about this. Our current system has really got us to this point because we have been acting as silos. I think we must try something different. This is why, in all the reading I’ve done, in all the degrees I’ve taken, I can see other countries that are older than us moving towards a system where we can have eyes on the patients, because that person is always our patient. Whether they’re in the community or whether they’re in the hospital, we should all be saying, “This person is at risk and is our patient.”

Mrs. Amy Fee: Thank you.

The Chair (Mrs. Nina Tangri): Mr. Sabawy. This is the last minute, so please be quick.

Mr. Sheref Sabawy: Can you describe some range of the services you offer as home care for the patients and if Bill 74 allows you to extend your services, innovate services, tailor new services to help patients?

Ms. Sue VanderBent: Sure. Home care provides nursing personal support and therapies—all of the therapies, so physiotherapy, OT, social work, dietetic, speech language—in the home. Home care can do much more remotely, and I’ve talked about remote care. We look after a lot of palliative patients. Many patients want to end their days at home, and we know from the recent medically-assisted-dying statistics that almost 45% of people are choosing to die at home.

I was a palliative care social worker and I can tell you that dying at home is a very gentle, natural death. It must be supported well, though. You must have good family support, you must have good professional support around you, you must have access to pain control and specialty beds, and you must have generally access to respiratory. We also could introduce ways of having a personal support worker with a family, particularly towards the end of life, where that PSW is connected to a nurse remotely. One nurse can actually have five or six PSWs whom she or he

is connected to as quickly as that. So if we run into a pain problem—breakthrough pain—or if we run into a breathing problem, we would be able very quickly to get care to that person—

The Chair (Mrs. Nina Tangri): Thank you very much. We’re going to have to wrap up now. We need to recess. Thank you very much for presenting to us today.

Ms. Sue VanderBent: Thank you.

The Chair (Mrs. Nina Tangri): Prior to recess, I’d just like to remind that the deadline to send a written submission to the Clerk of the Committee is 6 p.m. on Tuesday, April 2, 2019. The deadline to file amendments to the bill with the Clerk of the Committee is 12 noon on Thursday, April 4, 2019, and amendments must be filed in hard copy. Committee rooms 1 and 2 are being held as overflow rooms should this room overflow, where the TV is tuned in to the meeting.

We will recess until 2 p.m. this afternoon.

The committee recessed from 1000 to 1400.

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

The Clerk has handed out written submissions prior to this meeting. Moving forward, due to volume, I propose that the Clerk provide one hard copy of written submissions per recognized party, and all written submissions will be emailed to all members and substitutes of the Standing Committee on Social Policy. Are we all in agreeance of that?

Go ahead, Madame Gélinas.

M^{me} France Gélinas: Can I ask for a friendly amendment and have two copies per caucus?

The Chair (Mrs. Nina Tangri): Are we all in agreeance of two copies per caucus? It will be emailed out to each and every one of you, and substitutes. All those in favour? Any opposed? Thank you.

REGISTERED NURSES’ ASSOCIATION OF ONTARIO

The Chair (Mrs. Nina Tangri): Moving right on, I’d like to call upon the Registered Nurses’ Association of Ontario. Please introduce yourselves and state your names for the record.

Dr. Doris Grinspun: Thank you very much for having us today. My name is Doris Grinspun. I’m the chief executive officer of the Registered Nurses’ Association of Ontario, better known as RNAO. With me today is Dr. Lynn Anne Mulrooney, RNAO’s senior policy analyst.

Thank you for this opportunity to present the views of RNAO’s 42,000 RNs, NPs and nursing students to the members of the Standing Committee on Social Policy on The People’s Health Care Act.

RNAO supports a health system transformation that will enable a person-centred, seamless system that will promote health, prevent disease and provide personalized wraparound services to manage acute, chronic and palliative care needs.

In the interests of time, we are going to focus on a few key recommendations. However, we urge you to consider all 23 solutions-focused recommendations in our written submission.

RNAO is asking you to avoid making the same mistakes that were done when CCACs were eliminated. At the time, RNAO urged that the local health integration networks'—better known as LHINs—roles of providing oversight of the health system and providing direct services be separate. To avoid the challenges of trying to steer and row at the same time, it is important to ensure that Ontario Health provides planning, funding and accountability, and that the Ontario health teams, or OHTs, provide direct service delivery and its management.

Our first recommendation, then, is to prohibit Ontario Health from involvement in direct service delivery and management.

Our second recommendation is to ensure that primary care is the anchor for an integrated health system. RNAO has insisted for many years on the need for government to urgently recalibrate the balance between life-saving and wellness-enhancing services by strengthening the latter. By anchoring Ontario's health system in primary care, as the best health care systems do globally, quality of care, health outcomes and cost savings will be improved. Primary care provides person- and family-centred care that is comprehensive and continues from before birth to death. While undoubtedly other health services that could make up an Ontario health team provide critical functions, it is primary care that provides continuity of care over a lifetime.

Amendments must be made to this draft legislation to require every Ontario health team to include primary care as a mandatory service. To reflect the strong capacity that is already available in the primary care sector, RNAO recommends, in the strongest possible terms, that primary care be the lead organization in a minimum of 30 Ontario health teams. Many community health centres, aboriginal health access centres, nurse-practitioner-led clinics and family health teams are ready and eager to take on a leadership role. Don't squash them. To keep people out of hospitals and to support them upon discharge, community care, home care and mental health and addictions services should also be made mandatory for each Ontario health team.

To support integrated health services and further strengthen the capacity of primary care, RNAO is urging the immediate transfer of our 4,500 RN care coordinators working in LHINs and the care coordinator function to interprofessional primary care teams. As you see in our written submission, other transformative nursing roles that must be relocated to interprofessional primary care teams include rapid-response nurses and NPs providing integrated palliative care.

RNAO and Children's Mental Health Ontario—CMHO—recommend together immediately shifting the mental health and addiction nurses from LHINs into inter-professional primary care teams and local child and youth mental health agencies.

We want to emphasize that labour agreements ought not to be disrupted to successfully achieve this transition. This transition should result in a substantive strengthening of primary care that is cost-neutral as people move with their compensation intact.

This can and should be done without waiting for the formation of Ontario health teams. As RNAO has written to Deputy Minister Helen Angus, timely relocation in a planned fashion will help avoid confusion, multiple transitions for staff and possible attrition of nursing expertise likely to happen in a scenario where RNs and NPs go first to the Ontario Health agency while awaiting the formation of Ontario health teams. That's exactly what we saw with the mistakes of the LHINs.

Just imagine the current, already-working 10,584 RNs, NPs and registered practical nurses working to their full scope side by side with mental health nurses, rapid-response nurses, nurses integrated as palliative care providers and the 4,500 RN care coordinators transferred all from the LHINs, strengthening the primary care sector overnight. This will positively impact every single Ontarian in every corner of our awesome province. It will ensure same-day or next-day access to primary care, improve clinical services, enrich health promotion and disease prevention, help people navigate the system and address upstream challenges that many Ontarians face day in and day out, such as social isolation for seniors—by offering group activities—income insecurity and housing.

At the individual and family level, RNAO appreciates the prohibition that no integration decision shall permit a transfer of services that results in a requirement for an individual to pay for those services, except as otherwise by law. At the system level, however, RNAO urges the government to safeguard the sustainability and quality of the health care system by requiring not-for-profit entities to be the foundation of this transformational change. At the very least, they should be given first right of refusal for services.

Being agnostic about whether the provision of health services is for-profit or not-for-profit will create conditions sure to increase costs while exacerbating two-tiered health care, which, in the end, will dismantle our health system. At the very least, the government must prohibit the introduction of any additional for-profit health services.

Our last but not least 23rd recommendation is to require not-for-profit entities to be foundational to The People's Health Care Act, 2019.

As health care professionals, citizens, taxpayers, current or future patients, and human beings concerned about our loved ones, Ontario's nurses are strongly invested in our health system.

The Chair (Mrs. Nina Tangri): Thank you very much. We've just gone over eight minutes. I'd like to begin with the governing side. We'll begin with Natalia Kusendova.

Ms. Natalia Kusendova: Welcome, Dr. Doris Grinspun. It's wonderful to see you here. As a member of your organization for several years, it's wonderful to hear your deposition.

You made some very important points today. I want to thank you for your advocacy, speaking out for health, speaking out for nursing, the work that nurses do not only at the bedside but also advocating to different levels of government. It's truly inspiring and it's important to have nursing leaders at the table, so thank you for your presentation today.

For the benefit of my colleagues and the public, can you talk about nurses as the backbone of Ontario's health care system? The notion of hallway medicine and hallway nursing is something that we've talked about as a government a lot. This is addressing our key election priorities. That's why this bill is so important in really keeping our promises to the people of Ontario.

1410

Can you tell us what the key role that nurses play in our Ontario health care system is?

Dr. Doris Grinspun: Thank you, Natalia. It's wonderful to see Natalia as an MPP—an active member of RNAO and our assembly. We were very happy, actually, to serve as mentors at different points.

The nurses, as I said one time to Minister Smitherman, are not only the backbone, they're the brain bone, too, because nurses are the ones that are 24/7, regardless of where they are in the system, whether it is public health, whether it is long-term care, hospital care, primary care, you name it. They provide you with both a pulse on the system and the issues affecting the system, and day-to-day service. In doing so, we're asking that we need to take advantage of this opportunity to position nurses in the places where they ought to be.

Care coordinators and other roles that were just mentioned in the submission: They never needed to be in the LHINs. They shouldn't be in Ontario Health. They should be at the place where there is the interaction between nurses and patients. They should be in primary care.

There is no health system in the world that is high-functioning without a robust primary care system. You have a unique opportunity. You already have 10,000 nurses working in primary care. They are there, just not to full scope—and we can talk about what full scope means, whether prescribing NPs frees them up to do their full scope, or RPNs etc. If to that you add the 4,500 care coordinators to do care coordination, system navigation upstream—so it deals also with many of the social determinants, including social isolation and added aspects that they are absolutely educated to do—just picture what that will do for Ontarians: 15,000 nurses in primary care all of a sudden that the public doesn't even know about today? The public doesn't even know.

They're not doing the functions that they need to. They need to be broadened, those functions, and they need to be put to full use, because that's what they want. That's what nurses want: They want to be full contributors to the health outcomes of the public, and there's no better place with

this opportunity than to have all of those who are in the LHINs in primary care.

Ms. Natalia Kusendova: With this bill, Bill 74, The People's Health Care Act, what we are trying to accomplish is to truly centre the care around the patient and not around the brick and mortar where they happen to be, whether that's at home, in primary care or in nursing homes. That's why the creation of Ontario health teams is so important, because they will follow the patient no matter where they are.

The reason why I got into politics, actually, is because of the frustration that I felt as a new nurse. Hallway nursing, hallway medicine, working those shifts in a hallway: A hallway is not a place of work and it definitely is not a place of healing. Can you tell us a little bit more about the frustrations your members feel with our current health care system and how this bill will help to address some of those issues?

The Chair (Mrs. Nina Tangri): You have two minutes to wrap up.

Dr. Doris Grinspun: Yes. Hallway health care has been a long-standing problem in Ontario. I was director of nursing for six years, from 1989 to 1996, at Sinai. It was all the time there. It's not a place for patients. You cannot respect privacy. It's certainly also not a place for health professionals. You cannot solve it without solving the other areas of the sectors, starting with primary care, moving to home care and then long-term care, if people want to be in long-term care.

The priority, really, is primary care and home care so you help people stay in the community as healthy, vibrant citizens, which is what people want.

Ms. Natalia Kusendova: You've made some great recommendations in your 2012 report, Enhancing Community Care for Ontarians, which are consistent with some of the things that we're proposing here.

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

Ms. Natalia Kusendova: Can you highlight some of those recommendations?

Dr. Doris Grinspun: Absolutely. In fact, all three parties here—there was no fourth party because the Green Party was not in—supported the ECCO report. Christine Elliott, who was a health critic, was the first one in supporting that. That report says to anchor the system in primary care. That report says—this was about the LHINs—to move the care coordinators to primary care. Instead, they went to the LHINs. We are begging you not to do the same mistake. Move the care coordinators this time to primary care. Don't move them to the Ontario Health agency.

Ms. Natalia Kusendova: Thank you so much.

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

Mr. Sol Mamakwa: Meegwetch, Doris. Thank you for coming. You know where I'm from. I'm from northern Ontario, the most northerly riding in Ontario. When we talk about health care, I know we get played by jurisdictional Ping-Pong on our people, when we talk about provincial and federal. An example is, I know at Cat Lake

there were so many skin conditions that were there, and when I asked, in the House, the leadership of the government to respond to Cat Lake, there was no response.

I feel that when we talk about health transformation, it puts that in a very precarious position on people's lives. I'm just sharing that because I know that there has been no response on the Nishnawbe Aski Nation health transformation. A previous government had responded to a transformation process for people because of, again, that jurisdictional thing.

My first question, though, is this: I'm just wondering if you had an opportunity to consult in the drafting of Bill 74, and if so, would you be able to tell us when you started consulting on this bill?

Dr. Doris Grinspun: I must say, yes, I have been both informally and formally consulted, and I have been briefed. I also have asked that all services, including all Indigenous communities, be accounted for. Also, we have asked that the care coordinators, being in primary care in all of the communities, including Indigenous communities, take it upstream and expand it through all of what they have now. Yes, home care linkage, this is important; yes, long-term-care linkage, this is important. As important, if not more, is the linkage to the social determinants of health that care coordinators could play beautifully in terms of supporting people, navigating the maze, finding housing, dealing with addictions etc.

Of course I have been involved this weekend, as of Friday, with the issue of the consumption service clinics. We have been very heavily involved in trying to ensure that those services are treated as any other service for Ontarians. The same goes with Indigenous people. There are very serious issues with youth suicide, no clean water etc.

Sol, you have our commitment that we will continue to push for those services and for the leaders in all the various Indigenous communities to be very involved.

Mr. Sol Mamakwa: Thank you, Doris. As part of RNAO's pre-budget submission, you've called on the PC government to fill the 10,000 nursing vacancies in Ontario's public hospitals. Additionally, there are 4,500 nursing positions in the LHINs. Can you comment on that?

Dr. Doris Grinspun: Yes, absolutely. This was the press conference that we did in May 2018, Nursing Week. This precedes the current government. I have an inch of hope—hopefully, it will become a mile of hope—that this government will deal with that. We did discuss that with the previous government.

This had to do with Ontario hospitals keeping in the closet, so to speak, 10,000 positions—not posting them, not filling them. Those are RN positions. As you may know, Ontario has the lowest RNs per population in Canada—the lowest RNs per population in the country. That cannot continue if we want to actually have a successful health system.

Mr. Sol Mamakwa: Okay. Also, I am very glad to hear you talk about that nursing positions remain in the broader public sector. You mentioned it in your report. Can you tell us how these front-line public job sectors could be used to address hallway medicine?

Dr. Doris Grinspun: Can you repeat the question, please?

Mr. Sol Mamakwa: Can you tell us how these front-line public sector nursing jobs could be used to address hallway medicine?

Dr. Doris Grinspun: To end hallway health care—it's not hallway medicine, please. It's hallway health care because it's patients who are in the hallway—not medicine and not nursing. To end hallway health care, you absolutely need to strengthen the foundation of the system, which is primary care, and you need to strengthen all other sectors. So the 10,000 positions in hospitals will allow the flow. Primary care will prevent people from going into the hospital when there is no need. Home care will be able to maintain people, with the first home care visit being arranged to keep people at home in a safe way rather than a revolving door after that.

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Mr. Sol Mamakwa: Is hallway health care a problem of policy, legislative barriers, or is it because the health care system is underfunded?

Dr. Doris Grinspun: It's both. Actually, it's the first, probably, more than the second. I want to tell you that the issue is the old issue of being focused on hospitals only, the old issue of being focused on physicians only. I am sure that you are as startled as much as anybody else by knowing that we could have 15,000 RNs and RPNs and NPs in primary care. It's a secret, right? So it's recalibrating the system to where the system needs to be in terms of not always favouring hospitals or doctors or whichever other profession, but favouring patients and wrapping the services around patients with primary care, home care, community-based care, mental health and addictions etc.

I think that's a top priority because if you just think—15,000 nurses in primary wouldn't be an issue of funding; that would be an issue of putting them to full use, and we haven't. We haven't, and we must.

The Chair (Mrs. Nina Tangri): Thank you for presenting to us today.

ONTARIO COMMUNITY SUPPORT ASSOCIATION

The Chair (Mrs. Nina Tangri): I'd like to call upon the Ontario Community Support Association. If I can ask you to please state your names, introduce yourselves, and you have eight minutes for your presentation followed by six minutes each from the recognized parties.

Ms. Deborah Simon: Good afternoon, everyone. I'm Deborah Simon. I'm the CEO of the Ontario Community Support Association.

Mr. Patrick Boily: Hi. I'm Patrick Boily. I'm the manager for policy and stakeholder engagement with the Ontario Community Support Association.

Ms. Deborah Simon: Can I start?

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

Ms. Deborah Simon: I want to thank you for the opportunity to appear before this committee and to provide

the perspective of the not-for-profit home and community support services sector on Bill 74, The People's Health Care Act. It was great to be following Doris; there are some common messages that we share.

OCSA, just to give you a little bit of background, represents about 240 not-for-profit agencies across the province who provide compassionate, high-quality home care, community support and independent living services to over one million Ontarians. There are many organizations in your ridings that provide these invaluable services to people of all ages, including seniors and people with disabilities, as well as programs such as in-home nursing, personal support, Meals on Wheels, Alzheimer day programs, transportation, medical appointments, and supportive housing, just to name a few.

Our sector is part of ending hallway health care as we offer over 25 health and wellness services that keep people healthy and living in their communities, where they want to be, and get them discharged faster from hospitals. This includes the delivery of over three million meals, providing two million rides, and over 225,000 clients being served currently in adult day programs.

We know that the current model is not working for our clients. We share the conclusions in the first report by the council that home and community care services really haven't grown fast enough to provide care for caregivers, who are facing bigger and bigger challenges, and that there's a need for a long-term capacity plan for the entire system.

Our association supports the government's goal of creating seamless transitions between hospitals, home and community care, and across the entire system. We recognize that the government's new vision of local Ontario health teams that support patients through their journeys through the continuum of care offers plenty of opportunity to strengthen collaboration between providers.

The proposed model definitely has the potential to enable stronger and more direct relationships between service providers that can translate into smoother care for clients. However, we clearly want to see that the legislation includes community support and attendant care services in the core basket of services, the role for not-for-profit care delivery and community governance, as well as the need to address front-line worker shortages.

We'd like to share with you five recommendations that we have.

The first is that the Ontario health teams must incorporate a strong model of community governance and not-for-profit delivery of services. Shared community governance will ensure that these Ontario health teams understand the health needs of their communities. This knowledge is necessary to ensure that the services are really tailored to the specific community needs as opposed to a one-size-fits-all direction that wastes taxpayers' dollars and provides poor care. In addition, a strong shared community governance will focus on upstream services, including health promotion, social determinants of health and preventative health.

The important contributions not-for-profit home and community care bring to the health system cannot be

overstated. The return on investment can be measured in many ways. For example, volunteers contribute over three million hours of service each year at a value of \$78 million of free health care services to the system. We must ensure that these important contributions are not lost in a system transformation.

Our second recommendation is that the core services the Ontario health teams are expected to deliver in the province need to be identified. Core services must include community support and independent living, as well as home care. Keeping people healthy at home and out of hospitals isn't just achieved through in-home care services alone. Last year, community support services and attendant care services enabled over a million individuals to stay in their communities.

Our third recommendation relates to health human resources. For any transformation to be successful, it must include a plan to support and address continuing shortages of front-line workers across the health system. The current shortage of personal support workers is having a ripple effect across the entire system. People are staying in hospitals longer or delaying the start of home care services due to the lack of qualified human resources.

The government needs to implement a health human resource strategy to attract and retain PSWs, nurses and other health care providers in home and community care. Any strategy must include a plan to close the compensation gap for front-line workers between the home and health care sector and institutionalized care, such as hospitals and long-term care.

The government should also amend the Public Sector Labour Relations Transition Act, or PSLRTA, to ensure that it does not become a barrier to innovative service integrations. One way to do this is to return to its pre-2006 application, ensuring that it only applies to full organization integrations.

Our fourth recommendation is that existing local collaborations should be leveraged for the Ontario health teams. The good work to build partnerships across the sector has already taken place at the local level in many parts of the province. Home and community care organizations are working directly with hospitals to encompass new models of care and to streamline handovers and wraparound services around patients. The sector has shown itself to be supportive of integration for the benefit of patient and client care, and we caution against the strategy of reducing the numbers of providers arbitrarily.

Our last recommendation regards public accountability. OCSA recommends that the legislation be amended to ensure that at meetings of the boards of governors of Ontario health teams they are open to the public. In the administration and spending of public dollars there must be strong and open public accountability.

In closing, we're convinced that we can utilize the strength of the sector to help the government eliminate hallway health care.

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

Ms. Deborah Simon: We call on government to strengthen the relationship with our sector and ensure that

community support services and home care play a vital role in solving hallway medicine and build a better system for people that is based on health and wellness. With the appropriate supports, our sectors alleviate hallway medicine by keeping people healthy and out of hospitals in the first place and by shortening their stay by ensuring they have appropriate supports when discharged.

At this point, I would welcome any questions to further expand the rationale of our recommendations, and thank you for the opportunity.

The Chair (Mrs. Nina Tangri): Thank you very much. Who would like to speak? Mrs. Armstrong.

Ms. Teresa J. Armstrong: First of all, thank you so much for coming and presenting today. We really appreciate your input on this very important bill. I just wondered if you were extended the opportunity from the government to consult on this legislation during a draft form, and if so, when that was.

Ms. Deborah Simon: We did have an opportunity to meet with the minister after the initial draft was put out, and we've since been briefed on the technical pieces of the legislation. We've actually communicated much of what we've said in our brief to the minister to ensure that that draft actually takes some shape.

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Ms. Teresa J. Armstrong: Do you have a question as to, if you were able to meet with them first, before the draft, that you would feel a little more confident that those things were in that bill—

Ms. Deborah Simon: It's always good to be first at the gate. I think it's important to listen to stakeholders such as our sector, in terms of understanding home and community care. We're been there; we've lived it. Our providers have been out in the sector for a long time, so I think the earlier that government can come to us and consult with us, the better that the end product will be. I would always recommend, even with any amendments going forward, that we're here. We're really interested in providing our input.

Ms. Teresa J. Armstrong: When you reviewed the bill, Bill 74—can you explain whether or not the bill ensures that there's an actual integrated care delivery system that will provide home and community support services built in there?

Ms. Deborah Simon: Just to reiterate what I had mentioned in my presentation, community support services was an area that we were very concerned about, and still continue to be concerned about. I think we've gotten it on the home care front. I think there has been lots of interest, and we ourselves have been working with the hospital sector very much around how we can further integrate our services and be more supportive to the home care front.

Community support and attending care services are sort of the hidden gold in the communities that really needs to be pushed front and centre, mostly because of the need for better integration of social determinants, such as housing and the services that community support does provide, from a preventive perspective.

Ms. Teresa J. Armstrong: When you bring up access and social determinants, can you explain whether the bill ensures that all Ontarians will have equitable access to home and community care support services from the bill?

Ms. Deborah Simon: We're not sure right now. What we had asked in our presentation is really a better understanding of what the services will be that will be provided by the Ontario health teams. We know that there's a sense that we want to evolve services based on community need, but there are core services that are absolutely essential to any health delivery system. I think it would be in the interest of the communities that we serve to have those listed so Ontarians know what they can expect from an Ontario health team.

Ms. Teresa J. Armstrong: You also talked about the HR piece and how to attract people, and the gap of compensation. We've heard many times that in long-term care and community care there is a shortage of personal support workers, and there is obviously a high turnover—we see that a lot; we hear that a lot—because they're often not adequately paid for the work they do, and because they face very high workplace harassment and violence. Can you speak to that a little?

Ms. Deborah Simon: Absolutely. I think the strategy that was initially started on really looking at the personal support workers in this province absolutely needs to continue. We have been raising the flag on the issue of PSW shortages for some time now, and we're now seeing crisis levels of PSW lack of support in the communities.

The wage and compensation really still needs to be looked at again. We did a really great job of getting it up there, and we need to continue. The work that primarily women do in this province around personal support work is heavy. It's sometimes under-recognized, and certainly the individuals who provide the care do so not necessarily for the funds that they get paid in their jobs, but really for the care that they deliver to the people that they're serving. I can't emphasize enough how important that role is.

The whole team out in the community rests on the backbone of personal support workers in that they are the front face for almost 60% of the services that are provided through home and community care.

Ms. Teresa J. Armstrong: Can you elaborate on that? And then lastly, do you think that the changes to this massive health care bill will actually support the front-line staff in those positions when it comes to the restructuring of the care that's being done?

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

Ms. Deborah Simon: The strategy has got to be multi-pronged: a compensation strategy, an education strategy, and a retention strategy. I think there are many aspects of the issues that are really affecting PSWs and why we're seeing massive shortages of them in the community. I think we need a fulsome HHR strategy to move that forward.

Just to speak to your last question about front-line staff, I think it's important that we not pay lip service to including and listening to front-line providers in the community as we're moving through transformation right now.

Ms. Teresa J. Armstrong: Do you think this bill helps support front-line workers? The massive changes that happen—is it built into that?

Ms. Deborah Simon: I'm not sure if, right at this point, I see the intersect that really happens with front-line staff. But I can't emphasize enough how important—they have something to say about how services have been delivered, and they also want change. Just as Doris was talking about, they're the ones who have recognized those needs for a long time now, so we want to see that their voices are heard as we go forward.

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

Mrs. Belinda Karahalios: Thank you both for coming here today. I really enjoyed listening to your presentation.

I agree with you that PSWs do very meaningful work, very hard work, and they're not always recognized for that work. I worked with PSWs in my former job, and I see the value they bring to people every single day. Thank you for bringing that up.

As you know, we're building a public health care system centred around the patient and redirecting money to front-line services. To improve the patient experience, in bringing the funds to the front line where it belongs, we're hoping to provide better and more connected care.

The question for you today is, what types of barriers or challenges do the groups that you deal with—seniors, those with disabilities—experience in the health care system today?

Ms. Deborah Simon: Patrick, do you want to take it?

Mr. Patrick Boily: Sure. Some of the challenges the clients that our members serve—some of it is the fragmented care, in terms of being able to access. Some of it is understanding what the actual access is, to know how much service they can access, and that varies by region. Some of the time it's just not being able to access the services because of the lack of human resources. We've talked about the example where home care is being delayed because there simply aren't the nurses or the PSWs to be able to send that person home. There's also the example of community support services that we're lacking to ensure that people are able to be discharged quicker.

Ms. Deborah Simon: I want to add to what Patrick has said.

If we want it to be a truly patient-centred, client-centred system, recognize that the relationships that have built up in home and community are critically important. Many, many of the recipients of home and community care have had their providers for many years. Those relationships are deep. As we're transforming the system, we have to recognize that those relationships will need to continue or people will lose confidence in the system. Everyone wants improvement, but I think we need to really dig deep and make sure that we are not throwing the baby out with the bathwater as we're moving forward.

Mrs. Belinda Karahalios: Changing a care worker whom you've been with for years can be very traumatic for some patients, as well, and you don't really want to add that on to what they're dealing with already.

Could you provide some examples of the types of health programs and services that you provide to seniors and people with disabilities?

Ms. Deborah Simon: I'll start with what I think is really becoming critically important, and that's dementia care. I think all of us know that the numbers of dementia clients, particularly, across the system are growing.

The Alzheimer day program is a program that really grew out of a need for adult support for people with mild dementia, but it has certainly expanded. In those programs, it's not only just adult daycare, but they do wrap around an entire set of services. Some people need bathing in those programs, definitely. There's an opportunity, from a primary care perspective, to be able to have access to clients with dementia while they're in day programs. So that's a really critical program, as are many of the programs we offer in community support.

And don't underestimate meals. Food is a basic staple—it is not just a nice-to-have; it's a need-to-have. Meals on Wheels is more than meals. They provide services to people; they do checks. Sometimes the only contact that frail seniors have with any kind of health provision is that person who delivers the meals.

So those kinds of services—that's when I talk about preventive. These are services that are really under the surface—which no one really appreciates sometimes, except those seniors who are getting those services—and need to continue to be part of that continuum of big H health.

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Mrs. Belinda Karahalios: Thank you so much.

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

Ms. Natalia Kusendova: Thank you for your deposition today.

I'm a registered nurse, and I worked on the front lines of our health care system. When you spoke about the fragmentation and the built-in inequalities in our health care system based on geographical location, I can really speak to that, because as an emergency room nurse, I would discharge patients. Based on where they happened to live, they would either qualify for three hours of CCAC services or five hours of CCAC services, to the point where some patients actually had to hire patient advocates to help navigate through the mountains of paperwork to get the care that they needed.

What this bill is proposing, with our Ontario health teams, is to really centre the care around the patient and not around the bricks and mortars of where they just happen to be. Can you speak to those barriers and to that fragmentation and how this transformation in our health care system will actually help address that?

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

Ms. Deborah Simon: For sure, yes.

Absolutely, you're correct. Part of the issue with the fragmentation is capacity. When we think about our northern communities, we think about fly-in communities and being able to provide the same level of services that

perhaps in southern Ontario are available. That is somewhat of a capacity issue.

The importance, really, for the Ontario health teams, is identifying those services so that Ontarians are really clear that they can expect three hours of personal support care, based on their own needs or whatever their assessed needs are. It will be, I think, important. The capacity behind that is going to be equally important.

I think we're going to, at some point, have to recognize that there's going to need to be some beefing up of that capacity. It's not that the north didn't want to provide those services, but geography and the ability to keep workers in those areas is really challenging. As well—

The Chair (Mrs. Nina Tangri): Thank you very much. I'm going to have to conclude there.

Ms. Deborah Simon: Right—not to forget our Indigenous communities either, which are critically important.

The Chair (Mrs. Nina Tangri): Thank you for presenting to us today.

Ms. Deborah Simon: Thank you for the time.

MR. BRIAN FLOOD

The Chair (Mrs. Nina Tangri): I'd like to call upon Brian Flood, please.

If you can introduce yourself—I know I've said your name, but the organization. You have eight minutes to present, followed by six minutes each from the recognized parties.

Mr. Brian Flood: Thank you, Madam Chair. Thank you for giving me this opportunity to talk to you.

The reason I'm here today is because I'm very concerned about the part of the government's plan relating to the rolling in of the Trillium Gift of Life Network to the super-agency.

By way of background, I practised law in downtown Toronto. I was a corporate business lawyer with the Torys law firm. The Torys law firm is not connected to the Tory party. I was fortunate enough to become vice-chair and then chair of Premier Mike Harris's advisory board on organ and tissue donation in the late 1990s. One of the recommendations, as I will later tell you, was to create an agency to handle organ donation in Ontario. I became chair of that agency, the Trillium Gift of Life Network.

I am also a kidney transplant recipient. I was on a transplant waiting list, on dialysis, for almost six years—five years, nine months and 15 days, to be exact—and then my wife and I got a call early one morning, that it was my time. I can't tell you what a change it has made in my life today. It has made me dedicated to this cause.

I don't know if this is necessary, but I thought I'd just provide a two-minute or three-minute background to transplantation or organ donation in Canada and in Ontario. Just on transplantation: It's kind of one of the miracles of the last half of the last century. It started with the transplant of a kidney from one twin to another that worked, and it just went from there. There were difficulties with rejection and the meds to stop the rejection and

everything, but the medical community involved with patients with organ failure in this country, and particularly in this province, saw this opportunity to help their people and really took it on. They became, quite quickly, a really world-class group of transplant physicians and surgeons. And it is still that way—recognized around the world.

Organ donation was a different story. Of course, in order to have organ transplants, you have to have donors who donate their organs. I looked at it, and, in the 1990s, organ donation performance in Ontario was poor. Premier Harris recognized this and he issued his millennium challenge in 1999 to fix it, and he appointed an advisory board to come up with a plan. I was lucky enough to be a member, to become vice-chair and then chair of that board. We came up with what we thought was a good plan involving institutional, structural change in how organ donation worked in Ontario, and the appointment of a central, independent agency that would manage all this. That agency was the Trillium Gift of Life Network, and I became its first chair.

To say it was a tough process at the beginning is an understatement. We started with no budget, no employees, no office, nothing, and, perhaps as important, very little expertise to draw on to help us build. But build we did, as did my successors. Over time, we developed into a world-class organization. It took 15 years, but now Trillium Gift of Life Network is a world-class organization. It has world-class results in donation and it has world-class results in innovation. It's something that is a prestigious thing for our health care system and for our government to be proud of.

I should say that all of this development was not just done by Trillium Gift of Life itself; it involved a broad spectrum of the health care community. It involved critical care doctors, emergency ward doctors and, of course, transplant programs, and the hospitals themselves where organ donation occurred. They all eventually got together—and it wasn't without a struggle—to arrive where they are today. Of course, the best part of all this is that a lot of lives have been saved as a result of this, and, I tell you, it is a lot of lives.

A concern that's always there is that organ donation itself is very delicate. Perceptions of unfairness, perceptions of poor practices—all sorts of things can affect the public's confidence in organ donation, and the donation rates can go down. There's an example in Germany where there was a problem with the allocation of organs, and donation rates went down precipitously in a very short period of time.

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

Mr. Brian Flood: Yikes.

So I would say that Trillium is now a stand-alone agency with one focus and one focus alone, and has a culture to drive that focus, and that is saving lives through organ donation and transplantation.

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Now the government intends to make changes to this organization, and those changes are really of great concern

to me. I think they carry with them enormous risks. TGLN's operations, or whatever part they choose, are going to be put into the super-agency where it will be absolutely swamped. To give you a sense, Trillium Gift of Life Network is a very small organization. Its budget is less than one tenth of 1% of the total health care budget in Ontario. The idea that it will get the attention and focus that it now has—I just think it's small, and organ donation could suffer as a result of it.

The Chair (Mrs. Nina Tangri): Thank you very much. I'd like to pass it on to some questions now. Mrs. Karahalios.

Mrs. Belinda Karahalios: Thank you, Chair—

Mr. Brian Flood: Could I just make a couple of points? I'm realistic about the fact that the government seems determined to do this and that it has the majority and so it is likely to proceed, and so I just had a couple of comments I thought were important. One is I do want to congratulate the government on the board of directors of Health Ontario that they've appointed. I think it's a group with real substance and I really feel confident that they're going to try to do the best they can.

Secondly—I'll cut the other one out—I'm very, very concerned that the government in developing its plans has got lots of advice, but it hasn't got advice from the people who really, really know about organ donation in Ontario and know how Trillium worked. These are just absolutely wonderful people—it does not include me—that I absolutely would urge them as they move forward to give these people—

Mrs. Belinda Karahalios: Thank you, Mr. Flood. Thank you for that. I actually used to work for the Kidney Foundation of Ontario, so it's a pleasure to meet a kidney recipient. I did sign my donor card, just so you know.

I got to work with patients, nephrologists, renal social workers, nutritionists—the whole gamut—in the units across Ontario. I was very fortunate, in that respect, and I got to listen to some of the challenges that they were facing, both as patients and those who were practising in this field. One thing I did hear consistently from the doctors and nurses and other front-line workers was that they wanted change to help improve patient care and to reduce administrative duplication, and so I understand your concern.

Mr. Brian Flood: Sorry, I didn't hear your last words.

Mrs. Belinda Karahalios: Changes to improve patient care and reduce administrative duplication. I understand your concern—I'm not negating that at all—but I just wanted to ask, do you feel our current system is disconnected for patients and that a connected system could improve the lives of all, including those recovering from transplants?

Mr. Brian Flood: Do you know what? I can't answer that question. I just don't know enough about the system, and I know that the government wants to make sure things are connected. What I am quite confident about is that you don't have to move this thing inside this monster in order to do that.

Another point I'd like to make, because it shows the common misperception of organ donation in Ontario, is

that you made reference to signing a donor card, but donor cards are a thing of the past. Now the government has instituted a central registry system—

Mrs. Belinda Karahalios: Yes, it's online.

Mr. Brian Flood:—where you actually go to a website and register your consent to donation. It actually works. In a donation procedure, the hospital where the donor is will go into this system and ensure that they know what the status of the person is.

Mrs. Belinda Karahalios: Thank you, Madam Chair.

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

Mr. Sheref Sabawy: Thank you very much, Mr. Flood, for your input. I am really inspired with the past and you told us details about how you benefited from the system. Is there any specific area of the bill which you feel you're concerned about affecting this activity, any specific area of Bill 74?

Mr. Brian Flood: I am not a health care expert. I can't comment on your big plan; I just don't know. My only concern is the idea of rolling in the agencies. I'm a corporate lawyer. I've worked on all sorts of mergers and reorganizations and things. All the literature will tell you that seldom does a strong majority achieve the objectives for which they've done this thing. So I really do worry about the objective. I don't at all question the motives behind the objectives. In this particular case, I just question—

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

Ms. Kusendova.

Ms. Natalia Kusendova: Hello, Mr. Flood. It was really great to hear your deposition today. Reading your article that four lives have been saved from that donor that you received your kidney from, that's truly remarkable.

But I would have to disagree with one point that you're making here, that there are at least six businesses being merged. Unlike in business mergers, where most of six businesses have little in common—different roles, cultural strategies, expertise and more—in fact, we're trying to accomplish the opposite. The agencies that we are merging have one goal in common, which is to service the patients of Ontario.

I'm a front-line RN. What we found as front-line workers is that a lot of our agencies actually work in silos and do not talk to each other. Patients get frustrated because they have to start their health care journey with each and every single one organization starting from scratch. This merging of these agencies together to have that mission of centring the care around the patient will actually accomplish that, because the mission is the same: to service all Ontario patients. Do you have any thoughts on that?

The Chair (Mrs. Nina Tangri): The six minutes are up, I'm afraid. I'm going to have to go to the opposition. Mr. Mamakwa.

Mr. Brian Flood: I do. I'll talk to you after.

Mr. Sol Mamakwa: Brian, thank you for your comments and your story. I come from northern Ontario. I'm the MPP for Kiiwetinoong. When you talk about dialysis,

when we talk about diabetes, it brings to me stories of what's happening in my riding. A lot of people in the remote fly-in communities have to go to Thunder Bay or Sioux Lookout for dialysis, especially elderly people, people who do not speak the English language.

One of the things that happens is, because they get so homesick—they're not in their environment—they just forgo their treatment and go home. They just go home and die. When we talk about the health care system like that, it's really designed to fail our people.

But I do have one question: if you were approached or had an opportunity to consult in the drafting of Bill 74. If so, when did you start, if you were ever consulted?

Mr. Brian Flood: No, I wasn't consulted. But to be honest, I wouldn't consult me.

Mr. Sol Mamakwa: Okay.

Mr. Brian Flood: I know who should be consulted, and I'm concerned that people with real expertise about all this aren't being consulted. But it's not me.

Mr. Sol Mamakwa: Based on your story and your personal experience of being a kidney transplant recipient, can you further explain why you believe that the agency that you're on, the Trillium Gift of Life Network, should not be merged into an agency?

Mr. Brian Flood: I'm not sure what—

Mr. Sol Mamakwa: Can you explain why the network—

Mr. Brian Flood: Why they shouldn't do it?

Mr. Sol Mamakwa: Yes.

Mr. Brian Flood: What I tried to point out, and maybe I forgot to, was that the agency as it exists as an independent agency right now works, and when I was involved in Trillium, every successful or virtually every successful—I can't think of one that wasn't—agency of this nature was independent. I know of no successful organ-donation organization that was part of a big organization with multiple areas of responsibility.

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Mr. Sol Mamakwa: Okay. Also, you did an opinion piece in the Toronto Star. I'm going to quote you here: "The really frustrating thing is that it is so unnecessary. The move does not at all go to the heart of the Ford government's restructuring plan. So why do it? The government makes ill-defined claims of intangible and immeasurable benefits of the consolidation to the health care system but it is clear the real reason is to cut costs—cut management and staff." Can you explain that a bit?

Mr. Brian Flood: I did say that. I must say, at the time, I didn't realize how awfully small in comparison to everything TGLN is and how there's not much to cut there. I'm sure they can merge some back-office things and they can find efficiencies.

I have no problem whatsoever with Ontario Health overseeing—indeed, I would encourage oversight of Trillium and setting standards or whatever they feel will help Ontario Health and help with integration or whatever.

M^{me} France Gélinas: In your experience—

The Chair (Mrs. Nina Tangri): Madame Gélinas, let me introduce you for Hansard. Thank you.

M^{me} France Gélinas: In your experience as a lawyer who does mergers, what do you see, with a tiny agency like Trillium Gift of Life being part of this huge new agency—what do you think will happen to that small agency?

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

Mr. Brian Flood: Trillium, in its present form, with one exception—it had its own management team, it had its own board of directors, and it had oversight by the ministry, the Minister of Health. It's being moved into an organization where its board of directors—they look like they're going to be a good board, but they have so many awesome responsibilities. I just know what's going to happen. I've been on lots of boards. Trillium is going to be one or two pages in a board book for a meeting. It will get to appear before this board once every two years.

I think I'm confident that that board is going to make sure that there's some proper—I don't know—sub-board or something like that, a committee or something that will oversee Trillium. It's just an essential part of both holding it accountable and guiding it and helping it.

The Chair (Mrs. Nina Tangri): Thank you very much for presenting to us today, Mr. Flood. We appreciate your coming out.

ADVANTAGE ONTARIO

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

Ms. Jane Joris: Good afternoon. I'm Jane Joris, the board chair of AdvantAge Ontario. With me is Lisa Levin, our CEO. Thank you very much for the opportunity to present today. It's nice to see some of you again.

AdvantAge Ontario is a voluntary membership association that has been the trusted voice for providers of senior care for 100 years. We're the only provincial association that represents the full spectrum of senior care. This gives us a unique and vital perspective on how this sector and government can work together to best meet the needs of Ontario's seniors. Our members include 400 municipal, charitable and not-for-profit long-term-care homes, seniors' housing and seniors' community service providers, serving 36,000 long-term-care residents and 8,000 housing residents.

Today I'd like to speak about the proposed The People's Health Care Act, Bill 74, with a focus on schedule 1, the Connecting Care Act. We're very pleased to see the government focusing on a connected health care system that puts the needs of Ontarians first. Increasingly, patients have fallen through the cracks in our health care system. We agree that Ontario desperately needs a more patient- and resident-focused system that is better integrated across different care settings.

We support the overarching goal of this transformation as well as the safeguards in place in the proposed legislation for health service providers. I'll speak to the

areas of the legislation that will help our members move forward with building a connected health care system and also indicate some areas of concern that our members have raised and solutions that we believe will enable successful integration.

In our written submission, we have made seven recommendations. I will highlight four of these today.

Our members are pleased that the government embedded integration protections for religious, charitable, not-for-profit and municipal organizations in the proposed legislation so that they may continue to serve their specialized populations in the best ways they see fit. Similarly, the act protects long-term-care homes from being closed down, recognizing that they are fundamentally the home of their residents.

In addition, we are pleased to see the option of including non-health services, such as supportive housing, Meals on Wheels and medical transportation services, in Ontario health teams. This will further improve continuity of care and health outcomes.

Finally, we are pleased to see the government's recognition of the need for a gradual rollout of this transformation, which will be key to its successful implementation.

As government deliberates on how Ontario health teams will be governed, AdvantAge Ontario would like to flag potential unintended consequences that may result from certain governance models. Specifically, if Ontario health teams are structured such that one health service provider becomes a designated lead for a team and is the distributor of funds as well as the decision-maker, this could represent a conflict of interest. We are also concerned that decision-making and priority-setting may revolve primarily around the interests and needs of the lead organization, to the detriment of Ontarians.

To ensure provision of the best possible health care, Ontario health teams must be collaborative and make decisions collectively. Accordingly, we urge the government to encourage teams to have a shared governance structure where each health service provider has an equal voice at the decision-making table with regard to funding, health care delivery and long-term-care-home admissions.

It will also be important to ensure that funding decisions and allocations continue to be divided in a way that enables each health service provider to fulfill their role and deliver high-quality care. While a proposed blended payment model or single funding envelope will certainly help to incentivize providers to make person-centred decisions and be diligent with their resources, we need to establish safeguards that will protect the funding and quality of care delivered by each provider. We recommend that the government put safeguards in place to protect long-term care, supportive housing, and home and community care funding envelopes so they do not get eroded and re-allocated over time.

We also need to ensure that needs are met across sectors. Currently, admissions to long-term care are controlled through the LHINs. If the lead organization will now be responsible for long-term-care admissions, our members are concerned that the lead may make admission decisions focused on the specific needs of that provider,

leaving other individuals with similar needs without access to services. For example, a hospital-led team may focus on moving their ALC patients into long-term care, thus giving them priority over people in the community. This could result in burned-out caregivers and increased emergency department visits.

Finally, we recommend that the government ensure transparency by requiring all meetings of Ontario Health's board of directors and its committees to be open to the public, and by making a commitment to public accountability and transparency in Bill 74's preamble.

We are hopeful that the government will recognize some of our members as possible leads of Ontario health teams. Our members provide care to seniors across the care continuum, so they have much experience in helping individuals navigate through the health care system and transition across settings. They have done this effectively and efficiently by collaborating with partners across the health care system and in the community.

We have been pleased to collaborate with the government, and our members are eager to contribute their front-line insights toward building a more connected and harmonized system. Our recommendations are provided to enable successful implementation and ensure that all Ontarians have fair access to the services they need, when and where they need them.

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We urge the government to continue to collaborate with us and the sector to ensure that Ontarians get the care they need and deserve. We look forward to working together towards building a health care system that is focused on patient and resident needs across the health care continuum.

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

Ms. Teresa J. Armstrong: Thank you for being here today to present on this very important bill. You mentioned that you collaborated with the government, but I just want to be clear: Were you consulted prior to the draft of the bill, and if so, when were you consulted?

Ms. Lisa Levin: Yes. I sit on the long-term-care subcommittee of the Premier's council on ending hallway medicine—it's a longer name, I know—and so as some information about some of the details was brought forward before the bill was put out or leaked out, I was consulted at that meeting in particular. We meet regularly with government as well.

Ms. Teresa J. Armstrong: So you were consulted as a member of the council or you were consulted as a member of AdvantAge Ontario?

Ms. Lisa Levin: I believe I'm there in the capacity as—

Ms. Teresa J. Armstrong: In your capacity—

Ms. Lisa Levin: Yes.

Ms. Teresa J. Armstrong: Then, after the draft, were you continually consulting as they went along as well?

Ms. Lisa Levin: Yes. I sit on that committee, but in addition to that we've met with ministry staff. We meet quite regularly with different parts of the Ministry of Health.

Ms. Teresa J. Armstrong: Good.

One of the issues around Bill 74 is that people are feeling that it's being pushed and rushed a little bit too quickly, and being passed without any information on plans to avoid disruption in patient care. An example: We know that LHINs used to manage the list for long-term care, and right now, we know that it's about 33,000 people on a waiting list. I wonder if you could provide some insight as to whether members have been informed by the PC government on who will be managing the long-term-care wait-list, so that, for example, if someone's got number 10, they won't lose their spot if Bill 74 passes and the LHINs are dissolved.

Ms. Lisa Levin: I think this government has been very clear that it's going to take a long time to roll this out, which was reassuring to us, because it's a massive transformation. We want to make sure that it's rolled out carefully, with adequate feedback from stakeholders.

In terms of the wait-list itself, I haven't heard anything about those details. I believe it's because it's something that is going to be developed over time. I believe the next stage is that the EOI is going to come out on the teams themselves. I had a meeting last week with the ministry, and they said that in the first phase it will go slow and not everything's going to change at once. So I don't know what will change and what won't, but it's possible that that part may not change initially, or maybe ever. But certainly in our submission we talk about the need to ensure that the needs of the full community are met and not just, for example, those in hospitals and ALC beds.

Ms. Teresa J. Armstrong: I appreciate that in your presentation. You also say that you "recommend government to put safeguards in place to protect long-term care, supportive housing and home and community care funding envelopes so that they do not get eroded and reallocated over time." What kind of protections would you be looking for when you made that in your presentation?

Ms. Lisa Levin: Well, we weren't exactly sure, and we'd like to talk to government about that. I know that they're going to be developing regulations and so we're hopeful we'll be part of that discussion. We also want to make sure, though, that there is some flexibility, almost like a one-way valve, so that hospital funding doesn't take up the community funding, but at the same time maybe some of the acute care funding could go to community but only if we can get enough community in place so that we don't have people in hallways. It's a tough question. I don't know the answer to it, but certainly we'd like to talk about how to make that happen.

Ms. Teresa J. Armstrong: Yes. It would be good if we had some details around that, so people weren't feeling so apprehensive about this bill being pushed through.

I also want to ask you about the transparency requirement. Does it concern you that meetings aren't going to be open to the public and participation and transparency around what's going to happen next locally?

Ms. Lisa Levin: We're hopeful that in the regulations those details will be there. When we prepared this submission, we knew that this is the legislation, but then the regulations are next. So even though this isn't a point in

time at which to comment on regulations, we're hopeful that if that is not put in the preamble of the legislation, there can be provision made in the regulations so that there can be transparency, because this is a very large agency that has taken over or will take over a bunch of other organizations, many of which had open meetings, and these are critical matters to the people of Ontario.

Ms. Teresa J. Armstrong: In your seven recommendations that you provided, can you elaborate? If you had to pick a top three—I know it's difficult. I don't know if you prioritize them that way, but could you speak to those top three and how important they would be in order to make sure this bill is strengthened?

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

Ms. Lisa Levin: I guess the bottom line is, we just want to make sure that the bill moves forward in the way that's intended: to be patient-centred for Ontarians and to make sure that community is involved and around the table. I've had recent meetings with the ministry since we wrote our submission which have given me more reassurances that that will be the case. We want to make sure that it's not just driven by one player in a particular area, that all the players come together collaboratively and work together to make sure that the people of Ontario get the best possible health care.

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

Before you begin, can I please ask people not to stand at the door. If there are any empty seats, please fill them in the interest of safety. Thank you very much.

Mr. Anand.

Mr. Deepak Anand: Thank you so much for coming and congratulations on completing 100 years of service. It's remarkable; I can see that.

Looking over, you represent about 36,000 long-term-care residents and 8,000 seniors' housing residents. Going through your strategy plan, you boldly say that you want to build strong and collaborative relationships. So my question to you is, with Bill 74, what are the current barriers to collaboration between health sector partners and how could your member organizations, with 100 years of experience, work with our Ontario health teams? How can we—

Ms. Lisa Levin: I think some of the barriers lie in regulation. For example, the Long-Term Care Homes Act—there's a lot of regulation there. I've been told that the only industry that's more regulated than long-term care is the nuclear industry. Certainly it's very important that we have regulation in long-term care, that we safeguard our vulnerable seniors, but when you have a culture of so many rules and our members are so afraid that they're going to get slapped with an order, how can you be innovative?

Another example to look at is campuses of care. Many of our members that you referred to have campuses of care, where you'll have a long-term-care home, supportive housing and community services. The staff can't flow across them as well as we would like because of some of

the rules and regulations. That results in staff not being able to get full-time jobs when really they should have. It results in residents not being able to go from one setting to another and have continuous staff. In fact, there's not even a requirement that if you live on a campus, you get top priority placement to go from supportive housing to the long-term care on the campus.

Those are some of the things, and that's just within our own membership. But certainly we believe that this legislation will encourage more collaboration. That has already been started with bundled care and health links, and we're encouraging our members as well to go out and speak with partners and to lead and be part of teams.

Mr. Deepak Anand: Thank you so much.

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

Ms. Effie J. Triantafilopoulos: Thank you, both, for being here with us today. The information you're providing us is very, very informative. As my colleague Mr. Anand said, having 100 years in this sector brings a lot of experience to the table, and so we've been listening very carefully to what you have to say.

As you know, the changes that we've been proposing through Bill 74 are very much underlined to build a public health care system centred around the patient. We want to be able to redirect the money to front-line services, where it really belongs and in fact hasn't been for perhaps decades. Our focus is very much with that objective in mind.

We've been hearing that too many patients are in what they call the ALC beds and that they could actually be better served in long-term care, and we hear that as many as 1,000 patients receive care in the hallways in the hospitals. What I'd like to ask you is, how can we better—and do you believe we can better—integrate those patients who are currently in ALC beds to be able to move into long-term care or perhaps to move into home care environments based on our new model? How could you see that working and unfolding?

1520

Ms. Lisa Levin: I believe that under the new model, if it works the way that we all want it to, there will not be patients in ALC beds to begin with, because what we want to see happening is through—if the teams are formed properly, then discussions will be held that say things like, “Wow, we need to get more community services out in the community, and we can reallocate our funding in that way to do it.” People who don't have assistance with a bath because they're not high-enough needs to get the current publicly funded home care and who then fall and break their hip and end up in ALC, that won't happen.

We also are hoping that this government is going to fund more supportive housing, as well as build new long-term-care beds, so people can stay in their homes longer and not have to go into other situations, so that they don't need to go into long-term care. We also believe that by working together there will be better flow and more seamless transitions. In fact, we want to eliminate the word “discharge” altogether so that when people leave hospital

or leave one setting, they don't feel like they've fallen off a cliff, like they do now.

We think there is a lot of opportunity to not just get people out of ALC to begin with, but to avoid it overall.

The Chair (Mrs. Nina Tangri): You have one minute left, if you'd like to conclude.

Ms. Effie J. Triantafilopoulos: One quick question, and that is around the unique challenges in being able to provide care, particularly in rural or northern communities. Would you be able to share with us your own experience in dealing with those sorts of challenges or barriers that might exist?

Ms. Jane Joris: I heard Deborah talking earlier about the health human resource crisis. I work in a rural area—not in the north. Being able to provide the care that we would like to provide for our residents and our community services clients is difficult without the staff.

I also think that the communication between providers is critical. Right now, often there is a third party in the middle of that. If we could talk to each other, particularly in rural areas where there are not a lot of services other than us, if we have good conversations and good information, we'll know whether or not we can meet those people's needs.

The Chair (Mrs. Nina Tangri): I'm going to have to conclude there. Thank you very much for presenting to us today.

REGROUPEMENT DES ENTITÉS DE PLANIFICATION DES SERVICES DE SANTÉ EN FRANÇAIS DE L'ONTARIO

The Chair (Mrs. Nina Tangri): I'd like to call upon Regroupement des Entités de planification des services de santé en français de l'Ontario. Bonjour.

Please introduce yourself for the record. You have eight minutes to present, followed by six minutes each from the recognized parties.

M^{me} Estelle Duchon: Bonjour. Good afternoon. Je suis Estelle Duchon. Je suis la directrice générale de l'Entité 4. Avec moi aujourd'hui, il y a Diane Quintas, qui est la directrice générale du Réseau du mieux-être francophone du Nord de l'Ontario, et Jacinthe Desaulniers du Réseau des services de santé en français de l'Est de l'Ontario.

Ensemble, nous représentons les six entités de planification qui existent en Ontario. Nous avons été nommées en 2010 par le gouvernement de l'Ontario, et notre rôle est de nous assurer d'améliorer l'accès pour les francophones à des services de santé en français.

Donc, merci de nous recevoir aujourd'hui. Nous allons vous présenter trois recommandations qui ont pour objectif de bonifier le projet de loi afin de favoriser une planification efficace des services de santé en français et ultimement d'améliorer l'accès pour les francophones aux services de santé en français.

Quand j'essaie d'expliquer le rôle des entités de planification, je le décris en trois parties. Le premier, c'est celui que nous jouons auprès des communautés francophones pour les consulter pour mieux comprendre

leurs besoins et les modèles de service qui répondent à leurs besoins. Le deuxième, c'est dans la planification des services pour que quand une nouvelle stratégie est développée en démence, en santé mentale, sur les soins de longue durée, on puisse s'assurer qu'il y a un volet francophone. Et le troisième est auprès des fournisseurs de services de santé pour nous assurer que ces fournisseurs sachent comment offrir des services de santé en français. Globalement, tous les intervenants en santé veulent bien faire. Ils veulent bien servir leurs patients, mais ils ne savent pas nécessairement comment le faire et par où commencer. Et c'est là notre rôle.

Merci beaucoup de m'avoir écouté en français. Hopefully, you understood most of my messages today.

I'd just like to stop for one second and just ask you to imagine how you would feel as a francophone patient if you had to explain yourself in English. In an already stressful situation, you're getting to the hospital, you have to explain what's happening to you or to your kids, and it's really difficult for you to be understood because you don't speak English, or limited English. Hopefully, you realized while you are listening to me in French how difficult it can be for someone to be understood in a different language.

Those language barriers have consequences for the patients and for the health care system. For the health care system, it increases the number of errors in the diagnostics and it costs the health care system a lot more when you try to meet the needs of a patient you don't understand.

For the patient, you feel helpless. You don't know how to be understood and to explain your situation. But also, for the health service professionals, it's really difficult to understand what's happening with your patients. As a health care professional, you want to do the right thing for your patients. So having this language barrier and not being able to serve francophones really creates difficulties for this system.

The restructuring of the health care system proposed in Bill 74 presents opportunities to address those barriers and to improve access to health services in French. In order to seize this opportunity before us, we present our analysis of Bill 74 today and would like to make some recommendations.

M^{me} Jacinthe Desaulniers: Let's turn our attention to Bill 74. We'd like to start off by highlighting four positive points that we see in the legislation in terms of French-language services. First of all, the preamble—

The Chair (Mrs. Nina Tangri): Can I ask you to please state your name for the record?

M^{me} Jacinthe Desaulniers: Jacinthe Desaulniers.

The preamble mentions that the Ontario public health system must comply with the French Language Services Act, the fact that Ontario Health is subject to the French Language Services Act, the fact that the council for French-language services is maintained, as well as the French-language planning entities. But let me go, in the interest of time, straight to our recommendations.

Our first recommendation: We want to express that we understand that the government has a desire to integrate the system, for it to be more centred on the patient and

have better navigation. Francophones want this too. However, one of the things that we know is, when there are massive or significant integration transition periods, it can be very chaotic. There are many, many competing priorities. Often—not to say always—French-language services tend to fall to the bottom of the priority list and to be, unfortunately, overlooked and sometimes just unintentionally overlooked. That's why our recommendation is that we state the FLS expectation up front and clearly.

The first thing we'd like to see stated in the bill is that the Ontario health teams are also subject to the French Language Services Act. This would do two things: It would ensure that the needs of the francophone are taken into consideration systematically, and it would also make the organizations accountable for offering services in French.

We've heard from l'honorable Caroline Mulroney, who has said in a letter to us that she sees the Ontario health teams as being under the French Language Services Act, so our request is this: You've put it in a letter; now we need to see it in the legislation.

The second part of that recommendation is that, where opportunities to merge organizations are identified and implemented—and we know that's a big part of the bill and what's going to happen—the FLS obligations of all stakeholders involved be analyzed, documented, transferred and monitored to maintain services and ensure compliance with FLS. Simply stated, if you have, in the health care teams, designated and non-designated organizations that are merging, what are the obligations, and let's not lose services. In previous transformations, we've seen the loss of service in those instances.

Our second recommendation is that we are very happy that the French-language planning entities will work closely with Ontario Health at the provincial level. We think that will help to inform decision-making. However, it is also essential that we have a relationship, or we continue to have a relationship, at the local level, because that's where health care happens for patients and francophones. It's with the Ontario health teams and the HSPs.

Thus, we would like the obligation for the HSPs and the integrated health teams to collaborate with the French-language planning entities to be explicit.

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

M^{me} Jacinthe Desaulniers: We fully understand the desire to act quickly. That's a concern for us because when the bill will be passed, regulation 515/09 will be abolished. So we need to make sure that there is no legislative void and that the entities continue in this critical transformation phase, and that the existing regulation be adapted to make sure that the responsibility to collaborate both at the provincial level and at the regional level be explicitly stated.

We thank you very much for the opportunity to present this afternoon. We see this as a commitment to continue the collaboration that we've had with the government over the years.

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

Mrs. Robin Martin: Thank you very much for the presentation. It was very thorough. I met Estelle, I think, on Friday—

M^{me} Estelle Duchon: Yes, one week ago.

Mrs. Robin Martin: —at my constituency office. It's nice to see you again. We appreciate you laying out your recommendations so clearly. It's very helpful for our ongoing consideration of this.

Can you just describe for us where you feel we have deficits currently in the French-language service provision for health services and how this bill might help us address those?

M^{me} Diane Quintas: Do you want me to introduce myself?

The Chair (Mrs. Nina Tangri): Please.

M^{me} Diane Quintas: Diane Quintas.

There's obviously a lot of deficits, currently, in the system. What we'd like to really focus on is what needs to be done in the bill to ensure that the work we're doing to improve those deficits continues. It's not the bill that will fix the problems in the system and that will fix the lack of services available to francophones; it's more the work that needs to be done in the field with the health service providers and professionals offering the services. So the recommendations we propose are looking at ensuring that that work can continue to be done at a local level, at a provincial level—and also, with any new strategies that come out, that French-language services are there at the forefront and not as an afterthought.

Mrs. Robin Martin: Can you help me with how these suggestions will make that integration happen locally, for example, or at the—

M^{me} Diane Quintas: Our second recommendation looks at ensuring that the Ontario health teams would also fall under the *Loi sur les services en français*, the French Language Services Act, and that they would also have requirements to ensure that services are going to be offered in this new structure that will be created.

We've also got a recommendation that looks at, when we're creating these teams, that we're considering organizations that already have obligations under the French Language Services Act—that their services continue to exist. What we've seen too often is that when you have amalgamations or when you have organizations that work together and merge, you have one that is designated and you have four that are not. What happens to French-language services within those amalgamations? Often they're lost, they're forgotten, they're put aside. So what we're asking is that those services that exist help to influence and improve the rest of the services, as well.

Interjection.

The Vice-Chair (Mr. Deepak Anand): Go ahead.

Mr. Sheref Sabawy: If you can help us a little bit in understanding: Do you see those services to be integrated into the new service body, or would you still like some separate entities managing the French piece, the francophone piece?

M^{me} Diane Quintas: I think you're asking an interesting question, because one is a wish and one is a reality. I think as we look at—

Mr. Sheref Sabawy: I'm trying to understand your vision because—

M^{me} Diane Quintas: What we're proposing to you is that, as we look at the bill as it stands, what's going to happen is an integration. So we're trying to help and provide information as to how that integration can be done to ensure that those services remain. I don't think it would be realistic to think that we'll have a stand-alone, independent system that exists for francophones across all of Ontario, so we need to be integrated within the system that's there. But how do we ensure that within those integrations, that French services are available to those francophone patients, especially in areas where there might be fewer francophones, even more of a minority? There are differences when you look at northeastern Ontario and Ottawa versus Windsor or Thunder Bay, right? There are very vast differences in the number of francophones and the number of French-speaking providers, so how do we ensure that clients—the bottom line of all of this transformation, patients—still get the services that they need?

Mr. Sheref Sabawy: Actually, my question was for that specific area, because of the different distribution of francophones in some areas which have very light francophone existence versus other areas. Do you see some mandatory parts of the legislation, or just discretion?

M^{me} Diane Quintas: Sorry? Do I see—

Mr. Sheref Sabawy: Mandatory—any mandatory coverage or mandatory words in the legislation to fulfill that. With the fact that it's not equal distribution, it's going to be very hard, so how do you see that fulfilled without adding some burden on the legislation?

The Vice-Chair (Mr. Deepak Anand): You have a minute, approximately.

M^{me} Diane Quintas: I'm going to answer the way I answer to my staff when they say to me, “But I don't have that many francophones in that region”—not necessarily my staff, but anyone else.

The patient who comes through the door is the patient who needs to be treated. Whether there are five francophones or whether there are 5,000 francophones, if we're looking at serving the people, we need to look at how we best serve those people, how we best treat the patient in front of us.

The Vice-Chair (Mr. Deepak Anand): Member Kusendova.

M^{me} Natalia Kusendova: Bonjour. Merci beaucoup d'être avec nous. Merci de votre discours aujourd'hui. Je suis infirmière, et je travaille dans les soins d'urgence à l'hôpital d'Etobicoke.

My question is around the language barrier. It's one of the things that, as a health care provider, I face all the time. I just happen to speak French, and I happen to be able to service those patients, but how do we ensure that, going forward, we have more health care professionals who service the different needs of our populations? That's

including francophones, but there are also many other languages spoken across Ontario.

The Vice-Chair (Mr. Deepak Anand): My apologies. The time is over.

Ms. Natalia Kusendova: Sorry.

M^{me} Diane Quintas: That's twice today. You have no luck.

The Vice-Chair (Mr. Deepak Anand): Member Gélinas.

M^{me} France Gélinas: Bonjour, madame. Merci d'être ici aujourd'hui. J'aimerais commencer par une petite question : avant que le projet de loi 74 ne soit présenté en Chambre, est-ce que vous avez été consultées pour savoir ce qui devrait être dans le projet de loi?

M^{me} Diane Quintas: Non.

M^{me} France Gélinas: Aucune des entités n'a été consultée?

M^{me} Diane Quintas: Non, nous n'avons pas été consultées.

M^{me} France Gélinas: Et depuis que le projet de loi a été déposé, est-ce que vous avez eu la chance de parler à la ministre ou à son bureau?

M^{me} Diane Quintas: Nous n'avons pas eu la chance de parler à la ministre. Nous avons par contre fait des demandes auprès de différentes personnes au niveau du ministère de la Santé. On nous a accordé des rencontres.

Je trouve que la question qui s'est faite poser beaucoup aujourd'hui autour des consultations—les entités ont toujours travaillé avec le gouvernement, avec le ministère de la Santé et des Soins de longue durée pour partager nos visions de comment améliorer le système et comment assurer un service de santé en français. Je dois dire qu'on a souvent eu une bonne réception, une bonne écoute. Mais est-ce qu'on nous approche pour nous demander? Ça, c'est moins le cas. Alors, on n'a pas rencontré la ministre Elliott depuis qu'elle est ministre. On a par contre rencontré certains autres fonctionnaires ou sous-ministres ou sous-ministres adjoints.

M^{me} France Gélinas: OK. C'est clair que, dans le projet de loi, il n'y a rien de spécifique pour aider les francophones. Une grosse agence et 50 petites agences—il n'y a rien là-dedans spécifiquement pour aider les francophones. Mais il y a quand même beaucoup de choses qui risquent de nuire aux francophones.

Je vous demanderais : quel va être l'impact pour les francophones d'avoir des services en français si on ne met pas en place les recommandations que vous avez faites?

M^{me} Diane Quintas: C'est clair que les recommandations—et une des grosses recommandations, c'est que les entités puissent continuer à faire leur travail auprès de l'agence et auprès des équipes sur le terrain, parce qu'on est là pour assurer que le travail qui se fait inclut les services en français. Alors, si les entités n'étaient plus là, il n'y aurait plus cette lentille francophone—si on veut—ce rappel par rapport aux services en français.

La semaine passée, j'ai rencontré, au niveau de ma région, mon RLISS, où ils avaient soumis une proposition au ministère pour devenir une « Ontario health team » où

ils ne parlaient même pas des francophones dans la lettre. Pourtant, je leur avais parlé la semaine d'avant.

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Ce qui fait qu'il faut qu'on soit là pour continuellement leur faire penser à dire: « OK. On est en train de mettre ça en place; comment est-ce qu'on s'assure que les francophones vont être représentés? », parce qu'il y a un coût énorme à le faire par la suite. Si, une fois que tu as envoyé toutes les lettres sur le terrain, tu te rends compte que tu as oublié de mettre la lettre dans les deux langues puis que, là, il faut que tu renvoies toutes les lettres une deuxième fois à toutes les maisons, bien ça coûte pas mal plus cher. On est là pour ça.

M^{me} France Gélinas: Vous avez mis ça clair, que vous voulez avoir la chance de travailler avec toutes les équipes de Santé Ontario—c'est comme ça que je l'ai traduit. Qu'est-ce qui arrive avec les services en français quand ça ne s'applique pas aux tierces parties et qu'on voit un projet de loi où il y aura beaucoup de services qui étaient dans nos hôpitaux qui ne le seront plus, qui s'en vont à des services tiers, là où la Loi sur les services en français ne s'applique pas?

M^{me} Diane Quintas: Pour nous, c'est clair qu'on veut s'assurer que ça soit là aussi et que les organismes qui vont offrir des services soient redevables. C'est pour ça qu'on fait la demande que les « Ontario health teams » soient sujets à la Loi sur les services en français, et, de par ça, on l'espère, tous les services qui vont en découler.

M^{me} France Gélinas: Donc, quand vous demandez que les services en français s'appliquent aux équipes de Santé Ontario, pour vous ça veut dire que tous les services qui seront sous cette équipe-là devront également se soumettre à la Loi sur les services en français?

M^{me} Diane Quintas: Absolument. Et je vous rappelle, comme l'a dit Jacinthe, qu'on a eu la confirmation par écrit de la ministre Mulroney que ça serait le cas. Alors, nous, ce qu'on demande c'est vraiment de s'assurer qu'on le voit dans la loi, parce que la préoccupation qu'on a c'est qu'on ne le voit pas dans la loi. Puis on sait que si ce n'est pas là, écrit noir sur blanc, c'est facile de l'oublier.

M^{me} France Gélinas: Chair?

The Vice-Chair (Mr. Deepak Anand): You have one minute.

M^{me} France Gélinas: Chair, they said that they have received a letter from a minister, and I would ask that they share that with the committee.

M^{me} Jacinthe Desaulniers: Oui. Pas de problème.

M^{me} France Gélinas: Merci. En dernier lieu, est-ce que vous savez, les entités, à qui vous allez vous rapporter en ce moment? En ce moment, vous vous rapportez à qui?

M^{me} Diane Quintas: En ce moment, on se rapporte à nos RLISS de la région où on est desservi. Dans le projet de loi, il semblerait qu'on répondrait à la super-agence, alors Ontario Health.

M^{me} France Gélinas: Mais là, les RLISS n'ont plus de conseils d'administration; ils n'existent plus. Donc vous êtes—

M^{me} Diane Quintas: On flotte.

M^{me} France Gélinas: Vous flottez. Donc c'est toujours—

M^{me} Estelle Duchon: Notre entente de financement est toujours en action. On répond toujours à nos RLISS. Pour ce qui est de l'entente de financement, on est sélectionné par la ministre de la Santé en l'occurrence. Donc ça, c'est l'objet de notre troisième recommandation. C'est pour ça qu'on insiste sur le fait qu'il faut qu'il y ait un nouveau règlement qui soit adopté en même temps que la loi pour éviter un vide juridique où on se retrouverait sans entente de financement et où on ne pourrait plus, justement, assurer que les services en français, dans une phase de transition—

The Vice-Chair (Mr. Deepak Anand): We have about 10 seconds.

M^{me} France Gélinas: Donc, si on ne prend pas vos recommandations, c'est vraiment qu'on ne pourra plus assurer que les services en français soient—

The Vice-Chair (Mr. Deepak Anand): Madame Gélinas, thank you so much.

Regarding the letter, if you wish, you can pass it on to the Clerk. Thank you so much. Thanks for coming.

ONTARIO COUNCIL OF HOSPITAL UNIONS/CUPE

The Vice-Chair (Mr. Deepak Anand): Next is the Ontario Council of Hospital Unions and CUPE. Thank you so much for coming. You have eight minutes of presentation, followed by six minutes from both sides.

Ms. Heather Duff: Thank you. Good afternoon. My name is Heather Duff. I'm the chair of CUPE Ontario's health care sector. With me today is Michael Hurley, president of the Ontario Council of Hospital Unions/CUPE, and Doug Allan is our CUPE researcher.

CUPE is the largest union in Canada and in Ontario with 680,000 members nationwide. We are also the largest representative of health care workers in the province, with 70,000 health care workers. We live and work in practically every single city, town, county, village, DSSAB and unorganized territory.

The new government has promised to end hallway medicine, yet their fiscal plans threaten to make the situation worse. Their focus on restructuring health services will divert time and resources away from solving the basic problem of health care.

For decades, health care funding in Ontario kept pace with the rest of Canada, but with real cuts, provincial hospital funding is now 28% higher in the rest of Canada than in Ontario, at \$404 more per person per year. For health care as a whole, the rest of Canada provides \$561 more than Ontario.

The results of this underfunding are predictable: few hospital beds, extraordinarily high bed occupancy, very short lengths of stay, more readmissions, enormous wait-lists for long-term care, few hours of care for long-term-care residents, an explosive increase in acuity in home care patients, the removal of less-sick patients from home care services, and the exhaustion of unpaid family caregivers— all the elements of a hallway health care crisis.

The bill ignores the lack of capacity and instead pretends to address the basic problem by restructuring. As

with the last two restructurings of health care, this reform can only be understood as a rationale for not increasing capacity.

This is the third major government restructuring of health care in 22 years. The last PC government privatized home care, shut and merged scores of hospitals, moved chronic care to less-well-staffed long-term-care facilities, and cut hospital funding by hundreds of millions of dollars. The goal was to reduce hospital care, very reminiscent of this reform.

Despite claims that this would cut spending, the PC government slowly and quietly recognized reality. By 2000, after shutting and merging dozens of hospitals, they quietly made a U-turn, increasing hospital funding by 12.6% in one year. Funding increases over the five years after restructuring averaged 8.7%. Restructuring created a crisis but did not reduce costs.

Another round of restructuring began in 2000 with the creation of the local health integration networks. Again, the hope was to cut hospital use. This time, however, the cuts expanded to include tight restrictions on long-term care.

Despite the obvious problems with capacity in our hospitals, home care and long-term care, this new reform does not add any extra capacity. Instead, it focuses on restructuring our system with a simple insistence that all can be solved by moving services from high-cost to high-value providers, much like the two previous restructuring attempts. In this sense, restructuring is an excuse for not dealing with lack of capacity. Our problems can be solved, the notion goes, by restructuring, so there is no need to add capacity.

Just as bad, the new legislation gives the minister and the super-agency sweeping powers to privatize. There is no commitment in this bill to the principles of the Canada Health Act nor delivery by not-for-profit organizations. The functions of existing health agencies can be turned over to for-profit corporations; integrated care delivery systems can now be for-profit corporations; and corporate Canada has been given a prominent role on the board of the powerful new health care super-agency.

Michael?

Mr. Michael Hurley: Here we are with the largest restructuring of health services, probably, that has ever been undertaken in the province of Ontario—a massive merging together of services, many of whom are leaders in the world, without any credible explanation as to why that's happening. There is absolutely no consultation with any of the staff who work in home care, long-term care, the community sector, in the hospitals, in diagnostics, or with the doctors—nothing.

We talk about teamwork. The whole team toils away, under-resourced, understaffed, trying to deliver a quality service, and the government ignores them and proposes a major restructuring.

The board meets in secret, heavily weighted by private sector interests. We see legislation introduced which allows the minister, the agency, the ICDSs to privatize services, even though the evidence in an evidence-based

system would suggest that prior restructurings have been massively more expensive than any savings they've generated, and that privatization, even in our recent history under the Liberal government, has proven to be an enormously wasteful, expensive, unaccountable and secret boondoggle. But despite that, the capability has been built into this act to allow for privatization.

I just want to say, on behalf of the workers that we represent, that we will fight any privatization of health care services. The government is arming itself now with the capacity to privatize, but the actual implementation of that will require some time. We will do everything that we can—everything that we can—with our membership and in our communities to mobilize public opinion behind the science and evidence that already exist that privatization is destructive in terms of higher death rates and that it's destructive in terms of the cost, wasting precious resources. We're going to mobilize behind that.

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We're going to mobilize small-town Ontario, because small-town Ontario is a loser in this restructuring. The Sarnias, the Hawkesburys, the Campbellfords, the St. Maryses: They're all at risk as they are swept into these enormous institutions, the ICDSs, over which they're going to have very little control.

I have to say that with respect to the workforce and the labour relations aspect of this, in the very limited discussions that we've been engaged in, we've been asked how we feel about our work moving without the workers moving with it, which means how we feel about our work moving to private clinics, how we feel about our work moving to organizations like SteriPro etc. that do private contracts, with our people being laid off. That is the extent to which we have been consulted.

I'd just like to say, with respect to this bill, the best thing the government could do with this bill is to withdraw it. It would be to go back and reframe a discussion with everybody who should be at the table, to have a discussion about how Ontario should restructure itself, if that is at all necessary, to provide quality services.

The essential failing in Ontario's health care and cancer care etc. is just a lack of investment. It's not the need for a super-structure and a parallel Ministry of Health.

The Vice-Chair (Mr. Deepak Anand): You have about 45 seconds left.

Mr. Michael Hurley: I'm good.

The Vice-Chair (Mr. Deepak Anand): Questions from the official opposition? Member Armstrong.

Ms. Teresa J. Armstrong: Thank you very much for presenting. In case you wanted to finish something—did you want to finish off what you were going to say? You're all done?

The Vice-Chair (Mr. Deepak Anand): No, he actually said—

Ms. Teresa J. Armstrong: Okay. He had a little time left over.

The Vice-Chair (Mr. Deepak Anand): Yes, 45 seconds.

Ms. Teresa J. Armstrong: Perfect. You mentioned that you had limited consultation, and it was focused on

how the system was going to move forward with less workers. Is that kind of what you said?

Mr. Michael Hurley: The government is being lobbied hard to introduce labour law changes which would allow health care sector work to move without taking workers with it, yes. That's the extent to which we have been asked to have any discussions at all about this situation.

Ms. Teresa J. Armstrong: Have you been given the opportunity to consult broader, or has that just been literally the focus of your input, and they haven't been willing to expand that conversation?

Mr. Michael Hurley: No, no, no, despite requests. We've written the Minister of Health. We have a technical briefing tomorrow. The bill is already tabled. It has had second reading and it's at committee. No, there has been no consultation of any meaningful kind at all—none.

Ms. Teresa J. Armstrong: So why do you think they don't want to hear from front-line staff who do the work every day, who can contribute that value of how to improve the quality of care?

Mr. Michael Hurley: Because our interests are not as significant, in their world, as the interests that are pushing them, for example, to expand the privatization of services, perhaps.

Ms. Teresa J. Armstrong: Okay. Bill 74 proposes changes to labour relations in the public sector, as you've talked about. Could you further explain how these proposed changes impact health care workers, and which workers in particular would be the most impacted?

Mr. Michael Hurley: There are changes to the Public Sector Labour Relations Transition Act to effect the restructuring that would eliminate, for example, the application of that act in a partial integration.

Much of the restructuring that's going to happen, be it a proposal to privatize a support service or a proposal to move a clinic—one of the examples that has been used to us is the Ottawa fertility clinic, where an entire fertility clinic operation was moved to a private operation run by doctors. That's being used as an example of the kind of effect where workers get to transfer with their collective agreement, with their pension, with their benefits, which is undesirable in the current restructuring.

Ms. Teresa J. Armstrong: I also want to congratulate you on the recent report that you brought forward about violence in the workplace, and the long-term-care portion that you highlighted. How do you see this legislation helping to fix some of those problems?

Mr. Michael Hurley: With respect to violence in long-term care?

Ms. Teresa J. Armstrong: Yes.

Mr. Michael Hurley: Violence in long-term care, which is already at levels—44% of the women in long-term care on staff are reporting they've been sexually assaulted, and 81% of PSWs are saying they've been the subject of physical violence. What's going to happen is the movement of all of the ALC beds into long-term care without an increase in staffing. So we're going to see the frustration of the residents at the lack of attention, at the basic neglect—I don't think there's any other nice way to

put it—that they experience in long-term care and the frustration of their family members intensify.

Again, this is a resource problem. Improving quality of care and dealing with violence—these are resource problems. There’s no discussion of resources in this bill. This is about another project entirely.

Ms. Teresa J. Armstrong: Based on your expertise, you identified some problems with Bill 74. Going forward, what do you see can happen if these problems aren’t fixed?

Mr. Michael Hurley: What’s going to happen—

Ms. Teresa J. Armstrong: Yes. What do you think can happen? If the problems you identified aren’t going to be fixed, what do you see as the outcome of this massive restructuring change?

Mr. Michael Hurley: What I’m afraid of is that there’s going to be a massive privatization of clinical and other services. There’s going to be a huge deterioration in quality as large amounts of resources get moved to profits and away from care. It’s well documented what the impact will be in terms of morbidity and mortality rates. That’s what we’re very worried about, to be honest with you.

M^{me} France Gélinas: You talked about rural Ontario being the losers. Could you explain how that would be?

Mr. Doug Allan: The integrated care delivery systems—there’s a maximum of 50 of them, with a maximum of 300,000 people. I think this is very important for the Conservative members who may have a base among rural Ontario, as well as the other parties, but—

The Chair (Mrs. Nina Tangri): This is your final minute, if you can please conclude. Thank you.

Mr. Doug Allan: Okay. So 300,000 people—there will have to be 20 in the GTA. That only leaves another 30. We go through the communities in our brief and we find that there are scores of smaller cities—Alexandria, Hawkesbury, Cornwall, Sarnia and many other communities—which will not be the centre of the ICDSs. Our experience with that sort of merger in the past very clearly suggests it’s a major threat to the small communities which I think the Progressive Conservative Party has a significant base in. They have to be aware of that, and they have to deal with that to make sure that—their communities that they represent may not have been told about this. It’s a very serious threat here through this legislation. They will not benefit by being the second fiddle in an ICDS.

The Chair (Mrs. Nina Tangri): We’re going to move to the government side. Ms. Triantafilopoulos.

Ms. Effie J. Triantafilopoulos: Thank you all very much for coming today and presenting to the committee. We very much appreciate your views, and we’re listening very, very carefully. We on the government side very much value the work that your members do in our hospitals and in our long-term-care facilities and other health-related jobs. I know that our health care system couldn’t do the work it has to do without the hard work and dedication of your members. So I’d like to thank you for that.

What I would like to also say, as a preamble to my question, is the following: The right to universal access to publicly funded health care is a cornerstone of Ontario’s

health care system. The ministry remains committed to strengthening public health care, and Ontarians will continue to access reliable public health care through OHIP. There are no provisions in the proposed legislation that are aimed at what you were describing earlier in your comments or that would in fact change the current mix of not-for-profit and for-profit health care providers that currently deliver services to patients within Ontario’s publicly funded health care system. To the contrary, I would draw your attention to subsection 34(1) of the proposed Connecting Care Act, 2019. The proposed legislation contains a prohibition against integration decisions that would permit a transfer of services that would require an individual to pay out of pocket for those services.

Now I’d like to move on to my question. Restructuring health care will let us free up resources to spend on front-line health care. I’d like to mention that in the last five years Ontario spent 30% more than the Canadian average across Canada on administrative expenses in our health care system—30% more. So it’s not for lack of funding being in the system.

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I’d like to ask you a question, in a positive way: Do you see any opportunities where the system could be managed better to help patients and actually free up more resources for the front line?

Mr. Doug Allan: There’s a very obvious way in which this could happen which the Auditor General has identified. There’s \$8 billion that has been wasted on a policy begun by the previous Progressive Conservative government, through public-private partnerships. That is money that could be used, productively, for public health care. So I would advise you very strongly to reconsider your naive support for public-private partnerships, and instead invest that money into our public health care system and not turn it over to the large, for-profit corporations which benefit from this policy.

Mr. Michael Hurley: When you have a world leader like Cancer Care Ontario, does it need restructuring? I don’t think so. Our hospitals lead the OECD in terms of their efficiency, but the truth is the access problems are caused by the fact that we underspend all of the other provinces, per person, by something like \$400 a year, so we just don’t have the staff or the beds. We’ve been closing so many beds.

It’s not a question of over-administration, I don’t think. It’s not a question of the need for a restructuring. It’s the need for additional capacity, and certainly what I heard during the election was a commitment to increase capacity. What I see now is a proposal to restructure.

Mr. Doug Allan: A main way that privatization has driven up costs in the United States, which is primarily a for-profit system, is through extraordinarily high administration costs. I think we could quibble about the figures and there’s been some discussion about that, back and forth, but the administration costs in our public health care system are extremely low compared to the for-profit system in America. I think that’s a major problem with moving towards allowing, as your legislation or your bill does in so many areas, the increase in for-profit care.

That's what you're going to have to grapple with: When you do that, you're going to drive up those extra administrative costs. That's what is at threat here. That's one of the things that's at threat here.

The Chair (Mrs. Nina Tangri): Ms. Kusendova, and this is the last minute, if you can please wrap it up.

Ms. Natalia Kusendova: Thank you so much for being here. I'm a registered nurse. I actually worked in the front lines. The reason why I got involved in politics is because our health care system was broken and there was a huge crisis. I spent more time working in a hallway than an actual assignment, and this is what drove my passion to get into politics and run for election.

I just wanted to address the issue of capacity. After 15 years of zero investment into long-term care by the previous government, we have actually—this was one of our main campaign promises, to build capacity into our system. To date, we have already announced over 7,000 long-term-care beds, up to a total of 15,000 over the 10 years, so we are building capacity in the health care system.

Furthermore, we are building capacity by investing in mental health, because we know—and I know, as an emergency room nurse—that the patients that we are treating should be treated somewhere else. We have a lot of alternate-level-of-care patients that should be treated in long-term care. We have a lot of mental health patients. This domino effect is boggling our health care system.

When you say you don't take issue with the way our health care system is structured, I respectfully disagree. What we're doing with this bill is eliminating the bureaucracy that's happening in our health care system, precisely so we can put the money into the front lines where it belongs to help front-line workers like me and like the ones that you represent. That's exactly what we're doing.

The Chair (Mrs. Nina Tangri): I'm going to have to conclude there. Thank you. Your time is up, but thank you for presenting to us today.

PRINCE EDWARD COUNTY
COMMUNITY CARE
FOR SENIORS ASSOCIATION

The Chair (Mrs. Nina Tangri): I'd like to call upon the Prince Edward County Community Care for Seniors Association. If you could please state your name and introduce yourself and your organization. You have up to eight minutes to present, and six minutes each from each of the recognized parties.

Ms. Barbara Proctor: Good afternoon, Chair Tangri and honourable committee members. My name is Barbara Proctor. I am the president and chair of the Prince Edward County Community Care for Seniors Association. I'm a retired registered nurse with a 35-year career in health care, and I'm also a former member of the Prince Edward county municipal council.

With me today is Irene Harris, who retired from the Ontario Federation of Labour after working for over 30

years in the labour movement, and also we have Debbie MacDonald Moynes, executive director of the Prince Edward county community care—a position she has held for 38 years.

Your committee's task is to review the bill to enact The People's Health Care Act, 2019. Our task, as we see it, is to give you our perspective on how the legislation will impact on our agency and perhaps others in this province that rely on volunteers and fundraising.

We are a volunteer-driven organization, and we want, above all, to leave you today with a sense of the critical importance of volunteers in the community support services sector. Our agency has been supporting seniors for 42 years, and we have worked with many governments. We believe that all governments come into office with the commendable goal of wanting to improve health care. That goal, we always support. We ask, though, that you please proceed carefully and ensure that volunteers are not left behind.

Local oversight of local community agencies by volunteers has much to commend it, and we would suggest to the committee that maintaining local volunteer governance is an important concept. We are requesting that Bill 74 acknowledge the value of the delivery of community support services by volunteers and ensure that the investment and dedication of these volunteers can be sustained.

Our executive director, Debbie MacDonald Moynes, would like to share her perspective on the importance of volunteers, and then board member Irene Harris will speak to you about the amendment that we are recommending.

Ms. Debbie MacDonald Moynes: Thank you for the opportunity to speak today. I've been an executive director of a community support services agency for 38 years because I love working with volunteers. I'm also a volunteer myself.

Our agency, a member of the Ontario Community Support Association, exists to support seniors to live at home. We operate with eight full-time staff members, who coordinate the volunteers, and six contracted nurses—also, with the support of almost 400 active volunteers and a governing board of 10 elected members.

Our annual budget is \$654,000. Fifty-one per cent of our budget is funded by the Ministry of Health and Long-Term Care, and 7% is funded by the Ministry for Seniors and Accessibility. The remaining 42% comes from donations, client fees and fundraising. A major source of our revenue comes from a thrift shop we operate, which is staffed entirely by volunteers. A picture of some of these people is on the front page of our written brief, where you will also see a description of the other services that our volunteers provide.

Research points to volunteers living longer, healthier, happier lives. Volunteering one's time is a positive thing for one's own health and also for one's own well-being. Then there are the benefits to others. Through our agency, volunteers deliver meals, drive seniors to medical and other appointments, serve, visit, call, fundraise and answer the phone. Volunteers care, and they make a huge and lasting difference in the lives of the people that they deliver service to.

Meals on Wheels and escorted transportation help with practical, day-to-day activities. These services support the choice to live in the community. These services are prevention and maintenance. These services help caregivers too.

We're here today to say that volunteers have invested heavily in the health and well-being of their community in Prince Edward county and across Ontario, both in time and in fundraised dollars that go directly into services. The agency we represent wants to see the health care system improve. The loss of fundraised dollars and volunteers, however, must not be an unexpected casualty of policy change. We ask respectfully that the essential contribution of volunteers be taken into consideration so that volunteers are not left behind. The loss of volunteer effort in the delivery of health services in the community support services sector would negatively affect how we reach out to seniors. Our funding as a health services provider allows our staff to recruit and coordinate the efforts of almost 400 volunteers in our county alone. Volunteers in Prince Edward county and across Ontario help seniors live at home.

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Ms. Irene Harris: As you'll see from our written submission and from our comments here today, we know that Bill 74, depending on how it is implemented, will impact the provision of community support services, as we've said, which rely on local volunteers, fundraising and local accountability. It may also affect existing and positive local service partnerships, which community support service agencies like ours have developed over many years. Since our focus is on helping seniors live at home and not become patients in the health system, we ask you to make sure that health service providers in the community support service sector are always supported and acknowledged as an important part of health care.

We need Bill 74 to be amended in a way which ensures that the work of volunteer-based community support service agencies, which are listed as health service providers in section 1, that help seniors live at home will not be overlooked or undervalued when funding is determined by either the agency or Ontario health teams.

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

Ms. Irene Harris: We've looked at how to do that. The amendment that we're suggesting is that we add, in section 6, which is the objectives of the agency, section 6(b)(ix), "support community support services, which rely on continuous recruitment of community-based volunteers and fundraising in the delivery of services." We think if that was there, we would not get left behind.

The Chair (Mrs. Nina Tangri): Thank you very much. I'll go to the government side. Who would like to speak first? Mrs. Martin.

Mrs. Robin Martin: Thank you very much for coming and for your presentation. It was very helpful. Obviously, volunteers are a huge and important part of health service delivery in the province. We do rely on them for a lot of things, and we benefit, frankly, from the extra services that

they provide to people. I don't know what we'd do without them. So, thank you very much for your all of your work. I'm a bit daunted by the number of years of experience that you detailed with all of this—38 years, 35 years. It's quite the record.

I'm interested in your concerns about how the bill would be implemented, your proposed amendment, obviously, and the potential implications that you see on local volunteers and fundraising. I'm just wondering if you could just elaborate a bit on how you see that would impact your volunteers and your service providing.

Ms. Irene Harris: Here's the concern. The agency and the Ontario health teams: If there's not something in the act that says to them, "Don't forget the community support service sector. It's maintenance and prevention, and you have to support it," then when those health teams and agencies are looking at priority for funding, for how to work together, at how to build those partnerships, if they don't factor in the services that we provide, we could get left behind.

I think the other concern is that, if they're covering a large area—in our case, we're one of the rural areas. If it's a large geographical area that's covered, then how do you recruit volunteers from some health team that's located—it could be 100 kilometres away, and would you still do some work here in Prince Edward county? There are probably going to be ways that we can work that out; it looks like the act is permissive in terms of how the health teams will hold things together. That's a plus. But you really still need something in the legislation. We think our amendment is one stab at that, that would say, "Don't forget this sector. You have to support it. You can't ignore it." That would mean, then, factoring in our local-based fundraising and volunteers.

Mrs. Robin Martin: I think the legislation does include some provisions where it would mention non-health-specific service providers but who are affiliated and who work within the sector as well. So I think there has been some attempt to make sure that we're reaching out to all of the parts of the system. I guess what you're saying is, just be careful how these things are recognized and pulled together in the implementation of it.

Ms. Irene Harris: Yes, because when you look at the objectives of the agency, we're not totally in there. They talk about patients in there, but we're prevention and maintenance. The kind of work we do—they're not patients. That's why we thought that if you added an objective under the agency objectives—a new one—that would say "those community support services that rely on volunteers and fundraising."

Mrs. Robin Martin: I have to say, I think that an Ontario health team would benefit and see the benefit of the services that your group would provide.

Do you have a question?

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

Mr. Deepak Anand: Thanks for coming. By the way, I love Picton. I absolutely love Picton. I've been to your thrift store; amazing. There is a sale going on April 13. I will not be able to attend, but I need a rain check. Thank

you. I just thought that since you're here, I could take that opportunity.

Great work here. I think in terms of what you're saying in terms of the volunteers, the volunteers come and work with you guys because of the work you do for the community. Bill 74 is not necessarily talking about that. What it's talking about is patients at the centre of building that integrated system.

In terms of that integrated system, we actually want to ask you: In your opinion, how would the people you serve in Prince Edward county be better supported by these teams? How would you look at that—when these teams are built, how we can build these teams in a way that they can better support you and the community?

Ms. Debbie MacDonald Moynes: That's one of the things that we were trying to get at with the wording of the amendment that we brought before you today. We want to make sure that there is that connection with the community that we have been able to nurture and foster in Prince Edward county, but is also in communities across the province where people deliver Meals on Wheels and provide escorted transportation.

We're a health-funded agency. We are considered to be providing health services. We're a health services provider under the current act. If you look at the social determinants of health, much of what we do addresses helping people to remain active, independent and living in their homes. We ended our brief by saying that we want to be able to continue to do that in our community and for others in the rest of the province, other agencies that provide these services—essential services, we think—to be able to continue to do that as things are changed.

The Chair (Mrs. Nina Tangri): Thirty seconds to conclude, please.

Mr. Deepak Anand: Thank you. That's it for me.

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

Mr. Sol Mamakwa: Thank you, Barbara, Debbie and Irene, for your presentation. My name is Sol Mamakwa. I'm the MPP from northwestern Ontario, north of Sioux Lookout.

When we talk about care for seniors, a lot of my community members, elders, are from fly-in communities. When we talk about elder care, when we talk about long-term-care beds, our hospital has 30 beds for a population of about 30,000 people. Typically, we have a four-and-a-half-year wait-list to get a bed. Otherwise, we have to send our elders to Thunder Bay, Sault Ste. Marie, North Bay and Fort Frances. So we send them away—people who do not speak any English. It's a real struggle for our people.

One of the questions that I had, though, is whether there was an opportunity for you—if you were consulted in the drafting of Bill 74.

Ms. Debbie MacDonald Moynes: No, not at all.

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

M^{me} France Gélinas: I'm just curious. I am in awe of your agency. I love that kind of agency. You make such a difference in the health of your community. Thank you for all your years of service.

I take it that you're here because, like me, you know that community care and support services right now have

to be not-for-profit. It is in the law. Once Bill 74 is there, it's not going to be in the law anymore. You will be competing against for-profit.

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In your Meals on Wheels, do you buy any frozen meals from other sources than what you make?

Ms. Debbie MacDonald Moynes: Yes, we do. We purchase frozen Meals on Wheels.

M^{me} France Gélinas: Just to forewarn you that once Bill 74 comes forward, those people are free to underbid you directly to your clients, because after Bill 74, you don't have to be not-for-profit anymore. Underbid you—they have way bigger war chests than you do. Once you are no longer in business, sure, the price of meals will go up. But in the short term, they are able to underbid you, go to all of your clients and offer meals for \$1 to \$3 until you are no longer there. Then all of the volunteer work that you have talked about so eloquently that made your community what it is will all be gone.

You are right to be worried. I am also worried because I want you to be there for another 100 years for all of the good things that you do.

Another thing is that those teams—we're looking at about 280,000 people. How many people in Prince Edward county?

Ms. Debbie MacDonald Moynes: Just under 25,000.

M^{me} France Gélinas: So the chance that you have a team for your county is zero, which means that you will be dependent upon a bigger centre someplace else.

Everything that you've said is wonderful. You are there for the right reasons. You are there to help your community. What will it be like once you cannot compete with private Meals on Wheels anymore? What will that mean to your agency?

Ms. Debbie MacDonald Moynes: Meals on Wheels, as you very likely know, is more than the meal; it's also the visit by that volunteer. Even though it's two or three moments that they spend, if the volunteer doesn't find the client at home, they call the office. Our staff always find out where the person is and if they're okay. So there's a lot more to the meal than just taking the hot meal to the door.

We said in our brief that we feel that local governance is an important aspect of volunteers and why people volunteer for their community. They have to have that sense of community to want to give back to the people who live there. We're so proud of having so many volunteers and so many people interested to support their friends and neighbours in Prince Edward county.

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

M^{me} France Gélinas: I agree. All of this good work is at risk.

Mr. Sheref Sabawy: Point of order.

M^{me} France Gélinas: I support your—

The Chair (Mrs. Nina Tangri): One moment. A point of order.

Mr. Sheref Sabawy: I think what Ms. France is raising is not really embedded into this bill, is not related to the

bill. You are envisioning something just to scare the public. I don't think this is appropriate.

The Chair (Mrs. Nina Tangri): I ask all committee members, please, to keep the questions and remarks to the bill only.

We have 20 seconds if you'd like to conclude.

M^{me} France Gélinas: Absolutely. I support the amendment that you want to put to the bill. We have to make sure that you will continue to be there after Bill 74 is passed. The amendment that you are suggesting will help us do that. I hope it will be accepted by the Conservative government.

The Chair (Mrs. Nina Tangri): Thank you for joining us today and presenting.

ONTARIO NURSES' ASSOCIATION

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

Ms. Vicki McKenna: Good afternoon, and thank you. I'm Vicki McKenna. I'm a registered nurse, and I'm the provincial president with the Ontario Nurses' Association. On my left is Beverly Mathers. She is our interim CEO. And on my right is Lawrence Walter, our lead for government relations.

ONA is Canada's largest nursing union. We represent over 65,000 registered nurses and health care professionals, as well as more than 18,000 nursing student affiliates. We all strive to provide quality patient care each and every day across this health care system. The vast majority of ONA's members in the local health integrated networks, or LHINs, are regulated health professionals involved in the provision of essential front-line care for Ontarians, from care coordination, long-term-care placement, palliative care teams, children's services in schools and in homes.

Since the introduction of Bill 74, ONA has received an unprecedented number of inquiries from our members, who are concerned about their future and the future of their clients. ONA members share the government's commitment to ensuring that Ontarians have access to the best quality in front-line health care services, but they also want to know what all this transformation means: Who would be their employer? Who would be their bargaining agent? Will they have a collective agreement? What will be the terms of their employment?

The preamble in Bill 74 states that the people of Ontario and their government believe that their health care system should be centred on people—patients, their families and their caregivers—and we share that belief. Our recommendations are designed to ensure that those beliefs are realized as Ontario embarks on major changes to the health care system. Ensuring a streamlined transition to retain or recruit front-line nursing and health care staff is the essential goal to achieve a future system that's integrated and coordinated.

We turn now to the fundamental component of such a transition: to ensure that the Public Sector Labour Relations Transition Act, or PSLRTA, applies to all integrations and transfers. Currently, any restructuring of the LHINs is covered by PSLRTA. Bill 74 substantially alters this state of affairs. If Ontario Health remains a crown agency, PSLRTA will not apply to the transfer of the LHINs to Ontario Health. The same would be the case if the work of care coordinators or other front-line health care workers currently employed by the LHINs is subsequently transferred to another employer, even if that employer is not a crown agency. Instead, section 69 of the Labour Relations Act, the sale-of-business section, would apply. In ONA's submissions, this will cause substantial labour relations problems because the powers of the Ontario Labour Relations Board under section 69 are considerably limited compared to the powers of the board under PSLRTA.

ONA holds bargaining rights at 11 of the 14 LHINs, with variations in each of ONA's bargaining unit descriptions from LHIN to LHIN, for over 4,000 members. In order to integrate these disparate bargaining units into Ontario Health, the Ontario Labour Relations Board will be required to determine the number of bargaining units, the scope of those units and the bargaining agent or agents. PSLRTA provides clear mechanisms for making the necessary determinations designed to facilitate the transfer of collective bargaining rights and obligations during public sector integrations. To ensure clarity and predictability is maintained, ONA strongly recommends amending PSLRTA to add Ontario Health to the list of employers subject to health system integration under section 2 of PSLRTA, and amending the Connecting Care Act to include Ontario Health in the definition of health service provider.

In addition, it's crucial to ensure a collective bargaining dispute resolution mechanism is appropriate for health care workers. ONA submits that the essential services provisions under the Crown Employees Collective Bargaining Act are not appropriate for unionized employees of the LHINs who will become employees of Ontario Health under Bill 74. As the health system becomes more integrated under Bill 74, labour relations of front-line workers should also be integrated. It does not make sense to have health care employees from the LHINs governed by legislation that does not apply to any other front-line health care worker.

Similarly, the front-line health care providers who work in the LHINs are currently covered by the Labour Relations Act for grievance resolution. Moving the LHIN employees to the Crown Employees Collective Bargaining Act would mean that grievances would be heard by a grievance settlement board. These employees would be the only front-line health care employees subject to this grievance arbitration system, which would cause a number of labour relations problems that we set out in our submission on pages 6 and 7. For these reasons, we submit that current employees of the LHINs should not be subject to the Crown Employees Collective Bargaining Act.

Beyond these important labour relations considerations, we look now at the amendments to the health care framework contained in Bill 74.

We recommend that the preamble to Bill 74 be strengthened. First, we submit that the preamble must incorporate the principles referenced in the Local Health System Integration Act, LHSIA, and the five principles of the Canada Health Act, as well as adding the principle to promote the delivery of public health services by not-for-profit organizations to the preamble.

Further, we recommend that all references to limiting health care spending in the preamble be contextualized in terms of building capacity for better and safer patient care for all Ontarians.

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Moreover, we ask the government to commit to public accountability and transparency to demonstrate that the health system is governed and managed in a way that reflects the public interest.

A major question unaddressed by government is how the structural changes proposed in Bill 74 will create more capacity in the public system to deliver the care required by patients on waiting lists and lined up in our hospital corridors.

The Auditor General, for example, noted in her 2015 report: “Home care used to serve primarily clients with low to moderate care needs, but now serves clients with increasingly more complex medical and social-support needs.”

The auditor also documents issues of duplication and omission in the contracts with about 160 private sector service providers delivering home care, and comments on the resulting commercial confidentiality in the current model so that the true costs remain unsubstantiated.

Taken together, a number of provisions outline a system in Bill 74 where decisions by the minister and the agency on funding and integration may result in additional for-profit health care in Ontario. In our submission, we therefore ask the government to explicitly commit to build additional not-for-profit capacity in our system.

We also recommend that references be removed in all sections to “a person or entity” and to “non-health” organizations that are undefined in the legislation and may lead to further privatization.

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

Ms. Vicki McKenna: We do not believe the addition of for-profit delivery in the integrated system is a good use of public funds. For-profit delivery of health care does not allow for public accountability and transparency.

We further recommend a requirement to publish any human resources plans.

Finally, we’re concerned that Bill 74 does not ensure the protection of pay equity rights for women’s work in health care. The current amendment in section 15.1 of schedule 3 covers pay equity only if PSLRTA applies. We have outlined above that we’re concerned about the extent to which any affected employer’s liability for historical inequities will follow.

We recommend that an additional provision be inserted into section 15 in schedule 3, to be clear that any integration or transfer is deemed to be a sale of business and therefore under section 13.1 of the Pay Equity Act. Without the insertion, Bill 74 amounts to an attack on the full valuing of women’s work in the health care system.

The Chair (Mrs. Nina Tangri): Thank you very much. I’d like to pass it over to Mr. Mamakwa.

Mr. Sol Mamakwa: If you want to complete your presentation, you can use some of my time, if you’d like.

Ms. Vicki McKenna: I just have two more things to say, and I’ll be fast.

Ontario nurses look forward to a future public health care system that is patient-centred, integrated and coordinated. For this reason, and to ensure an orderly transition, we call on the government to make the amendments to Bill 74 that we’ve outlined. We would look forward to actively participating in the implementation of these decisions.

Mr. Sol Mamakwa: Chi meegwetch. Thank you very much for the work that you do as part of the Ontario Nurses’ Association.

Again, I am from the riding of Kiiwetinoong, the most northerly riding in Ontario, in northwestern Ontario. My riding consists of fly-in communities, First Nation communities. I know, depending on where you get the service, we fall into some of the provincial and federal responsibilities, so it’s a bit more complicated, and so we go back and forth. When we talk about transformation, changing the way we provide care, these will be the people who will be most impacted.

I have learned that the system of health in the north is very complex. Sometimes we say that the health care system that exists actually kills our people. There are stories that are surrounded by it when we say that, just because of the impacts of that jurisdictional ambiguity—or jurisdictional potato—that people’s health is played with.

One of the first questions that I had was, in the drafting of Bill 74, I’m not sure if you had an opportunity to be involved in it.

Ms. Vicki McKenna: An opportunity in the drafting? No.

Mr. Sol Mamakwa: Okay. Also, on March 8, 2019, the Toronto Star reported that the volunteer board members were informed by email that their services were no longer required. On March 11, 2019, the board appointees to the agency held an in camera meeting. This was all happening, as you know, before Bill 74 was even passed.

Has this government informed ONA or the 4,500 nurses what will happen next to their positions, now that they have begun dismantling the LHINs? Also, based on your expertise, do you have any concerns about the impact to patient care?

Ms. Vicki McKenna: Yes and no. We have limited knowledge around the true impact. We understand that front-line health care providers will still have work. But what kind of work, where they will work, who they will work for and how they will actually deliver services—this has been a major question from a number of the over 4,000

who work in our LHINs right now. They're very concerned about what it means to them and their clients, absolutely. They are truly concerned about that for sure.

Did you want to add—

Ms. Beverly Mathers: I would say too that the fact of the matter is, they're very concerned about where their patients will be getting service in the future. Now they have relationships with their patients, their clients. They know the community services that are out there, that exist. There is a shortage of home care workers.

The real delay in terms of getting home care is in fact with the providers that exist, because there is a shortage of RNs, RPNs and PSWs who work for home care agencies. That's where the delay is in home care systems. The home and community care coordinators actually contact patients very quickly and get them lined up for services. The problem is, there is no one in the community to provide those services. That's really where the big barrier is at this point.

Mr. Sol Mamakwa: Okay. In your work, in your expertise, can you please tell us whether this government needed to introduce this legislation to solve hallway health care?

Ms. Vicki McKenna: In this particular bill, we don't see the capacity built in the bill itself. We don't see the increasing capacity in this bill. We do hear there will be reinvestment of any savings in the front line. The capacity piece that I heard earlier wasn't in this bill.

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

Ms. Vicki McKenna: We don't see it there in this bill. That's simply how we see it.

Mr. Sol Mamakwa: How much more?

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

Mr. Sol Mamakwa: Is hallway health care a problem of policy or legislative barriers, or is it because of the health care system being underfunded?

Ms. Vicki McKenna: I wish there were one answer to that, but there isn't. It is policy. It is underfunding. It's under-resourced. Looking across the country, Ontario, which should be the lead province, is actually at the bottom as far as bed capacity and as far as investment in hospital care, for instance, per capita.

Mr. Sol Mamakwa: Thank you.

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

Ms. Natalia Kusendova: Hello. Good afternoon. Thank you so much for your presentation today. I'm a registered nurse and, in fact, I'm a member of your organization. I pay my dues religiously; they come off of each paycheck. Thank you for coming today to speak on my behalf, as well as on behalf of my colleagues the 65,000 nurses that you represent.

In fact, one of the main reasons I got involved in politics is because as a new nurse—I entered the health care system working in the emergency room—I saw how fragmented and broken it is. I spend more shifts working in the hallway. We all dread the hallway shift. We go in, we check our assignment and if we're in the hallway, we know it's going to be a tough day. That's one of the reasons why I really got involved in politics: because I

realized that something needs to change. With the population trends, we know we have an aging population—more seniors, people living longer. We do need to build more capacity in the health care system, which is something that you mentioned today.

I have a very simple question, nurse to nurse: Do you think that our health care system right now is working?

Ms. Vicki McKenna: I think that we deliver excellent health care in the situations that exist and in the structures that currently exist today. But it's not good enough; I do agree about that. There is a lack of integration. There is a lack of coordination. Absolutely, that's true. But we have a capacity problem that also—there isn't one simple solution to this. We need capacity; we need integration; we need coordination. Bill 74 is one piece that may move to integration and coordination. We're not sure that it will. Other integrations and coordinations that have happened historically have not done anything to decrease, on the admin side. This bill is supposedly supposed to do that; however, you still need people to be able to administer organizations.

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We don't know what the end will be, but what we do know is that we do need it. We welcome integration and coordination, there's no doubt about that, but it's how it will be done, and if this bill is about providers at all, then it needs to consider providers in it, and there are protections that are missing, such as pay equity pieces. There's also the bargaining and contract security that needs to happen for our workers.

Ms. Natalia Kusendova: So just to address that, this bill is about the patient. We really want to centre the care around the patient, rather than—

Ms. Vicki McKenna: Sorry, I don't mean to—well, I am interrupting you, because in the preamble, the government does say three things, right? They say "patient," certainly; they say "providers" as well, and I'm just—there are three things that they say.

Mr. Lawrence Walter: Families.

Ms. Vicki McKenna: And "families"—so patients, families, providers. That's what it says in the preamble.

We agree: The patient has to be at the centre. If we only made decisions in health care about patients, we would all be in a lot better place than we are right now.

Ms. Natalia Kusendova: Absolutely. I believe that this bill, Bill 74, is about centring the care around the patient—I've said this three times already in this committee—and not around the brick and mortar where the patient happens to be, whether that's at home, whether it's in the emergency room, acute care or long-term care.

To address the capacity issue that you raised, our government ran on the promise to eliminate hallway nursing and hallway health care in Ontario, and we have already addressed the issue of capacity by announcing over 7,000 long-term-care beds. We all know that we have a lot of patients in our health care system right now who are occupying acute care beds who should, in fact, be in long-term care, so we are addressing the issue of capacity by introducing the funding necessary for the long-term-care beds, which the previous government had done nothing

about for 15 years. So we are long overdue for long-term-care beds to be increased in our province.

Furthermore, we are also investing in mental health. Once again, we know the domino effect when we have mental health patients in those stretchers in the emergency room when they should be cared for in the community and in other agencies. So we are addressing the issue of capacity 100%.

My question is around those LHIN care coordinators, because some of my friends actually work for CCACs and they have expressed their frustrations with the previous system where, depending on their catchment areas, they would have to work with different LHINs, and depending on where the patient was located geographically, they would be allocated a different amount of hours for home care services. That's why this transformation is so crucial to ensure the equitability of our health care system. Do you have any thoughts on that?

Ms. Beverly Mathers: We think equitability is key. We also, though, worry with the structure of the—we don't know where the LHINs are going, the work of home and community. That is not clear in the bill. It's very concerning to us.

The one key thing—and our care coordinators say this to us regularly. Our care coordinators are concerned about how fragmented home care would be.

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

Ms. Beverly Mathers: Right now, there are 14 of them, it's true, and, while they may not all be created equal, they do all strive to provide consistent care throughout the province. What's not clear in the Ontario health teams is, will that continue, or is that going to be further fragmented?

Ms. Natalia Kusendova: So my last question would be, did you survey your 65,000 members, and do they all agree with all the recommendations that are in your submission?

Ms. Vicki McKenna: Well, we just came from a meeting with our CCAC leaders. We just walked out of that meeting. We've been in town hall meetings where we've had over 20,000 of them on lines where I've been talking to our members across—have I surveyed each and every one of them? Certainly we've had lots of opportunity to discuss with them. These are their thoughts; these are their concerns about what's going to happen in the system.

There are a lot of unknowns here and we want to be upfront and honest about them. We want to work to improve the health care system. We're in it, obviously, for the patients and for the people of this province as well, and our members are people of this province too.

The Chair (Mrs. Nina Tangri): Thank you for presenting to us today.

NEIGHBOURHOOD PHARMACY ASSOCIATION OF CANADA

The Chair (Mrs. Nina Tangri): I'd like to call upon the Neighbourhood Pharmacy Association of Canada.

Please introduce yourself. You have eight minutes to present, followed by six minutes from each of the recognized parties.

Ms. Aimee Sulliman: Thank you, Madam Chair and esteemed members of the committee. My name is Aimee Sulliman. I'm the senior vice-president of public affairs at the Neighbourhood Pharmacy Association of Canada. It's a pleasure to be with you today to speak to you on behalf of Neighbourhood Pharmacy. Our members and I want to thank you for the opportunity to participate in the hearings on The People's Health Care Act.

Neighbourhood Pharmacy is the trade association representing the business of pharmacy—the chains, banners and retailers of pharmacy. There are 10,500 pharmacies across the country, with 4,327 right here in Ontario. Our members fill over 75% of all prescription medications from the Far North, coast to coast and to points in between, from communities such as Thunder Bay to communities ranging from Niagara, Mississauga, Burlington, Toronto, Kitchener, Waterloo, Cambridge and, of course, to Ottawa.

We support the government's vision and overarching goal to transform Ontario's health care system. Specifically, we're pleased to see the government taking swift action to create more seamless and connected health care—change that puts the people of Ontario first.

As well, we commend the government on their bold leadership in creating a single point of oversight for our health care system through the new agency, Ontario Health. This will enable Ontario's health care to be more streamlined and integrated, as well as enable more health care dollars to go where they are needed most: the front lines of care, such as pharmacists.

For 15 years, pharmacy services and our capacity to improve care closer to home and unlock capacity in our health system has stagnated.

Ontario has fallen behind most other Canadian provinces when it comes to the accessibility and expanse of services available and reimbursed through pharmacy. While Alberta reached the podium with gold-standard results in access to pharmacy services, Ontario has lagged further and further behind. That means that the services available in pharmacies in Alberta and other Canadian jurisdictions aren't accessible to people in Ontario. This is a missed opportunity to put the knowledge and skills of pharmacists to best use.

The challenges of hallway medicine will not be solved in isolation or singularly through physician offices and hospitals. The demand and need is simply too great, and resources are simply too scarce. We are pleased to see that the government has embraced the option to include a range of service providers and models as part of the vision for Ontario health teams. We believe that pharmacy and pharmacists are one such provider that will not only be an asset to Ontario health teams but will continue building capacity in our system. Our members have the experience and know-how and are connected to communities across the province where capacity is needed. Whether it be in the community pharmacy; long-term-care settings, managing the complexities of medication adherence and drug-

to-drug interactions of our aging population; or amongst our specialty care providers, pharmacy remains committed to creating capacity and ensuring that the transitions of care are well managed for patients.

Pharmacy and pharmacists are ready and willing to take on a greater role to deliver more efficient care for Ontarians. Pharmacy is well positioned with the ability to streamline services, facilitate improved integration across the health care system and as a community-based point of care for people experiencing minor health and medication issues, allowing more people to access care in the community and without having to visit the hospital emergency room.

By ensuring we're optimizing the scope of all practitioners—namely, pharmacists—we can provide more proactive and preventive health care and help to reduce the burnout of health care professionals while alleviating the burdens of wait times for patients. Doing so will create capacity in the delivery of care, when and where people need it, while respecting taxpayers through the delivery of more efficient and accessible care.

As the government embarks on the transformation of Ontario's health system, the voices of front-line health care professionals, including pharmacists, as well as the patients they serve every day, will be key. In our recent pre-budget submission, we proposed launching a pharmacy table in Ontario to bring these insights to government. Through close partnership and continued dialogue, we will improve patient experience and accessibility to care while respecting taxpayers.

At the pharmacy table, in partnership with the Ontario Pharmacists Association, we will set priorities, contribute to strategies, and optimize efforts to tackle issues, such as the foremost public health crisis ravishing our communities—and a driver of hallway medicine—the unabated opioid crisis. According to the Public Health Agency of Canada, over 4,000 Canadian lives were lost to opioids last year. That's nearly 11 people every day. More must, and can, be done.

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Pharmacists are the medication experts working in every neighbourhood of this province. Let's use their accessibility, understanding and compassion to prevent the cycle of addiction before it begins, as part of Ontario's broader mental health and addictions strategy, while delivering better care for patients living with pain.

As jointly proposed with the OPA, by launching pain management services in pharmacy, pharmacists can educate people on the potential risks associated with opioids and offer alternative therapies where appropriate. We agree that people living with acute or chronic pain should have access to the therapies they need. Patients would be provided with one-on-one support to appropriately manage pain while mitigating the potential risks of addiction.

Opening the door for pharmacists to play a greater role in medication management and monitoring will help close the current gap in care and help fix the problem of hallway medicine by preventing the harms of dependency before it happens.

To improve care, we must fully optimize the skills and capacity that currently exist within our health system and with our health care professionals; namely, pharmacists. That means ensuring the transitions are managed seamlessly through technology and through continued partnerships with care providers in the community, hospitals, long-term care and specialty care settings.

Neighbourhood Pharmacies and our members cannot wait to get started in transforming Ontario's health care delivery for the people. We're eager to work closely with the government in the months and years ahead to finally build a coordinated health care system in Ontario—one that will create capacity and efficiency to achieve our shared goals of delivering more accessible, high-quality care in communities across Ontario. Thank you.

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

Mr. Sheref Sabawy: Thank you very much, Aimee, for your submission for the new bill. I like the fact that you're talking about the 10,500 pharmacies and the 4,327 community pharmacists available as front-line providers for services.

We need to understand what types of challenges and barriers pharmacists currently have, how we can remove those barriers, and how we can take advantage of Bill 74 to open the door for those changes.

Ms. Aimee Sulliman: That's a terrific question.

Currently in Ontario, we fall behind other provinces in terms of the scope of practice. That really is the major challenge that pharmacists and pharmacies in Ontario face.

Certainly, when we look at the Premier's council on ending hallway medicine, led by Dr. Devlin and others, and when we look at the esteemed board appointed to lead this agency, I think, really, we consider, how do we think of the footprint of health care beyond hospitals and the infrastructure beyond physician offices? And pharmacy is a very logical place to think first.

What will happen to unlock the value that already exists in terms of those pharmacies is scope of practice, so whether it be point-of-care testing, whether it be common ailments, whether it be allowing for all publicly funded vaccines to be administered, whether it be in the community setting or in long-term-care settings for our elderly to prevent recent outbreaks that we've seen, on the prevention side of things, the changes within scope are absolutely critical.

While Bill 74 doesn't include scope of practice, it certainly speaks to the need to ensure that all partners in health care are working together.

Mr. Sheref Sabawy: Thank you very much for the answer.

You talked about the dialogue with stakeholders and how you can make use of the spectrum of the pharmacists' availability and the service they can offer to the end-users. Do you think the bill, as it stands now, will be able to reveal that, or do you think that something can be added to it to make best use of the change?

Ms. Aimee Sulliman: We believe that the bill is sufficient at this stage and as it is written. We believe we've

been well consulted. We also believe that in terms of the emerging changes and the evolution, the iteration of changes that are happening, Ontario health teams will evolve. We believe that the government's willingness to innovate and openness to different models and partners, whether they're led by hospitals, whether they're led by health care practitioners, whether they're led by different providers within the health care system—the opportunity to have those different models and those partnerships speaks to the challenges that we face, quite realistically, in health care. There's no one provider, there's no one interested party, that can act alone in solving the challenges we face, so we think it's sufficiently broad in enabling that innovation that will ultimately improve outcomes for patients.

Mr. Sheref Sabawy: Just one more, last question: Do you think the amalgamation of those different services—specifically speaking, eHealth—might benefit the patient, in your opinion, from the perspective of a pharmacist and service provider? Do you think this is going to benefit the patients, the public?

Ms. Aimee Sulliman: We believe, in terms of the administration and saving money in the efficiency of administration, that that will allow for reinvestments in patient and front-line care, like pharmacy, that is much needed in services to be delivered. In terms of eHealth, I think, to your question, there are many different models of e-health that exist within pharmacy today, so ensuring that the technology allows the different pharmacy models to be connected is absolutely vital.

Mr. Sheref Sabawy: Thank you very much.

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

Mrs. Belinda Karahalios: Thank you for coming today. I was a pharmacy assistant when I was going through university so I got to see how much the pharmacist—the pharmacy team, really—can bring to the patient's experience.

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

Mrs. Belinda Karahalios: Okay; I will hurry up. The pharmacist, really, has that extra set of eyes. In lots of cases—not all—the patient will spend more time with their pharmacy team than with their physician and/or nurse, so I think it's really important—you were mentioning how Ontario is kind of behind the times, if I can use that expression, compared to provinces like Alberta. What are some of the things that you would like to see?

Ms. Aimee Sulliman: Ontario has the benefit of having pharmacy technicians, which is a wonderful first step in enabling that capacity for scope. I think that enabling scope and changes in terms of common ailments—whether you have pink eye or whether you have strep—being able to go to the pharmacy and not only be diagnosed but also dispensed and prescribed the medications for that so that you don't have three different points of care and you don't have to wait four and a half hours to see a physician, or, if it's a Saturday, you don't have to travel to a walk-in clinic. Being able to see that and, I think, enabling that technology for some consultations is also important. Point-of-care testing is also important, so things

like being able to test for strep within a pharmacy would speed up that process when we see the surges around cold and flu season—

The Chair (Mrs. Nina Tangri): I'm going to have to stop you there. We have to move on to the opposition. Madame Gélinas.

M^{me} France Gélinas: I'll give you the opportunity to finish. You had talked about point-of-care testing, common ailments, and vaccines.

Ms. Aimee Sulliman: Yes.

M^{me} France Gélinas: So those are the three, or are there more?

Ms. Aimee Sulliman: There, of course, will be more as scope evolves. Thank you, and I know you've been very supportive of expanded scope for pharmacy as well, so thank you. It was great to see you at the OPA reception as well.

I think when we look at the burnout that physicians and other health care practitioners face, it's really important that we're all working together within the health care system to provide and deliver more care, whether it's in the long-term-care setting and creating that capacity for nurses as well, ensuring that medication compliance and adherence is absolutely vital in that oversight of drug-to-drug interactions. When we think of pharmacy, both within the community as well as the long-term-care setting, it's really important.

There are services that are provided within a specialty care infrastructure that our members have invested in that are absolutely vital that the public health care system simply doesn't have the capacity to deliver on, whether it's infusions for oncology medications or rheumatoid arthritis. They have really created capacity where innovations in science have led the way and we've been able to actually deliver on that promise to the patient in providing timely access to care.

1700

M^{me} France Gélinas: You've talked about community; you've talked about long-term care. Do any of your members work in hospitals?

Ms. Aimee Sulliman: The members of the Ontario Pharmacists Association work more in hospitals. Some of our members do work in hospitals and have partnerships with hospitals. You would have recently seen in the news—not to call out one member over the other—that Bayshore recently partnered with Josh Tepper's hospital, North York General, in providing support in the continuity of care and the transitions to the community from hospital.

It will vary, based on the business models of our members, and based on the diversity of services that they provide.

M^{me} France Gélinas: For the example that you've just given us, do you see this as an opportunity for growth for other ones of your members?

Ms. Aimee Sulliman: Certainly, there are many nurses who are hired, and part of the delivery of care within our members—and certainly, I think, ensuring a sustainable and viable pharmacy community is vital to solving the alternative levels of care and primary care within Ontario.

Thinking about the footprint beyond hospitals is really key. We're all in this together. What role that pharmacy can play in terms of the transitions, in terms of people being able to live longer within the community or in their homes, where they want to be—we have to unlock that value that pharmacy presents.

M^{me} France Gélinas: Was your association ever consulted before Bill 74 came out?

Ms. Aimee Sulliman: We did have the opportunity to meet with the minister's office on a range of issues, and have found them to be quite responsive and open to the discussion around how we can improve care.

M^{me} France Gélinas: At what stage—was the bill presented to you at the time, or did you—

Ms. Aimee Sulliman: No, we did not have any views of the legislation itself in advance. I think we probably came to see the legislation at the same time as the rest of the public, when it was introduced during first reading.

M^{me} France Gélinas: You know that we will be getting Ontario health teams. Does your association have any position on making sure that not-for-profit organizations become the leaders of Ontario health teams?

Ms. Aimee Sulliman: We're a not-for-profit association. Our members have different models of delivery. I would say that what matters to us most is whether it's a hospital-led model or a physician-led model or a model that's a combination thereof—that we're working together in the interests of the patient, and that the legislation is there to protect the interests of the patient and improve the outcomes of the patient.

M^{me} France Gélinas: Are any of your members not-for-profit?

Ms. Aimee Sulliman: I couldn't speak to their financial filings. I haven't read all of their annual reports.

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

M^{me} France Gélinas: You put forward a number of suggestions but, really, as the bill stands right now, none of those suggestions are in Bill 74.

Ms. Aimee Sulliman: No, they're not, but we believe that the intent is there in terms of the preamble, combined with the other pieces of legislation and policy changes that the province is making.

We look forward to the budget on April 11. Our pre-budget submission did include a recommendation around the pharmacy table, and we've had the opportunity to provide a submission to the Premier's council, which we're more than happy to share with members of this committee as well.

M^{me} France Gélinas: Okay. For changes to the scope of practice, which is the conversation we started at, again, it needs legislation changed to change the scope of practice. Do you know if this is in the works?

Ms. Aimee Sulliman: I think there will be many opportunities in terms of the regulatory changes related to allied health care professionals, whether it be in red tape or otherwise. I can't speculate on where the government sees—or at what stage they believe that's in. We remain

very hopeful on the progress of that. Thank you for your support.

The Chair (Mrs. Nina Tangri): I'm going to have to conclude you there. Thank you very much for presenting to us today.

DR. MICHAEL RACHLIS

The Chair (Mrs. Nina Tangri): I'd like to call Michael Rachlis, please. Please introduce yourself. You have eight minutes to present, and we're going to have five minutes each of questions just in the interest of time.

Dr. Michael Rachlis: First of all, thank you very much for inviting me to speak to you today. I'm very pleased to do so. I just want to highlight that I'm going to talk about some bad things about the system, but I'll just mention some good things first because I think it's an interesting contrast.

One is, 12 years ago, my mother, who was then in her early eighties, developed chest pain late at night after dancing the night before at a family wedding. I took her down to Mount Sinai and got Brian Goldman as the ER doc. They don't think she's having a heart attack, but they do the two blood specimens six hours apart. She is having a heart attack. Within 24 hours, she has an angiogram stent; 24 hours after that, she's back at my place; 24 hours after that, I'm taking her by plane home to Winnipeg. So that's our health system if you're lucky enough to have a clear diagnosis like chest pain and then an MI.

Many of you may have had the opportunity in your families or friends to have used palliative care services through the province. That is just superb. You're just going crazy, you can't figure out what to do, you ring this doorbell, the door opens, and then you get 24/7 wrap-around care. You're never confused about where to go. But most health care isn't like that.

You have a lot in common. It's wonderful to come to this civil gathering. I know that there are philosophical disagreements between people here, but you're all MPPs, you're all citizens, and now, as MPPs—some of you may be more recent—you're getting people coming to you complaining about complex conditions like elderly people waiting for long-term beds—not even palliative care long-term beds. The family is going crazy, and the only alternative is the ER to get care. They're waiting for specialists; they're waiting for this—and you're dealing with young people with mental health problems all the time. We still have a terrible system for that.

So that's my introduction. Thank you for inviting me.

Briefly, I'm an old man. I used to be a family doctor years ago—I haven't done any clinical medicine for 20 years—I trained in public health over 30 years ago and I've worked for the last 30 years as a private consultant, mainly for governments and health organizations. I spent most of 2012 to 2018 working in Manitoba, where I also was able to help my parents with end-of-life care for my mother and Alzheimer's for my dad.

I've worked for the NDP; I worked for the Conservatives; I've worked for every province; I worked for every

political stripe. In Manitoba, one of the last things I did was co-chair a specialty services committee within Manitoba's hallway medicine task force.

So what's the problem with Ontario's health care, what should be done about the problem, what's in Bill 74, how should it be improved with some specific amendments, and what else, besides Bill 74, do we need?

First of all, it has been mentioned—I think it is mentioned sometimes in a partisan context, but I think it's most important for government members to understand this problem because you're holding the can at this point, right? In four years' time, people are going to be looking to you being responsible for the issues. We have very few hospital beds in Ontario. Canada has the fewest hospital beds per capita of any OECD country; Ontario has almost half the number of hospital beds as Canada. Ontario has almost 70% fewer beds than the OECD average, so we don't have very many hospital beds.

We have terribly uncoordinated out-of-hospital services. Canada has the longest waits amongst OECD countries, or amongst the 11 or 12 wealthy countries regularly surveyed. We have the longest waits for family doctors and the longest waits for specialists, and we're the heaviest users of emergency rooms. Emergency room utilization is going up 2% per year. Good health systems have continuous reduction in their use of ERs.

There's terrible lack of coverage for a number of items which drive people to ERs, and today you have to recognize, with the demise of OHIP+, that there are going to be people who will end up in the emergency room because of that. But there are tens of thousands of people right now who end up in ERs because they don't have dental coverage and they've got dental problems. That's who is coming to ERs. We've got people who can't fill prescriptions who are landing in ERs as well.

Put all this together: This is hallway medicine. All this talk about, "How wonderful. We'll work things out. We'll do things in a long way"—which I think we need to do—just recognize that in four years' time there's unlikely to be any change in this, except maybe fewer hospital beds. There won't be dramatically better community services unless some miracles happen, and therefore, things are almost certainly going to be worse in four years' time.

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What should do we do? We need really different ways of delivering care. I don't necessarily believe that we need to get a whole bunch of new hospital beds. But as I've just outlined, we have almost no hospital beds compared to the rest of the world, and we've got inadequate primary care and poorly coordinated community services. So unless we do something completely different—we could build tens of thousands of hospital beds, but unless we do that, we need really different ways of delivering care outside of hospital, not just around the edges but fundamentally different ways, and we need full public coverage for these other things that drive people to ERs.

I've got a quote here from Tommy Douglas—and I don't mean to be partisan in saying this, but CBC said he was the greatest Canadian ever—just to highlight that

Tommy Douglas is often seen as this guy in black and white films who bequeathed us a system that doesn't work very well. That is so unfair. Tommy Douglas was as modern as tomorrow's sunrise. If he were here now, he would be saying the same things as he said in Montreal in 1982: We have a health system that is pathetically, "lamentably out of date."

Here are some of the new delivery models we need. The Hamilton—I'm sorry for my ignorance; is anybody here from Hamilton? No? Then you're probably not going to know about it, because even in Toronto almost no one has heard about it. The Hamilton mental health model was developed by Nick Kates, head of psychiatry at McMaster, and other people there, including the 150 doctors in the Hamilton Family Health Team, by far the largest and most professionally managed family health team in the province. They have implemented over the course of 20-plus years a system where they've integrated almost 30 psychiatrists, part-time, into the offices of 150 family doctors. There are 80 mental health counsellors based in the family doctors' offices. In that community—but not your communities—for your constituents, you could actually say, "You've got a problem with mental health? Then you can go to your family doctor."

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

Dr. Michael Rachlis: What is the result of this? Dramatic reductions in the rates of referrals to psychiatrists, especially in clinics, because people are getting managed in primary health care, and a reduction in the use of hospitals.

There's a comprehensive community care system for long-term-care-eligible patients. We need more long-term-care places. There are ways of actually providing comprehensive quality care within the community to people who are long-term-care eligible. I'm happy to tell you more about that.

The most important things about how Bill 74 can be improved: I would say, put some objects in that were in the LHIN legislation. I don't know why health promotion and disease prevention were taken out. There's a good business case for prevention, engagement of patients and communities, and to promote health equity.

Ensure the new integrated health care delivery systems are operated as public or private not-for-profit corporations.

Ensure that there's effective public and patient engagement.

Amend the Ontario Health Insurance Act to include a public option for Ontario physicians to work for an integrated delivery system. We're not the most important people in the system, but unless there's a provision to get the funding to pay doctors to be part of these models, they won't work. Health care programs don't work unless they have dedicated physicians.

The Chair (Mrs. Nina Tangri): Thank you. I'm going to move on to Mr. Mamakwa.

Mr. Sol Mamakwa: Michael, if you want to finish, I can let you finish.

Dr. Michael Rachlis: Thank you. Then I want to say, what else do you need besides 74? You really need to understand the status quo. Again, I think it's probably more important for the government ministers. You've got your hands on levers of power.

Why have we failed? This is Fraser Mustard's 1974 task force. It is brilliant. If it had ever been implemented, we wouldn't have the problems we've got today.

This is the 1987 John Evans task force for the Liberal government and David Peterson. This report says, in the executive summary, "There is a remarkable consistency and repetition in the findings and recommendations for improvements in all the information we reviewed. Current submissions and earlier reports highlight ... primary care, to integrate and coordinate ... to achieve a community focus ... on health promotion and disease prevention."

They noted that in 1987 it had been recommended for 15 years and never been implemented.

How are you going to actually do this? I'm talking in the context of an acrimonious environment with a lot of people, including key workers in the system.

I think that you need to understand the status quo. I would say it is physicians in particular that have a bit of a stranglehold on the physicians' budget, which is why I've recommended a public option. The Ontario Medical Association controls the money in the OHIP pot of funds. This has been recognized in public only once, that I know of; in private, everyone recognizes this.

I think that actually, instead of less transparency and less public debate, you really need more of it, because it's when the doctors—or it may be other providers; pharmacists, I think, should be working co-located with doctors, never mind these 18 places where you have to go. Everybody hates co-location except for patients.

To get people to actually integrate and deliver care around the patient—they won't do it unless there is public, democratic engagement. I'd say that we won't get real reform until the CEOs of the local community's largest business, or a labour leader or the leader of the United Way campaign or local minister or rabbi or imam, says to an influential doctor in the community, "It looks like all you have to do is change the way you do your work and we could get immediate care for most of our problems. Will you do that?"

If you continue to do things behind closed doors, where people can't get into the debate, you will not have the leverage from the public and the patients to change the mind that providers have. Thank you very much for letting me explain that.

The Chair (Mrs. Nina Tangri): You have two minutes.

Mr. Sol Mamakwa: Thank you for the presentation. I come from northwestern Ontario. Back in February 2016, the Nishnawbe Aski Nation and also the Sioux Lookout First Nations Health Authority declared a public health and health emergency because of the rate of diabetes, the rate of hepatitis C and the rate of rheumatic fever in the region, also invasive bacterial diseases such as MRSA and the historical and generational trauma with the suicides

and the sexual assaults that are happening in our communities.

When we talk about public health, I know that Steini Brown, the dean of the academic institute where you are based, sat on the Premier's health council, and now is a board appointee to the agency. Are you able to tell us whether you had an opportunity to formally consult in the drafting of Bill 74 with Dr. Brown or this government?

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

Dr. Michael Rachlis: No. I'm afraid no one asked me.

Mr. Sol Mamakwa: Okay. Going back to your 2007 paper called Privatized Health Care Won't Deliver, can you tell us more about your research on how for-profit delivery of health care impacts the quality of care?

Dr. Michael Rachlis: There's lots of evidence. There are different ways of looking at it, but my view is that the evidence indicates that for acute care, long-term care and home care, there is pretty good evidence that for-profit providers have slightly worse outcomes and higher costs. There is so much difference within each of those models, and none of them are really working up to their full potential, but that's the trend.

Some of the integrated models we're talking about rely on shifting money around to do the right thing. For example, one of the comprehensive community care organizations that I really like in the United States has fantastic outcomes when they're not for profit. But as they've allowed for-profit companies to come in in the last four years, they're not having the same outcomes.

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

Dr. Michael Rachlis: I feel there's a danger in people taking the money out instead of using it for patient care.

The Chair (Mrs. Nina Tangri): Thank you. Mr. Anand?

Mr. Deepak Anand: It was wonderful to hear you talk. I hope your mother-in-law is feeling better now.

The Chair (Mrs. Nina Tangri): She passed away.

Mr. Deepak Anand: No, who had the stent? Your mother-in-law had a stent, right?

Dr. Michael Rachlis: Oh, it's my mother who had the heart attack. I'm sorry; I had trouble hearing what you were saying.

Mr. Deepak Anand: Okay; I'm sorry about that. I'm sorry to hear that she passed away. I thought she was still with us, so I wanted to wish her the best.

I looked at this, and you talk about how prevention is better than cure, in your words. As an advocate for health care system innovation, could you please provide an example of a successful but possible innovation model that we can use, and how might Ontario learn from these models?

Dr. Michael Rachlis: One thing I think that is in the public debate is that people who leave hospital are very high-risk—elderly people with congestive heart failure: roughly 25% to 30% are readmitted within two months. There have been at least 40 randomized control trials showing that better interventions using nurses—and the better integrated they are, the better results they have—can

reduce the cost by over 50%. In fact, a University of Alberta study said that for every patient who is given immediate home care for congestive heart failure, there is a savings to the system of over \$2,000. That's one example.

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The other example is this comprehensive community care model that I'm talking about, based on the US Program of All-Inclusive Care model. That can save roughly 20% in health care costs. This is for people who are eligible for long-term care but they're cared for in the community. It improves their health, they live longer and they're less likely to use hospitals and nursing homes.

Mr. Deepak Anand: Thank you so much.

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

Mrs. Robin Martin: Thank you, Dr. Rachlis, for your presentation and for your insights. It's very helpful to hear from you. My husband is from Winnipeg, and I understand that you're from Manitoba. He would say that all good things come out of Manitoba, so we're expecting big things.

I think that there is a lot of what you have said which we agree on. I know, for example, that in other things that you have written, you're an advocate for patient-centred health care, and we're focused on that. You're also an advocate for integration. The example you just gave of a nurse following up with a patient after discharge from hospital after congestive heart failure is a good way to make the system work better. Can you just elaborate a bit on how that works? Because I think that's consistent with what we're looking at.

Dr. Michael Rachlis: You've just spent thousands of dollars on a hospital admission for someone with CHF, you're taking their vital signs four times a day, and then you send them home. They get their next vitals done in three weeks when they come to the ER. That makes no sense. There should be somebody who, for many patients, checks out the home before the patient goes home, goes home with the patient and then continues to see them. The evidence is, as a recent study indicated, not surprisingly, that the more integrated the nurse is with primary health care and with the rest of the system, the more effective it is.

I know I'm going to run out of time, so I just want to make one quick comment.

Mrs. Robin Martin: Sure.

Dr. Michael Rachlis: Again, to you folks, to inspire the conversation we really need to have, the respectful, civil conversation that I think all of you are capable of to move us forward, I can think of no better health minister in my 40-plus years, almost 50 years, of observing Canada's health care system than Larry Grossman, because Larry Grossman championed the patient-centred model of care.

By the way, for people who don't know, he was a Conservative Minister of Health in the early 1980s. He really got it. He championed patient-centred care and he championed public engagement and democracy. He brought the patient groups, the mental health groups and

all sorts of other groups together with the providers and hammered the providers who weren't going to change, with the patients and their families demanding better integrated care. They sacrificed their cherished autonomy to actually serve the patient.

So I just wanted to make the point strongly that if you folks really want to make a difference and if you want to make things better within the next four years, we need that kind of open, respectful dialogue.

The Vice-Chair (Mr. Deepak Anand): We have 30 seconds.

Mrs. Robin Martin: Oh, dear. I'm just going to add in here, now that I have 30 seconds, that we do really want to make a difference. We appreciate you bringing some of these ideas forward to us. We'll continue to read your articles and some of the reports that you've brought to our attention to make sure we get it right—and maybe look at Larry Grossman.

The Vice-Chair (Mr. Deepak Anand): Thank you, sir.

ALZHEIMER SOCIETY OF ONTARIO

The Vice-Chair (Mr. Deepak Anand): Next is the Alzheimer Society of Ontario. Please, your name and the organization name. You have eight minutes, followed by five minutes from both sides.

Ms. Cathy Barrick: Thank you very much. I'm Cathy Barrick. I'm the CEO of the Alzheimer Society of Ontario. Joining me is Kyle Fitzgerald, who is our manager of government relations. Good afternoon, and thank you very much for the invitation. I want to start by again thanking you for offering us the opportunity to give some thoughts and feedback on Bill 74 and how it might impact the front-line service that we provide.

The Alzheimer Society of Ontario has been advocating for people living with dementia and their care partners for over 40 years. The 29 local Alzheimer societies across Ontario provide front-line care and support, including counselling, referrals, recreation programs, respite services for caregivers, and education and information sessions. Across Ontario, we directly support 70,000 clients every year.

As a front-line health care provider, the focus of the Alzheimer Society has always been delivering quality care and support to clients and families. We welcome any legislative changes that will make it easier for us to provide the programs and services our clients rely on. We are in full agreement with the stated goal of Bill 74, creating a health care system that is, to quote from the preamble, "centred around people, patients, their families and their caregivers."

We also welcome the emphasis placed on centring Ontario's health care system around keeping patients in their community and, where possible, at home. A more community-focused approach offers benefits not only to patients but to the health care system as well.

The Alzheimer Society is a community support provider, meaning we are integrated into the communities we

serve. Community support groups allow people to live in their community, where they want to be, for longer. Over 60% of Ontarians living with dementia live in the community, and with a greater emphasis on community supports in our health care system, this number could be even higher.

Keeping Ontarians living with dementia in their homes instead of in a hospital or long-term care has benefits for both the person living with dementia as well as the health care system. Community supports help divert patients from hospital who do not need to be there in that expensive level of care and form part of the solution to confront hallway health care.

Community supports have also been shown to delay admission of someone living with dementia into long-term care by more than 11 months, saving the person's family and the health care system \$50,000. Community supports, like those provided by the Alzheimer Society and our other community partners, promote a better quality of life for clients and cost savings for the health care system.

We therefore ask the committee to consider clarifying section 21, subsections (1) and (2), of The People's Health Care Act. On page 10 of the bill, you will see that these two subsections separate funding provided by the new agency, Ontario Health, into two categories: health services and non-health services. These two terms are not given a clear definition, which may present challenges, should the bill become law in its current form. Would Ontario Health be expected to assess each service that a provider offers and separate them into health-related and non-health-related? If so, what criteria would be used?

If the intent of these subsections is to separate front-line services from administrative support, that could be more clearly specified to avoid a situation where services and programs people rely on are classified as non-health-related and possibly see their funding reduced. We have included language with this clarification in our written submission for your reference.

Much of Bill 74 discusses integration and coordination within the health care system. This is a goal the Alzheimer Society shares, and we have been pursuing more efficient operations on our own accord for decades. Within our own organization, we have centralized certain operations to reduce costs and, across Ontario, the 29 local Alzheimer Societies are forming proactive partnerships to provide a seamless experience for our clients.

We have integrated some local societies where a single entity in a defined region makes the most sense for front-line service delivery and consolidation of administrative duties. We continue to look for these opportunities within our own organization and with our community partners alike, and we welcome the emphasis being placed on better coordination across health care. We must also recognize that integration has a potential impact on the services we provide.

For a person living with dementia, visiting a hospital to access day programs may not be ideal. We hear every day that navigating the health care system can be complicated for people living with dementia and their care partners. Integrating smaller community organizations into larger

entities may produce cost savings, but could have unanticipated impacts for vulnerable clients who already struggle to access the services they need.

Accessible community support services are an integral part of the health care system, and we want to ensure our services remain focused on placing the client at the centre of all we do. We would recommend that client experience be a major consideration before the minister exercises their powers of integration under this act.

Section 45 on page 25 of the bill speaks of the public interest. We would recommend adding the client experience as something that must be considered and have suggested language to that effect in our submission.

As a front-line health care provider, the Alzheimer Society is open to embracing any legislative changes that help us better support our clients. We welcome the commitment in Bill 74 to focus on building a patient-centred health care system, one that aims to keep Ontarians living in their communities, which is what they want.

On behalf of the Alzheimer Society of Ontario, we would like to thank you for the opportunity to present, and I look forward to your questions. Thank you.

The Vice-Chair (Mr. Deepak Anand): Thanks so much. Member Fee?

Mrs. Amy Fee: Thank you both, first of all, for being here today and taking the time to come and speak with us. My grandmother passed away several years ago, and she did have Alzheimer's. So I saw that challenge that my mom went through, trying to support her. Not only was my mom living a few hours away, but she was trying to deal with figuring out long-term care, retelling her story over and over again and trying to make sure she had what she needed to stay in her home as long as she could before she moved into long-term care. So I've seen the challenges from my grandmother's lens and from my mom's lens trying to support her. I'm wondering if you can kind of talk to me more about the challenges and the barriers that people with Alzheimer's are facing, and their families and caregivers as well.

1730

Ms. Cathy Barrick: Yes, most certainly. I think you've actually hit the nail on the head. That's a story that we hear every day from clients and caregivers that we're dealing with. One of the things that I love most about the proposed legislation is that it's a system that's built around the client, so that they do not have to call multiple agencies on their own to figure out where to get service and to repeat their story multiple times. Sometimes you qualify for service here but not there, so I think having it more holistic and, as I said, centred around the client would be most beneficial. I think finances are often a big issue for caregivers and people. Transportation, respite, isolation, navigation of the health care system—all of these things which you highlighted in your own experience are things we hear and that I think can be addressed if we do really focus on an integrated model.

The Vice-Chair (Mr. Deepak Anand): Anyone else? Member Martin, go ahead.

Mrs. Robin Martin: Thank you for coming in. Thank you for your presentation. What kind of programs and

services does your organization provide for people with dementia? If you could give us a few examples and then maybe let us know how you feel this could work within a more broad-based Ontario health team.

Ms. Cathy Barrick: Yes. We provide a lot of what I guess you would consider very traditional community support services. We provide education and counselling support, public education, things like that, which support caregivers and people living with dementia. But, over the last number of years as well, we've embraced some new and more innovative, maybe non-traditional, programs that can make a really huge impact.

For example, the Music Project uses music to help people living with dementia have a more enjoyable life, really, and also provides respite for caregivers. We provide day programs in some areas. We have programs that work with caregivers and people living with dementia to live safely at home. We're also working with our community partners, such as first responders, police, firefighters, paramedics and pharmacists, to help them identify when people are struggling and get them safely home. Things like that.

Mrs. Robin Martin: That sounds very helpful.

My father, as well, suffered from dementia—I don't think it was exactly Alzheimer's, but I know you do service both of those groups. It is a real challenge to try to figure out how best to help and serve them, so it's great to have organizations like yours.

For this new legislation, do you foresee a way that the integrated model that we're providing is going to make life better for both the patients as well as the service providers who are dealing with people with Alzheimer's?

Ms. Cathy Barrick: Most definitely. As your colleague Amy mentioned, the difficulty, first of all, in navigating and knowing even where to go when someone is diagnosed with dementia continues to be a challenge, and then repeating the same information. Honestly, at the Alzheimer's Society, that's actually one of our strengths, I would say; we actually already embrace this kind of approach anyway. Our community services in the communities in which we operate—we are very close partners with them already. I think that, in a health care system, when you include primary care, hospitals, health teams, etc., into that fold, it can only strengthen it. Right now, community services and primary health care often operate—not completely in silos; we most definitely interact and intersect. But I think anything that reduces those barriers so that we're all on one team will only help patients and caregivers.

Mrs. Robin Martin: This is something I've been thinking about: the role for specialty needs. In a sense—

The Vice-Chair (Mr. Deepak Anand): You have about 30 seconds.

Mrs. Robin Martin: Okay. Alzheimer's is kind of one type of a specialty; not everybody has it—or dementia; not everybody has it. Do you see it getting more attention, if you will, in an integrated system?

Ms. Cathy Barrick: I think it certainly could. Part of the reason is because, when you look at hallway health care and ALC beds, a huge amount of those are people

with dementia. So I think it would be to the government's benefit to give them special attention, because there are interventions often given at the community level that can prevent that.

The Vice-Chair (Mr. Deepak Anand): Thank you so much. Ms. Armstrong?

Ms. Teresa J. Armstrong: Thank you for presenting today at the committee. Would you like to finish what you—

Ms. Cathy Barrick: No, that was it.

Ms. Teresa J. Armstrong: You're good?

Ms. Cathy Barrick: Yes, thank you.

Ms. Teresa J. Armstrong: Okay. One of the questions we've been asking today is if you had the opportunity to formally present or meet with the government while it was a draft bill, for Bill 74, and if so, when did that occur?

Ms. Cathy Barrick: We were actually quite fortunate, and have been quite fortunate: We've met with several ministers, including the Minister of Health. As well, our local societies have been strongly engaged in meeting with MPPs, so we've provided feedback—obviously, also through our budget submission—through those meetings in terms of the issues that we've identified as problems and how we would like to see them addressed.

Ms. Teresa J. Armstrong: Good. As the critic for home care and long-term care, I strongly believe that seniors with complex behaviour needs need to have critical, hands-on care. Virtual care cannot replace the hands-on care needs that we have right now. I wondered if your organization would support enhanced legal protections to ensure that virtual care doesn't replace or reduce the hands-on care that we're talking about when it comes to dementia patients—or, excuse me, Alzheimer's.

Ms. Cathy Barrick: I think there's room for both. Particularly when you're looking at communities that may have more difficulty accessing specialized care, I think there certainly is room for technology and remote care, so to speak, to be useful. I fully agree and support the idea that, particularly with people with dementia, hands-on care and people-to-people—that's again the strength of the Alzheimer Society. It's about people helping people. So I think there is room for both.

Ms. Teresa J. Armstrong: Okay. You also talked about your recommendation. That also came up today. What's your concern if that recommendation isn't adopted into the preamble? How do you see that outcome, by not having that in writing for that recommendation?

Ms. Cathy Barrick: In terms of the client experience?

Ms. Teresa J. Armstrong: In terms of the integrated health care teams. Are you going to be left out? Are you going to be included in it if it's not in writing? What are you thinking? Because they've actually specified that that should be something that should be in the health care bill so that community support providers are considered as health delivery.

Ms. Cathy Barrick: Yes, definitely. I think the nature of the bill is meant to be inclusive of community support services. We certainly have not gotten the impression that we are not an important part of the system, and so we appreciate that. But further clarity in the bill—just to

ensure, and to make us all feel better, honestly, that we are an integral part of the system. We want to be at the table to provide the supports in ways that only we can in the community.

Ms. Teresa J. Armstrong: Great. In your expertise, can you please tell us whether the Ontario government needed to introduce this massive legislation overhaul to solve hallway health care? And is the hallway health care problem with regard to policy and legislative barriers or because the health care system is underfunded?

Ms. Cathy Barrick: Well, that question is probably above my pay grade, in the sense that I don't know. I don't work in a hospital. I think it's probably a little bit of both, to be honest. I think there are systemic problems in the health care system as it stands, including barriers that clients that we support deal with, as well as I think when you—I was actually just in the emergency department twice with my grandmother who has dementia, recently, and the staff there are run off their feet. So I think, if we can address some of the systemic problems to keep people out of the hallway, then perhaps the overburden would subside. That said, I think some additional support in front-line service would be most welcome by everyone.

Ms. Teresa J. Armstrong: I met with my local Alzheimer's organization. They do wonderful work in London, and they talked about the need—they've had very small amounts of increases, and they were looking to have, I think it was, \$100 million put into the Alzheimer Society. Do you think that's a really important piece of the integral part of this legislation in order for success to happen if you're going to be part of that community support services?

The Vice-Chair (Mr. Deepak Anand): We have 30 seconds.

Ms. Cathy Barrick: For sure. More funding is always welcome, and it's not just for the Alzheimer Society. We are one of many community support services in health care that provide support. Ongoing investment—not only is it the right thing to do to support these people that are facing this, but it's actually the right thing to do for health care. We can do things at a community level that are cheaper, that are client-focused, that keep people at home where they want to be and improve their quality of life.

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Ms. Teresa J. Armstrong: Thank you.

The Chair (Mrs. Nina Tangri): Thank you very much for presenting to us today. We really appreciate it.

Ms. Cathy Barrick: Thank you very much.

CANADIAN MENTAL HEALTH
ASSOCIATION, ONTARIO DIVISION

ADDICTIONS AND MENTAL
HEALTH ONTARIO

CHILDREN'S MENTAL HEALTH ONTARIO

The Chair (Mrs. Nina Tangri): I call upon the Canadian Mental Health Association, Ontario division. Please state your name for the record. You have eight

minutes to present, followed by five minutes each from the recognized parties.

Ms. Camille Quenneville: I'd like to thank the members of the Standing Committee on Social Policy for allowing me to speak today. My name is Camille Quenneville. I'm CEO of the Canadian Mental Health Association, Ontario division.

CMHA Ontario is a not-for-profit, charitable organization that works to improve the lives of all Ontarians through leadership, collaboration and the continual pursuit of excellence in community-based mental health and addictions services. Our vision is a society that embraces and invests in the mental health of all people. We are a trusted adviser to government, contributing to health systems development through policy formulation and recommendations that promote positive mental health. Our 30 CMHA branches cover the entire province, and we have a proud history as Canada's oldest nationwide charity, as we are currently in our 101st year of existence.

We know that Ontarians generally prefer to receive care within their community, particularly for mental health and addictions issues. For this reason, community-based agencies like CMHA need to continue to play a prominent role in the future health care state to ensure continuity of high-quality local mental health and addictions services across the province.

Our 30 CMHA branches provide services and supports across a continuum of care, including illness prevention, crisis response, treatment and recovery. They also provide outreach, case management and related services, including supportive housing, employment supports and court diversion programs.

Our branches provide standard services, but are also unique and cater services to the communities they serve. A great example of this is our CMHA Durham branch in Oshawa. It has a nurse-practitioner-led clinic on-site and a pharmacy with a specially trained pharmacist with expertise in mental health and addictions meds, amongst a variety of other services, including housing and employment support. It's a one-stop shop where an individual can receive treatment and support, not only for their mental health, but for co-occurring primary care concerns.

In London, our CMHA Middlesex branch operates a crisis centre that has become the first stop for individuals in crisis. Positive relationships with police and hospitals mean that the crisis centre is where people will seek help and where they are diverted from the emergency department 24/7.

Our CMHA Lambton-Kent branch is a great example of cross-sectoral partnerships that work. The branch and the two regional hospitals in its catchment have created an integrated mental health delivery system that provides positive, seamless patient and client experiences across communities and sectors.

At CMHA Ontario, meanwhile, we offer several provincial programs to complement the great work of our branches. Some of you may be familiar with Bounce Back, which is a skill-building program designed to help those 15 years and older manage feelings of low mood, depression and anxiety. It provides telephone-based coaching,

using workbooks. It is evidence-based and easy to access, with appointments booked online by the user at their convenience. A simple referral from your primary care provider or a self-referral gets you started.

We also have a unique sports program called Talk Today, which started as a partnership with the Ontario Hockey League. We provide mental health training and awareness to the league's junior hockey players. The program has been so successful that CMHA now operates it across the western and Quebec major junior leagues as well, which means across Canada. We also serve colleges and universities and other minor sports organizations through Talk Today. We're spreading messages of positive mental health through activities young people like to naturally engage in, which is sport. This made-in-Ontario program has proven successful across the country.

I'd like to mention our work as the secretariat for the provincial Human Services and Justice Coordinating Committee. HSJCCs are planning tables that bring together service providers to find solutions for people with defined, unique needs who come into contact with the justice system. Priority consideration is given to such persons with a serious mental illness, developmental disability, acquired brain injury, drug and alcohol addiction and/or fetal alcohol syndrome.

As the leaders in community-based mental health and addiction service provision in Ontario, CMHA Ontario works closely with key partners; namely, Addictions and Mental Health Ontario and Children's Mental Health Ontario. In fact, these three organizations collaborated together on this government submission. In reviewing Bill 74, The People's Health Care Act, we offer the following key recommendations:

(1) Community-based mental health and addictions providers must play a central role in the delivery of mental health and addictions care through Ontario health teams. Mental health care must be delivered in collaboration with addictions care within these teams. There must be no silos, as mental health and addictions issues are often intertwined and co-occurring.

(2) Ontario health teams must focus on providing people with continuity of mental health and addictions care across the lifespan, from children and youth to adults and seniors. When planning services, OHTs should focus on closing critical service gaps for youth at key transition points. Special consideration is required for child and youth services, as they were previously governed as a discrete sector and were recently moved to the purview of the Ministry of Health and Long-Term Care.

(3) Ontario Health must identify and implement a standardized set of core services for addictions and mental health care across the province. Core services should be available at the local, regional or provincial level. Consideration should be given to specialized services such as residential treatment, specific services for children and youth, and services for people involved in the justice system.

(4) Ontario Health must focus on the implementation of a strong data strategy for community-based mental health

and addictions care so that the level of care provided through Ontario health teams can be measured and maximized. A strong data strategy is the foundation of continuous quality improvement, and it also ensures that Ontarians will receive the high-quality mental health and addictions services that we all know they deserve.

(5) Ontario Health must establish a baseline of funding to community mental health and addictions service providers that must commit to both protecting and growing these funding levels to support capacity building within the sector. When a system transformation takes place, we must ensure that the capacity for front-line community-based mental health and addictions care is bolstered so that providers can help clients with appropriate care in the community, diverting patients from hospitals.

These are our five recommendations in response to Bill 74, The People's Health Care Act.

The Canadian Mental Health Association, Addictions and Mental Health Ontario and Children's Mental Health Ontario and our respective branches and member agencies continue to be integral partners in ending hallway medicine. We look forward to supporting this health care system transformation so that people can get the right mental health and addictions care in the right place and at the right time.

With that, I'm happy to take your questions.

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

Mrs. Robin Martin: Thank you, Ms. Quenneville, for your presentation and thank you for the written submission, which highlights a lot of the points you made.

As you know, we've been conducting mental health round tables across the province and working with the Premier's council to collect ideas on how to improve mental health.

I see what we've been doing in the mental health sector as working very well with what we're talking about in Bill 74. You mentioned the importance of a central role for community mental health in these health teams. You mentioned the continuity of care. You mentioned the importance of a data strategy and standardized services. These are the things that we've been talking about, at least in our mental health round tables, and I see those as fitting quite well within what we're proposing in Bill 74.

I just wanted to ask you where you see the greatest opportunities for the mental health and addictions sector—which is very close to the minister's heart, as you know, and very close to my heart—through this proposed health system transformation.

Ms. Camille Quenneville: Before I get to the specifics, I want to say thank you for the opportunity to participate in those consultations, on behalf of my branches across Ontario. The vast majority have participated and have appreciated the opportunity to give a first-hand account of the work that they do in their branches.

For the purposes of this committee, I will tell you that I'm also a member of the Premier's council working group on mental health and addictions, so I have the opportunity to provide input there, as well.

To answer your question, there are two key pieces that I'd like to really communicate today in terms of the critical importance to move on this quickly. The first is the data strategy. For far too long, mental health and addictions has been really far behind in rigorous data collection in a manner that is relevant and useful to be able to reflect what's happening, what care is provided, how that service was delivered. As a result, we are handicapped in trying to provide better quality improvement services etc. It isn't the issue that most sectors have to deal with, but we have been too far behind on that, and I would highly encourage an investment to move that forward.

1750

The other is core services. Again, this speaks to a standardization and the need for all of us to be able to—wherever we are in Ontario, if we're struggling, if a family member or friend is struggling, we need to know what should be available, what those core services are that we should be able to access, regardless of where we live, and accompanying that are obviously standardized procedures around how that care is delivered.

Those are the two key pieces amongst those that you mentioned, certainly. We know a mental health strategy will be coming out later this spring or early summer. I fully anticipate and hope that those two are reflected in this. I can assure you that you have my commitment and, without question, the commitment of my members and, I would dare say, both Addictions and Mental Health Ontario and Children's Mental Health Ontario to work with you to see the full implementation of that.

Mrs. Robin Martin: The CMHA is this unique organization where, as you mentioned, there are 30 branches across Ontario, all of which individually have some great programs, but we don't necessarily have the line of sight on them or the opportunity to scale up or pick out where the best are and share them. Do you foresee this legislation helping with that kind of best practice—

Ms. Camille Quenneville: I certainly hope so. I just want to make sure everyone is clear: We have some standardized services, so there is some commonality. I think the beauty of an organization as old as ours is that you begin to reflect the community that you're in and you take on programs that are specific to that community.

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

Ms. Camille Quenneville: Thank you. There are lots of reasons why things like the crisis centre in London pop up. Often, it has to do with excellent relationships with the hospital, it catches the LHIN's attention—historically, obviously—people put their heads together and make it happen. There's no reason there shouldn't be one of those in every single CMHA across Ontario. It is a model of care—

Mrs. Robin Martin: Some are specific to the area, but others aren't; right?

Ms. Camille Quenneville: But others aren't.

To your earlier point, it is a best practice and it should and could be scaled, without question.

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

Mme France Gélinas: It's nice to see you again.

Ms. Camille Quenneville: Likewise.

Mme France Gélinas: You shared with us that you are a member of the Premier's council. I was just curious. Before the bill was rolled out, did you know that Cancer Care Ontario was going to be part of the super-agency and all of this? Was this all shared with you, and is this something you were consulted about?

Ms. Camille Quenneville: No, not at that table, nor would I necessarily expect it would be, to be quite honest. I'm on a working group. I'm not on the actual Premier's council. There might be a difference there; I don't know.

Mme France Gélinas: How much of Bill 74 did you work on within your working group?

Ms. Camille Quenneville: I have to tell you, we have discussed it—and I know this might sound a bit silly to this committee, but I did also sign a non-disclosure agreement around the conversations we have around that table, so I'd like to be a bit careful. Suffice to say that I think we were consulted appropriately, and I'm grateful to have the opportunity to learn at that table that I have.

Mme France Gélinas: How many meetings did you have about Bill 74 before it was tabled?

Ms. Camille Quenneville: Our meetings aren't specific to any one issue, to be quite honest with you—they haven't been.

Mme France Gélinas: Okay. You've seen in the bill that in order for Ontario health teams to be formed, you have to offer three of the six—hospital, long-term care, palliative care, primary care, community mental health, and community support. Does it worry you that mental health and addictions tends to be the poor cousin of the poor cousins, and that if we don't mandate that it has to be in every team, we will have teams where it won't be?

Ms. Camille Quenneville: It's fascinating; I'm in the middle of a provincial conference that we're hosting, so I actually had access today to all 30 of my branch leaders, and we were fortunate that we had the Deputy Minister of Health come in and talk to us. So I'm obviously learning what my branches are doing in real time in terms of the meetings that they're having in their own communities. As I said to them today, I'm immensely proud of the work they're doing. They have excellent partnerships. Historically, there has been little incentive to actually work together because funding doesn't necessarily either benefit you in that department; sometimes it works against you.

The long and short of it is, I think that a lot of my members now are really having very healthy conversations with their partners. They're not feeling marginalized. In many cases, a lot of the hospitals are now waking up and realizing that, "I'd better pay attention and see what's out there in the community because otherwise, I don't actually have the makings of an Ontario health team model."

So it's an interesting time. Every community is different, and I want to respect the processes that they are taking. But I would just say that I haven't had the sense that they're feeling marginalized, and I certainly hope not; they haven't communicated that to me.

Mme France Gélinas: We talked about making sure that every team has mental health and addiction, but you've also gone further. You said to set "a standardized

set of core services for addictions and mental health care across the province.” None of this is in the bill. Who would you see doing that work? If we have 50 teams that go at it in their 50 different ways, who would be responsible for defining that set of core mental health and addictions services?

Ms. Camille Quenneville: I’m happy to report—

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

Ms. Camille Quenneville: Oh, thank you.

My organization has actually done an awful lot of work on that front. The Ministry of Health has done an awful lot of work on that front. There is really no daylight between where the sector is and where the ministry is. I think some of this is fairly straightforward in terms of what should be included. It is exceptionally complex. I’m part of a committee, as well, at the Ontario Hospital Association,

that’s looking at this. Lots of folks have their hands in this pot, but that’s always a good thing because it will create a better product at the end of the day. I think there has actually already been a fair bit of work done on that front, and very good work.

M^{me} France Gélinas: That would include people we serve in northern Ontario, Aboriginal, francophone, etc.?

Ms. Camille Quenneville: Absolutely.

M^{me} France Gélinas: Okay, thank you.

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

Ms. Camille Quenneville: I know I’m between you and a nice dinner, so thank you.

The Chair (Mrs. Nina Tangri): I’d just like to let everyone know that we are going to be recessed until tomorrow morning, Tuesday, April 2, 2019.

The committee adjourned at 1759.

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M^{me} France Gélinas (Nickel Belt ND) Mr. Sol Mamakwa (Kiiwetinoong ND)

Mr. Sol Mamakwa (Kiiwetinoong ND)

Also taking part / Autres participants et participantes

Ms. Natalia Kusendova (Mississauga Centre / Mississauga-Centre PC)

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