Legislative Assembly of Ontario

Assemblée législative de l'Ontario

Official Report of Debates (Hansard)

SP-9

Standing Committee on Social Policy

Your Health Act, 2023

1st Session
43rd Parliament

Monday 20 March 2023

Chair: Goldie Ghamari
Clerk: Lesley Flores

Journal des débats (Hansard)

SP-9

Comité permanent de la politique sociale

Loi de 2023 concernant votre santé

1re session
43e législature

Lundi 20 mars 2023

Présidente : Goldie Ghamari
Greffière : Lesley Flores

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House Publications and Language Services
Room 500, West Wing, Legislative Building
111 Wellesley Street West, Queen's Park
Toronto ON M7A 1A2
Telephone 416-325-7400
Published by the Legislative Assembly of Ontario

Service linguistique et des publications parlementaires
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400
Publié par l'Assemblée législative de l'Ontario

ISSN 1710-9477

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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 20 March 2023

Lundi 20 mars 2023

The committee met at 0901 in committee room 2.

YOUR HEALTH ACT, 2023

LOI DE 2023 CONCERNANT VOTRE SANTÉ

Consideration of the following bill:

Bill 60, An Act to amend and enact various Acts with respect to the health system / Projet de loi 60, Loi visant à modifier et à édicter diverses lois en ce qui concerne le système de santé.

The Chair (Ms. Goldie Ghamari): Good morning, everyone. The Standing Committee on Social Policy will now come to order. We are here for public hearings on Bill 60, An Act to amend and enact various Acts with respect to the health system.

As a reminder, the deadline for written submissions is 7 p.m. Eastern Daylight Time on Monday, March 27, 2023. Legislative research has been requested to provide committee members with a summary of oral presentations and written submissions as soon as possible following the written submission deadline. The deadline for filing amendments to the bill is 5 p.m. Eastern Daylight Time on Wednesday, March 29, 2023.

The Clerk of the Committee has distributed today's meeting documents to you virtually via SharePoint. To ensure that everyone who speaks is heard and understood, it's important that all participants speak slowly and clearly. Please wait until I recognize you before starting to speak.

For the virtual participants on Zoom, after I have recognized you, there may be a brief delay before your audio and video are ready. Please take a brief pause before you begin speaking. In order to ensure optimal sound quality, virtual participants are encouraged to use headphones or microphones if possible.

As always, all comments should go through the Chair.

Are there any questions before we begin? Yes, MPP Gélinas.

M^me^ France Gélinas: It's not really a question; it's more of a comment that you will see that there is only one representative of the north that was able to—

The Chair (Ms. Goldie Ghamari): At this point, I've asked if there are any questions about the proceedings. We can save comments for debate.

M^me^ France Gélinas: Okay.

The Chair (Ms. Goldie Ghamari): Thank you.

MINISTRY OF HEALTH

The Chair (Ms. Goldie Ghamari): I will now call on the Honourable Sylvia Jones, Minister of Health. We are joined today by the minister and other officials. However, the committee has limited the number of in-person speakers to one per organization. Do the members of the committee wish to allow more than one speaker from the Ministry of Health to sit at the table?

M^me^ France Gélinas: Yes.

The Chair (Ms. Goldie Ghamari): Minister, you will have 20 minutes to make an opening statement, followed by 40 minutes of questions from the members of the committee. Questions will be divided into two rounds of seven and a half minutes for the government members, two rounds of seven and a half minutes for the official opposition members and two rounds of five minutes for the independent member of the committee. I will provide reminders of the time remaining during the presentations and questions. Please state your name for Hansard, and you may begin.

Hon. Sylvia Jones: Thank you very much, Chair. Sylvia Jones, MPP for Dufferin–Caledon, Deputy Premier and Minister of Health.

Thank you to all the members of the social policy committee for the opportunity to appear before you as the first presenter for public hearings for Bill 60, the Your Health Act. I'd like to take this opportunity to thank all members from both the government and opposition sides of the Legislature who have participated in the second reading debate, with a special thank you to my two parliamentary assistants, the member for Eglinton–Lawrence and the member for Newmarket–Aurora, for joining me to lead the bill's introduction.

I'd also like to take this opportunity to introduce the Deputy Minister of Health, Dr. Catherine Zahn, who is here with me this morning to participate in the Q&A session. As well, we have assistant deputy ministers Patrick Dicerni, Greg Hein and Dr. Karima Velji, chief of nursing, joining us by Zoom this morning to answer any questions committee members may have.

It's been over a month since we released Your Health: A Plan for Connected and Convenient Care, and we are already seeing results in our health care system across Ontario. Already, we have seen emergency department wait times coming down, and we've started to shorten wait times for key surgeries. Nearly 100,000 people have connected to convenient care at the pharmacy for treating

common ailments. Through the Your Health plan, our government is taking action to strengthen all aspects of health care, particularly where people access it most frequently. Bill 60, Your Health Act, 2023, supports our efforts to do so.

The Your Health plan, which is supported by this bill, builds on the significant progress our government has made over the last several years. Since 2018, we have increased health care funding in our province by $14 billion. We have expanded Ontario's health workforce with more doctors, nurses and personal support workers. In fact, since 2018, we've grown our health care workforce by 60,000 new nurses and 8,000 new physicians. We've added more than 3,500 hospital beds across Ontario including acute, post-acute and critical-care beds. We're building new hospitals in every region of the province, getting shovels in the ground for 50 new major hospital development projects. Since 2021, we have provided funding to support operations of 49 new MRI machines. We're adding nearly 60,000 new and upgraded long-term-care beds. And we're investing nearly $5 billion over four years to hire more than 2,700 long-term-care staff, including nurses and personal support workers, and increasing the amount of direct care residents receive.

We continue to make it easier and faster for individuals of all ages to connect to mental health and addictions supports by building on our Roadmap to Wellness. We have made it more convenient to book or take a health care appointment by launching virtual care options and adding more online appointment-booking tools. Our government is better connecting health care organizations and providers in our communities through Ontario health teams.

Through Bill 60, our first objective is taking steps to help those who want to work in Ontario. There are many health care workers from across the country and across the world who want to work in Ontario, and we are making innovative changes to make it easier and faster for them to begin working and providing care to people in Ontario. With the legislation's new as-of-right rules, Ontario will become the first province in Canada to allow health care workers registered in other provinces and territories to immediately start providing care without having to first register with one of Ontario's health regulatory colleges. If passed, Bill 60 would result in amendments to certain health professional acts which would allow out-of-province registered health professionals to practise immediately in Ontario while waiting for their registration with their respective Ontario health regulatory college, because I think we can all agree that a doctor from British Columbia shouldn't face bureaucratic delays to be able to practise here in Ontario.

This change will help health care workers overcome excessive red tape that makes it difficult for them to practise in Ontario. It will also help hospitals and other health organizations temporarily increase staffing when they need to fill vacancies or manage periods of high patient volume, such as during a flu surge. Participants will need to be, of course, in good standing with their home regulatory college and have a job offer at a health care facility, like a hospital or a long-term care home, in Ontario to be eligible for these as-of-right programs. This will allow nurses, paramedics, therapists and other health care professionals to work outside of their regular responsibilities or settings as long as they have the knowledge, skill and judgment to do so. That's the kind of innovative solution that will help bring reinforcements to the front lines of our health care system.

We are also continuing to make it easier for internationally trained health care professionals to use their expertise here in Ontario. We are working closely with regulatory colleges to make it easier and faster for qualified health care professionals to work here as well without facing unnecessary barriers and costs, including requiring colleges to comply with time limits to make registration decisions. These proposed changes are another way we are looking to reduce administrative barriers and help to allow qualified professionals to work in Ontario quickly and efficiently.

Another way we are supporting this is by expanding the Ontario Learn and Stay Grant. We know that there are unique health challenges in small, rural and remote communities and that recruiting and retaining health care workers in these regions requires a dedicated approach. Last spring, we launched the Ontario Learn and Stay Grant to help these communities build their own health workforces. This program covers the cost of tuition, books and other direct educational costs for post-secondary students who enrol in high-priority programs in more than a dozen growing and underserviced communities and commit to work in these communities when they graduate. This year, we are expanding the program beginning in spring of 2023, targeting approximately 2,500 eligible post-secondary students who enrol in high-priority programs like nursing, paramedicine, medical lab tech or medical lab science.

0910

Another aspect of Bill 60 I would like to highlight is repealing the Independent Health Facilities Act and replacing it with new legislation, the Integrated Community Health Services Centres Act, 2023, to better reflect the settings where care is taking place across Ontario. The health care landscape has changed significantly since the enactment of the Independent Health Facilities Act in 1990. There is a need for a legislative framework that better responds to current surgical demands in a manner that is integrated within the broader health system that prioritizes safety and patient needs, and better reflects the modern health system landscape and priorities. This proposed change would support the expansion of surgical, procedural and diagnostic services in the community, which is another important part of our plan for convenient and connected care. We are reducing wait times by increasing access to surgeries and procedures such as MRIs and CT scans, cataract surgeries, orthopedics, colonoscopies and endoscopies.

For over 30 years, community surgical and diagnostic centres have been partners in Ontario's health care system. Like hospitals, community surgical and diagnostic centres

are held accountable to the highest quality levels—the standards Ontarians deserve and expect across the health care system. To further support integration, quality and funding accountability, oversight of community surgical centres will transition to Ontario Health. This improved integration into the broader health care system will allow Ontario Health to continue to track available community surgical capacity, access and assess regional needs, and respond more quickly across the province and within regions where patient need exists.

We're also expanding oversight and patient protections when it comes to your health. Integrated community health service centres will now have to post any uninsured charges both online and in person. Every community surgical and diagnostic centre must have a process for receiving and responding to patient complaints. Patients cannot be denied access to treatment if they don't purchase uninsured services. We're also expanding the oversight of the Patient Ombudsman to include integrated community health services centres. These safeguards are in place to ensure that no extra charges occur for OHIP-funded procedures.

By further leveraging the support of community surgical and diagnostic centres, we will eliminate surgical backlogs and reduce wait times.

We know that lengthy wait times for surgeries are one of the biggest challenges you and your family are facing in Ontario. While Ontario leads the country in the number of people who received the surgery they need for hip and knee replacements, we still aren't meeting the right benchmarks. We need to do more.

As a first step, we are tackling the existing backlog for cataract surgeries, which was one of the longest waits for procedures in the province. Four existing community-based centres located in Windsor, Kitchener-Waterloo and Ottawa have been identified as successful applicants to a recent call for applications. These centres will be able to support an additional 14,000 publicly funded cataract surgeries every year. These additional volumes make up to 25% of the province's current cataract wait-list, which will help significantly reduce the number of people outside of appropriate wait times for this surgery.

We are also investing more than $18 million in existing centres to cover care for thousands of patients, including more than 49,000 hours of MRIs and CTs, 4,800 cataract surgeries, 900 other ophthalmological surgeries, 1,000 minimally invasive gynecological surgeries and 2,845 plastic surgeries.

I would like to emphasize that this is all publicly funded. The costs of receiving these insured services in community surgical and diagnostic centres is covered by an Ontario health card, never your credit card.

As the government significantly expands the number of surgeries being done through community surgical and diagnostic centres, it will do so with measures in place to protect the stability of staffing at public hospitals, including requiring new facilities to provide detailed staffing plans as part of their application and requiring a number of physicians at these centres to have active privileges at their local hospital.

Further, Ontario Health will ensure that these centres are included in regional health system planning. Funding agreements with new community surgical and diagnostic centres will require these facilities to work with local public hospitals to ensure health system integration and linkages, including connection and reporting into the province's wait time information system and participation in regional central intakes, where available.

Community surgical and diagnostic centres will also coordinate with local public hospitals to accept patients that are being referred, ensuring people get the surgery they need as quickly as possible. In addition to shortening wait times, providing these publicly funded services through community surgical and diagnostic centres will allow hospitals to focus their efforts and resources on more complex and high-risk surgeries. This is another way our government is making it easier for people to connect to care and access publicly funded services in more locations, because we all know the sooner you have access to the care you need, the better your outcomes.

Long wait times take a toll on people's physical and mental health, creating more anxiety and stress. We have all seen loved ones struggle because the wait for their knee or cataract surgery is many months too long. Delays and complications in care only add to the toll of dealing with health issues. For health care to help, it needs to happen in a timely manner. This is the primary reason we are investing to expand surgeries across Ontario so that you and your family can have faster access to care.

The final aspect of Bill 60 is to enhance privacy obligations related to certain health administrative data through proposed amendments to the Freedom of Information and Protection of Privacy Act. These proposed amendments will benefit patients by supporting improvements to the health care system through linking de-identified data while enhancing privacy protection, transparency and accountability for entities that collect, use and disclose government data. The Information and Privacy Commissioner, who provides oversight to ensure compliance with the proper handling of data, has collaborated in the development of the proposed approach.

But we know that none of this would be possible without the dedication of our world-class health human resources right here in Ontario. Ontario has one of the most dedicated and highly trained health workforces in the world. They step up day in and day out to keep you and communities across the province safe and healthy. We've made significant progress recently to increase the number of health care workers available to provide you care and support. Together, we have come far: Over 60,000 new nurses and nearly 8,000 new doctors have registered to work in Ontario. In fact, last year was a record-breaking year for new nurses in Ontario with over 12,000 new nurses registered and ready to work, and another 30,000 nursing students studying at a college or university, providing a pipeline of talent and reinforcements for decades to come.

But we know we need to do far more, and we are doing more. Hiring more health care professionals is the most effective step to ensure you and your family are able to see a health care provider where and when you need it. Well-trained and well-supported doctors, nurses, personal support workers and more are the people you rely on when you need care. This year, we're training more health care professionals than ever before, with 455 new spots for physicians in training, 52 new physician assistant training positions, 150 new nurse practitioner spots, 1,500 additional nursing spots and 24,000 personal support workers in training by the end of 2023. And we're investing to reduce fees for nurses who are ready and available to resume or begin practising in Ontario for retired and internationally educated nurses. Some $15 million will temporarily cover the cost of examination, application and registration fees for internationally trained and retired nurses, saving them up to $1,500 each. This will help up to 5,000 internationally educated nurses and up to 3,000 retired nurses begin working sooner to strengthen our front lines.

0920

Part of the investment will also be used to develop a centralized site for all internationally educated health professionals, to streamline their access to supports such as education, registration and—

The Chair (Ms. Goldie Ghamari): Three minutes left.

Hon. Sylvia Jones: —employment in the profession or an alternative career. This initiative will make it easier for internationally trained health professionals to navigate the system and get the support they need on their path to getting licensed to practise in Ontario.

To continue to support our health system, we will scale up the Enhanced Extern Program and the Supervised Practice Experience Partnership program for an additional year. Since 2022, more than 2,000 internationally educated nurses have been enrolled through the Supervised Practice Experience Partnership program, and over 1,300 of them have already fully registered. We are providing additional funding to hire over 3,100 internationally educated nurses to work under the supervision of regulated health professionals, in order to give them an opportunity to meet the experience requirement and language proficiency requirements they need to become fully licensed in Ontario.

With that, I want to thank you, Chair, and all of the committee members, for allowing me to come and make a presentation as public hearings begin on Bill 60. I look forward to answering any of your questions, and as I mentioned in my opening, I am joined by officials from the Ministry of Health. Should there be any question of a technical nature, I'd be happy to bring them in to help respond to ensure committee members have all the information they need as we begin the public hearings.

The Chair (Ms. Goldie Ghamari): Thank you very much.

We'll begin this round of questioning with the official opposition for seven and a half minutes. MPP Gélinas, you may begin.

M^me^ France Gélinas: Thank you for your presentation, Minister. My first line of questions has to do with the first schedule of the bill, which would allow for-profit surgical suites to become more available in our communities. Before you made that decision, what kind of data had you got on the number of operating rooms that are not being used, that sit empty right now in our publicly funded, publicly delivered hospitals?

Hon. Sylvia Jones: Thank you for the question and thank you for acknowledging that this, in fact, is an existing expansion of what we already have in community, which is the surgical units and the stand-alone community surgical centres. Specifically, the data is that we have wait times that we are not finding acceptable in the province of Ontario. When people have to wait for months for critical surgery, it impacts their ability to be part of community.

Specifically the hospital question—we of course have a program in place, which has been in place since COVID began. Almost a billion dollars has been provided to hospitals who have existing OR capacity as well as health human resources capacity to expand their surgical opportunities. That program, as I said, has been in place since COVID began, and has been very successful, but it's not an either/or. We can expand as well, and that is, of course, the expansion that we are referencing in Bill 60.

M^me^ France Gélinas: So we all agree that there are ORs right here, right now in Ontario with surgical suites that sit empty because, for all of the procedures that are funded on a set amount—hospitals get a set amount of hips and knees, they get a set amount of cataract surgeries to be done, and then there's no money to do more. When you did your expansion of the 14,000 new procedures in cataract surgery, many of the hospitals in those communities would have loved to bid on those 14,000 new cataract surgeries. Why was it only the for-profits that were allowed to bid on those 14,000 new cataract procedures?

Hon. Sylvia Jones: Again, I'm going to remind all committee members that since COVID began, our government has set aside and offered a program that allows public hospitals that have capacity both in OR time and in health human resources to access the program that is almost a billion dollars. That allows them to expand where they can to ensure that the surgeries can continue to come through.

Specifically as it relates to your question regarding the cataracts, those requests for proposals were actually from 2021, if my memory serves me correctly. I'm getting a nod.

Dr. Catherine Zahn: Yes.

Hon. Sylvia Jones: So we made an assessment based on the applications that came in, in 2021, of the wait times in specific communities. We very much targeted where existing capacity existed and where the need was the highest, which was why you saw Windsor, Kitchener-Waterloo and Ottawa ultimately being chosen for the cataract expansion.

M^me^ France Gélinas: But there were hospitals in Ottawa, in Windsor, in Waterloo that had OR time sitting empty that would have loved to get those 14,000 new

procedures coming to the existing not-for-profit-delivery hospital. Why did it all go to for-profit cataract suites?

Hon. Sylvia Jones: So, again, a billion dollars since COVID began has been made available to hospitals that have OR capacity and health human resources capacity. Those funds have flowed and are in place. In the last fiscal, it was $300 million that hospitals could access if they wanted to and had the ability to expand their OR capacity.

M^me^ France Gélinas: What was the demand for those $300 million versus the $300 million that were available?

Hon. Sylvia Jones: I'm going to turn that over to Dr. Zahn.

Dr. Catherine Zahn: Thank you, Minister. I'm Dr. Catherine Zahn.

The initial $300 million that was attributed to surgical catch-up in the hospitals was not fully spent. One of my staff could provide more details about that, but it is clear that the hospitals were struggling with the impact of COVID, overloaded emergency departments and more serious and urgent surgical capacity. I'm going—

M^me^ France Gélinas: That was for the first round. How about—

Hon. Sylvia Jones: No, no. That was for year 3.

M^me^ France Gélinas: That was for year 3?

Dr. Catherine Zahn: That was recently, yes.

M^me^ France Gélinas: Okay. Do you have a plan to share with Ontarians as to how many of those private, for-profit surgical suites we will have in three years' time, five years' time from now?

Hon. Sylvia Jones: As you know, Bill 60 actually lays out a process for individual organizations, whether they are for-profit, not-for-profit or partnerships, to apply. As part of that application process there will be, of course, an assessment of the need. So if we see a wait time for a particular surgery that has not been able to be dealt with through the surgical backlog fund of almost a billion dollars or existing capacity in other community programs—

The Chair (Ms. Goldie Ghamari): One minute left.

Hon. Sylvia Jones: —then you will see more of an expansion in those areas. But it is very much application-based, and then assessments are made on need for the surgery as well as area for the surgery.

M^me^ France Gélinas: Do you see any problems with the for-profit, who will do the easy cases in the community, taking up staff from hard cases that will go to the hospital? You have the choice of working steady days Monday to Friday, being paid more, seeing easy cases in the community or working night shifts, statutory holidays and evening shifts in the hospital, handling hard cases. Where do you figure the HHR, the nurses, will go?

Hon. Sylvia Jones: Again, in Bill 60, the assessment of where the health human resources will come from and the plan for it is part of the application process because, to your point, we want to make sure that as these applications come through, they have been thoroughly vetted for wait times, for need in community, for the ability of the individual organizations to provide what the application is actually saying—

M^me^ France Gélinas: So what's happening in Ottawa right now—

The Chair (Ms. Goldie Ghamari): Thank you. That's all the time that we have for this round. I'd also like to remind committee members to not speak over the witnesses, just for the purposes of Hansard. It makes it difficult to record.

We'll now turn to the independent member for five minutes. You may begin.

0930

Mr. Adil Shamji: Good morning, Minister. Good morning, Dr. Zahn.

During the pandemic, in my role as an emergency physician, I saw many examples of families and patients suffering in long-term-care homes. This was disproportionately represented in patients coming from, specifically, for-profit long-term-care homes. That has been borne out now in the evidence, as well, and we've seen examples of that not just in long-term care—many other examples of health care and in many other jurisdictions around the world. Many organizations, including the Ontario Medical Association, have been clear that their position is that facilities like independent community surgical centres should operate in a not-for-profit manner.

So I'm curious to know: Why has this government gone against our province's experience as well as the advice of many reputable organizations to embrace for-profit models of care?

Hon. Sylvia Jones: I'm going to start with what is not in Bill 60—but the member raised it. First of all, Ontario, through the leadership of Minister Calandra and long-term care, now has the highest number of inspectors for our long-term-care homes—

Mr. Adil Shamji: If you could just focus on the not-for-profit model, please.

Hon. Sylvia Jones: Well, respectfully, you raised the long-term-care example, so I think I have the right to answer the long-term-care example.

We now have the highest number of inspectors going into our long-term-care homes, because we know that for many, many years, the focus of previous governments was not on our long-term-care residents in our long-term-care homes.

The combination of for-profit, not-for-profit, municipally run long-term-care homes—let's not pretend—all were challenged under COVID. Any congregate care setting had issues and concerns as a result of COVID. The partnerships that formed between local hospitals assisting local long-term-care homes really speaks to the value of and why we have continued to encourage the Ontario health teams—because we see those partnerships continuing long term.

Specifically as it relates to why one model and not the other—again, I'm going to say, it's not a binary, it's not an "either/or"; it's an "and." We have existing in the province of Ontario not-for-profit surgery centres; we have for-profit. We have independent long-term-care homes; we have municipally run; we have for-profit. It is not a bad thing as long as the service that is provided in

those individual facilities is consistent, and Bill 60 ensures that that is the case.

Mr. Adil Shamji: "Or," "and"—that's a decision that this government has made. As I mentioned, many organizations have recommended that the decision be exclusively not-for-profit models of care, including, for example, the Ontario Medical Association. You mentioned that it doesn't really matter as long as the quality of care is consistent. I illustrated in the last example, because I believe that—well, the evidence indicates that the quality of care has not been consistent across both models, which brings me to the discussion around what oversight will look like.

Minister, you mentioned that there will be an ombudsperson. This is a measure that, unfortunately, has not been particularly effective so far in preventing upselling and upcharging, has not been particularly effective in providing an avenue for patients to complain. In fact, the Auditor General identified this in 2021 and said that the oversight mechanisms should rest within the ministry. What do you say to that, and why have you not chosen to take the Auditor General's advice?

The Chair (Ms. Goldie Ghamari): One minute left.

Hon. Sylvia Jones: Again, with the changes that we are proposing in Bill 60, we actually have a more formalized process for individuals who have concerns when they receive service in a diagnostic or surgical community centre. First example—just like public hospitals, there has to be a formalized complaint in-house, if you would. When that is not satisfactory, then the patient or the patient's family have the ability now, if Bill 60 passes, to go directly to the Patient Ombudsman. So we have actually embedded in Bill 60 additional oversight pieces that would more closely match what a patient experience is in a publicly funded hospital.

Mr. Adil Shamji: Licensing and credentials are the prerequisites to performing many medical tasks. Unfortunately, this legislation replaces many of those licensed and credentialed health care workers with another person, as prescribed in the regulations. Can you tell us—

The Chair (Ms. Goldie Ghamari): Thank you. That's all the time that we have for this round.

We'll now turn to the government for questions. Who would like to begin? MPP Wai.

Mrs. Daisy Wai: Thank you, Minister Jones, for your presentation. It is really comforting when I hear—and I know that wait times in emergency rooms have been really growing so fast and there has been suffering for a lot of patients, whether it was before the pandemic time, when there was already a lot of wait times, and especially after the pandemic time.

I also know that there are 49,000 hours of MRI and CT scans. That is so important, because a lot of them are waiting for this scanning time in order to decide what the next steps are for their treatment, especially if they really do have cancer. Not to talk about the hip and knee replacements—I know a lot of constituents suffering with pain.

So my question is, what protections are there in place so that we can ensure the community, when they go to the surgical and diagnostic centres, are getting the same kind of high quality that they would be receiving from hospitals? And most importantly, how can we reassure the patients that they will not be taken advantage of, whether financially or whether for their treatment?

Hon. Sylvia Jones: It's a great question.

Embedded in Bill 60, if passed, we have a more formalized process for individual patients who believe that they have questions or concerns with the service that they were provided. Initially, just like you have in a hospital, there must be a formalized process embedded in the individual organizations, and then what is not in place today, which Bill 60 would embed in legislation, is the ability for that patient to go to the Patient Ombudsman to have their concerns investigated, assessed and ultimately decided upon. I think it's an important piece, because people understand generally what is going to happen if they have a concern in a hospital, and so to mirror it in our diagnostic and community centres has a lot of value for me.

Specifically regarding diagnostic expansions of MRIs and CTs, it's important for us as a government to appreciate that not every hospital in the province of Ontario currently has an MRI, so when we started that expansion, we were looking at how we can get those diagnostic imaging processes closer to home. And so having hospitals for the first time be able to get their MRI funded through the Ministry of Health for decades to come speaks to our government's commitment to make sure that, when it is possible, we get that care as close to home as possible.

Mrs. Daisy Wai: Thank you very much, Minister. I just want to make sure we continue to promote that they would only have to use their OHIP card and not their credit card, because we do not want these clinics to really charge them extra without them realizing or understanding it.

The Chair (Ms. Goldie Ghamari): Next question? MPP Jordan.

Mr. John Jordan: We're all aware there's a health human resource problem in this province and beyond. I'm wondering if you could tell the committee how this particular legislation will help with that human resource challenge.

Hon. Sylvia Jones: Thanks for the question.

Certainly, there have been a lot of programs put in place—with the Ministry of Colleges and Universities, for example, the Learn and Stay program, so that if a student is interested in training as a paramedic, a lab tech or a nurse, they would have their tuition and books covered. Those are some examples that we've already got.

Embedded particularly in Bill 60, if passed, is the as-of-right piece, and that's very exciting to me, because it means that individuals who are practising in other Canadian jurisdictions and under those regulatory colleges have the ability to basically start working in Ontario as soon as they come here with a job offer, because they continue to be covered by their existing oversight college while we go through the process in Ontario of assessing and ultimately licensing them with an Ontario regulatory

college. I'm going to highlight very specifically that these are for health care professions that have and operate under a regulatory professional college.

0940

The Chair (Ms. Goldie Ghamari): Next question? MPP Pierre.

Ms. Natalie Pierre: Can you tell us what the ministry has been doing to address the long and increasing wait times for outpatient surgeries in Ontario?

Hon. Sylvia Jones: Well, I'll start with our announcement earlier this year: the expansion of the cataracts in existing publicly funded, community-based organizations in Ottawa, Kitchener-Waterloo and Windsor. As I mentioned previously, that was a process that actually called for applications in 2021. Bill 60 is going to allow us to expedite that when there is existing capacity or opportunity when there are longer-than-average wait times. We know that in the province of Ontario, our cataract surgeries were one of our longest wait times. So being able to make those assessments and have those expansions happen is pretty exciting news for people who have been waiting for cataract surgeries in the province of Ontario. Bill 60 will formalize the process for how those expansions can happen.

I want to highlight the need for, as those applications come through—there are many pieces that include, what is your partnership with the local hospital? Your physicians—

The Chair (Ms. Goldie Ghamari): One minute left.

Hon. Sylvia Jones: Where are they also actively practising in their own hospitals?

I don't know if you wanted to add anything further, Dr. Zahn.

Dr. Catherine Zahn: Thank you very much, Minister.

There are a number of safeguards that have been put around this legislation—and hope to be seen in regulations. One is the importance of the ministry evaluating in the application project the staffing models of the individual centres, requiring that there be every effort made to access patients from the centralized waiting list rather than individual offices, and to require that at least some of the physicians who are providing these procedures have active staff appointments with admitting privileges to the hospital—

The Chair (Ms. Goldie Ghamari): Thank you. That's all the time that we have for this round.

We'll now turn to the official opposition. MPP Gates, you may begin.

Mr. Wayne Gates: Thank you very much for being here today, Minister.

I'm just going to start by asking a simple question. Can the minister begin by giving some background on her experience in the health care sector prior to becoming a minister?

Hon. Sylvia Jones: As the member opposite knows, I have served as the member for Dufferin–Caledon since 2007. I have served on three select committees that directly related to concerns and issues within the health care system, of course, including the mental health and addictions piece. My interest and engagement in ensuring that the people of Ontario have the most access, the closest access and the best access in Ontario is something that is very, very important to me.

Mr. Wayne Gates: So from that—you don't have any experience. You're not a nurse. You've never worked in the health care profession.

Staffing agencies' costs have gone through the roof under the human resources crisis your government has created. Some non-profit long-term-care homes are paying agencies $150 an hour for a registered nurse. I sense that Bill 60 has almost no safeguards to prevent this crisis from worsening.

How will you combat staffing agencies from taking advantage of a worsening health human resources crisis?

Hon. Sylvia Jones: I'm not sure if the member opposite was listening to my opening comments and some of the answers that I've already raised. As part of the application process, the individual organizations or agencies that are putting forward proposals for community surgical or diagnostic centres will, in fact, have to lay out very specifically and get assessed through the regional Ontario Health process to make sure that they have both the ability to—and a plan for their health human resources.

Of course, in the meantime, we've spoken many times about the expansions that have happened, both through internationally educated nurses and clinicians, to make sure that they can quickly be assessed through the College of Nurses or the CPSO.

As I mentioned in my opening remarks, in case the member missed it, last year was a historic year for the number of nurses—internationally educated, wanting to practise in Ontario—ultimately getting their licence.

Mr. Wayne Gates: I don't think anybody should be charging $150 an hour to get a nurse into a long-term-care facility.

Are you aware that in long-term care, in the last three years, we've had 5,400 die? How many long-term-care facilities, retirement homes have been fined or closed because of their incredible, terrible record of having our moms, our dads, our grandparents, our aunts or uncles, our brothers or sisters, die in these homes? You did mention more inspectors. How many have been fined, how many have been closed—in particular, maybe the ones where we had to send the military in, where they found somebody dying of dehydration?

Hon. Sylvia Jones: There is no doubt that during the pandemic COVID in particular hit our most vulnerable—by far, the most vulnerable: our elderly, individuals living in congregate care settings.

I believe we all need to be proud of Ontario and Canada's record. We were second only to Japan. When you consider the size differential between those two countries, the protections that we put in place, the partnerships that happened between hospitals, in long-term care with our health human resources, who never gave up, even when they didn't know all of the things that we now understand about COVID-19, and during the pandemic, kept coming to work, kept working to protect our most

vulnerable, and kept our system—it is devastating how COVID-19 hit literally worldwide. But we need to also acknowledge that Ontario and Canada literally led the world in protecting our citizens.

Mr. Wayne Gates: I'm just going to say that I'm not proud, quite frankly, that 5,400 died, with over 80% dying in for-profit long-term-care homes. And your government did nothing. You never fined them. You never closed them.

I'm going to turn this over to my colleague Lisa Gretzky.

Mrs. Lisa Gretzky: Thank you. I would also say it's really nothing to be proud of when 5,400 people died and the military had to go in because there were people who simply couldn't get water. So much better is possible. I can't believe the minister would say she's proud of that record.

My question is going to build on what my colleague from Nickel Belt asked, which is about the health human resources crisis and these clinics, frankly, worsening that.

Your government's Bill 124 is driving nurses out of the sector, out of our hospitals. It caps their total wages and benefits—that whole package—at 1%, and yet inflation runs about 6.5% to 7%. At Windsor Regional Hospital, there are openings for over 200 nurses that they cannot fill. As my colleague mentioned, there are agencies that are opening up because of your government's policies in order to poach nurses, to charge more for those nurses to go work, to fill in gaps. We have a shortage of anesthesiologists, which is oftentimes—between the nurses and the anesthesiologists—why we don't have ORs running at full capacity.

The minister said "when there's capacity in hospitals." I think the point my colleague was trying to make is that, rather than repealing Bill 124, rather than investing in staffing in our hospitals—we'd like to know why you choose to put the money into for-profit clinics rather than taking that money and addressing the staffing crisis that we have in our hospitals. Why won't you repeal Bill 124? Why are you fighting health care workers in court, using taxpayer money that actually could be going into not-for-profit health care?

The Chair (Ms. Goldie Ghamari): One minute.

Hon. Sylvia Jones: I'm going to reinforce what has already been raised, which is how we are ensuring that individuals who are accessing through a primary care physician, through a community clinic, through a community diagnostic centre, through a hospital—all have those programs, all of those procedures covered by your OHIP card. It is really important for people to understand that no matter where the service is provided, it is covered by your OHIP card.

0950

I have said many times, and maybe the member opposite would understand it better if Dr. Velji covered some of the really exciting changes that have happened to expand—

The Chair (Ms. Goldie Ghamari): Thank you. That's all the time we have.

We'll now turn to the independent member for five minutes. You may begin.

Mr. Adil Shamji: Perhaps continuing along the theme that we were just discussing, many OHIP-funded services in Ontario are already behind a paywall and patients are paying with their credit card. The classic example of that is virtual for-profit primary care. If this government has been unsuccessful in regulating those, how can the government be trusted in regulating anything else, including these integrated community surgical centres?

Hon. Sylvia Jones: The member opposite would know very well the stand of the OMA and the process that happens when the Ontario Medical Association and the Ministry of Health negotiate what fees will be for individual things—procedures and accessing. Again, I would—

Mr. Adil Shamji: That has nothing to do with the paywall, though.

Hon. Sylvia Jones: I will say that virtual care in the province of Ontario with your primary care physician is, for the first time, part of the OMA agreement. It was never in existence before. The only time it happened previously was during the pandemic, when virtual care was necessary, because we were trying to protect as many people as possible. So it was an agreement between the Ontario Medical Association and the province of Ontario that embedded virtual care with your primary care physician.

Mr. Adil Shamji: And currently, loopholes in that agreement are being exploited to place OHIP-funded services behind a paywall, and again, this government has not taken action to address that. So again, how can this government be trusted to protect against such charges in this new model of out-of-hospital care?

Hon. Sylvia Jones: Again, as a physician, the member would know that these agreements are negotiated and settled through the Ontario Medical Association. This agreement in particular, we have to highlight, was done without any need for outside arbitration.

The ability for primary care physicians to access and use virtual care when appropriate is a very important piece of our most recent agreement, and we need to acknowledge that it has been a valuable piece. It is not a case of "you can only use virtual care," because the stats and the research—including the OMA's own—proves that exclusive virtual care actually provides not as appropriate care as a combination of in-person and virtual.

I'm going to ask Peter Kaftarian if he has anything else to add for that.

Mr. Adil Shamji: That's fine. What I didn't hear was anything to address this problem before the next physician services agreement in four years, so—

Hon. Sylvia Jones: Sorry, can you repeat that?

Mr. Adil Shamji: What I heard was nothing from this government that plans to address this problem before the next physician services agreement in the next three and a half years.

Hon. Sylvia Jones: Well, again, the member would know, because he's a member of the OMA, that even during existing agreements, there are changes that can

happen if they are mutually agreed upon by the OMA and the Ministry of Health.

Mr. Adil Shamji: So why are these changes not being pursued?

Hon. Sylvia Jones: Because as I mentioned, what we see is exclusive virtual care is actually not the most appropriate type of care. A combination of virtual and in-person provides the best quality of care. I would hope that you as a physician would acknowledge the OMA's expertise and the research that has shown that exclusive virtual care is not ideal.

Mr. Adil Shamji: Sorry, I'm not advocating for that. I am advocating for this government to protect patients from unnecessary charges, like paywalls to access OHIP-funded services, which is against the Canada Health Act. That's all I'm advocating for, and I haven't heard anything from this government, from yourself or any of your members, that is convincing that any action on this will be taken.

Bill 60 favours the provider over the patient at every step.

The Chair (Ms. Goldie Ghamari): One minute left.

Mr. Adil Shamji: It exempts the director from the Public Service of Ontario Act. The director can be one or more persons or even a company. They will not have to disclose any aspect of their licensing process. The public will not even be allowed to know who is applying for licences. The applicants will not be subjected to freedom-of-information requests. Cabinet can waive licence terms. And protections for patients from upselling are not enforceable.

Why does this legislation prioritize the interests of private health care providers over the public interest, and what benefit could this lack of transparency possibly have?

Hon. Sylvia Jones: So if we go back to the application process, we see a more formalized process that is currently in effect where individual agencies, organizations can apply. There is no assumption that they will get that application approved. As the member would know, licences are often given in five-year increments, so we always have the ability within Ontario Health—

The Chair (Ms. Goldie Ghamari): Thank you. That's all the time we have.

We'll now turn to the government. MPP Martin, you may begin.

Mrs. Robin Martin: Minister, I've been listening to the questions, and the last one, for example, talks about the public interest. My understanding is twofold: that there is a public interest in ensuring access to medically necessary services, surgeries and diagnostics as quickly as possible for their health, and also that nothing in Bill 60 requires the provider of the services to be private, for-profit, not-for-profit—it's not dictated within there, it could be any of the above; we're just looking to get services. Is that correct?

Hon. Sylvia Jones: Absolutely. Again, it's not an "either/or"; it's an "and." So the combination of it could be an existing not-for-profit; it could be an existing for-profit; it could be a new entity, and all exist right now in the province of Ontario, and have for decades.

The process ensures that as individuals and organizations come forward, the assessment is done by Ontario Health to make sure, as I have mentioned previously, the need is there, the wait times for a particular surgery are necessary.

In your opening, you referenced something that's really important to me as a more rural member, and that is, not all services must be provided in highly urbanized centres. The ability to have those diagnostic pieces in smaller centres, the ability for communities that have historically had to travel hours to get access to now have opportunities that—perhaps the partnership is with the local hospital; perhaps it is with a not-for-profit or a for-profit that is interested in serving in that community. All of those assessments will be factored in as we make the determination of whether it is needed and whether it is appropriate.

Mrs. Robin Martin: Just to be clear, because there was some aspersion cast on your experience in the health care sector, my understanding is, as Minister of Health, you have access to advice from a raft of qualified people, including the lady beside you, Dr. Catherine Zahn, who's your deputy minister—but all the other civil servants in the Ministry of Health as well as Ontario Health, the agency of the ministry that provides the minister with clinical advice, as well as innumerable health stakeholders who you talk to on a regular basis. Is that not correct?

Hon. Sylvia Jones: Absolutely. I think my role, first and foremost, is to be a good listener and ultimately make decisions based on what the needs of the patient are.

Mrs. Robin Martin: I believe you acted as Solicitor General during COVID. In that capacity, you worked hand in glove, I believe, with the Ministry of Health on the delivery of vaccines, and other health stakeholders and advisers. Is that also correct?

Hon. Sylvia Jones: It is.

Mrs. Robin Martin: Thank you.

The Chair (Ms. Goldie Ghamari): MPP Rae.

Mr. Matthew Rae: Thank you, Minister, for your presentation and for answering our questions today. We share borders for our ridings. Representing a rural riding, I know even my local hospital CEOs are appreciative of the fact that the government is willing to help relieve some of the cataract backlog, because they know they can never clear it, especially in our rural hospitals. So I appreciate the ministry's movement on that and those innovative solutions.

My question builds on some of the answers you provided earlier. Has the ministry issued a call for applications to license additional independent health care facilities for cataract surgery, for example? What is the status of the cataract call-for-applications process?

Hon. Sylvia Jones: The cataract surgeries that were announced earlier this year were actually a call that was made in 2021, so I would hope in the years moving forward that there is not that much of a delay between applications coming in and, ultimately, decisions being made.

Having said that, anyone who has asked, whether it is a colleague or someone who is interested in putting an application in—I say, take a close look at Bill 60, follow the public hearings, follow and review the legislation, because that is your best template to know what the application should look like and how it will ultimately be assessed.

So, no, we haven't called for applications yet.

The Chair (Ms. Goldie Ghamari): MPP Quinn.

Mr. Nolan Quinn: Thank you, Minister. In addition to the call for applications, how is the minister utilizing existing IHF capacity to help address the COVID-related surgical and diagnostic-imaging backlog?

Hon. Sylvia Jones: Diagnostic imaging: Of course, we have made a number of announcements that our government has committed to funding operations of new MRIs, 49 in total, in fact, since 2018. And again, I'm going to highlight that many of those are actually in hospitals that have never had an MRI before, so it's back to community access. In one example, I had a physician come up to me; she almost had tears in her eyes. She said, "A week ago, I spent three hours trying to find an MRI slot for my patient and then organizing the transport to happen. By doing what you've done, which is funding an MRI in our hospital that's never had one, it means I will be able to see more patients, not being chased where MRI times are available and organizing transportation."

Those are real examples of how, when you bring the diagnostic closer to community, it means patients are better served. They're not having to travel in bad weather in January to access an MRI an hour and a half away, and the physician who is looking after and assessing that patient can have that turnaround much faster, so treatment can begin when appropriate.

The Chair (Ms. Goldie Ghamari): MPP Martin. Also, one minute left.

Mrs. Robin Martin: Minister, what have we learned from COVID-19 that will change how we deal with outpatient surgeries, wait times? Are there innovations and supports we have now got that we can look to?

Hon. Sylvia Jones: I think the big lesson that we learned with COVID-19 was when organizations work together, whether that was a hospital assisting a long-term-care home or physicians who were able to quickly change how they looked after their patients, it ultimately led to better outcomes. Which is why I feel strongly about continuing the work of building out our Ontario health teams, because those are all about making sure all of the clinicians, all of the organizations in a community have the ability to assess and treat and transfer patients far more seamlessly. It's a really important piece that COVID has shown works and that has strong benefits for the patient.

Mrs. Robin Martin: And this is some of the integration, I guess, that Bill 60 speaks to, changing the name from "independent health facilities" to "integrated surgical centres."

The Chair (Ms. Goldie Ghamari): Thank you very much. That's all the time that we have. Thank you, Minister, for your presentation.

This concludes our first round of hearings. The committee will now recess until 1 p.m. this afternoon to resume public hearings on Bill 60.

The committee recessed from 1003 to 1301.

The Vice-Chair (M^me^ France Gélinas): Good afternoon, everyone. Bonjour tout le monde and welcome back. The Standing Committee on Social Policy will now come to order.

As I mentioned this morning, I really want us as members of the social policy committee to look at the deadlines that we had given for people to come and appear. You will see that we have some openings this afternoon. There are many people in northern and rural Ontario that would have liked to put their names forward, but the deadline was such that it was impossible for them to do so. I hope that we all take an inclusive lens next time we set deadlines so that people in northern and rural Ontario also have an opportunity to have their voices heard.

This afternoon, we are continuing public hearings on Bill 60, An Act to amend and enact various Acts with respect to the health system. As a reminder, witnesses have been scheduled into groups of three for each one-hour time slot. Each presenter will have seven minutes for their presentations. Following all three presentations, there will be 39 minutes of questions for all three witnesses, which are divided into two rounds of seven and a half minutes for the government members, two rounds of seven and a half minutes for the official opposition members and two rounds of four and a half minutes for the independent member. Everybody's good with that?

ONTARIO HEALTH COALITION

MS. SARA LABELLE

The Vice-Chair (M^me^ France Gélinas): I will now call upon our presenters to please come forward. I see that they're already there. We have Natalie Mehra, the executive director of the Ontario Health Coalition, as well as Sara Labelle. Welcome, ladies, and a reminder that each of you has seven minutes for your presentations, followed by questions from the committee members. I will provide reminders of the time remaining during the presentations and questions. Usually, when you have about one minute left, you will hear, "One minute." That's to let you know.

Before you start, please make sure that you say your name so that Hansard can record your name properly. You may begin. Ms. Mehra; you're the first.

Ms. Natalie Mehra: Thank you very much, France, and thank you, everyone. Happy first day of spring. Now if it would only stop snowing and warm up.

Thanks for hearing me on this piece of legislation. We are obviously deeply concerned. For 100 years or more, literally hundreds of towns across Ontario have worked to build their local public hospitals. There are, what, 260 sites for public hospitals across Ontario now. Those communities have donated. They've donated through their payroll deductions to their local hospitals. They have fundraised. They have volunteered. They have literally built their local

hospitals. And the goal of all of those communities has been to bring services closer to home.

For more than 70 years across this country, we have struggled to build a public health care system for all based on cornerstone principles of equity and compassion. Those are foundational principles of public medicare.

For more than 50 years, Ontario has built its public hospital governance system; that is, the Public Hospitals Act and the governance of our public hospitals, public access to information, quality of care for patients, safety for patients and staff in those hospitals. This is a long-standing tradition in our province, and this legislation goes against all of that. Ontario has had a ban on private hospitals since 1973 for good reason. The Independent Health Facilities Act was always a go-around around the Private Hospitals Act.

Nonetheless, the vast majority—by far the largest category—of independent health facilities, a.k.a. private clinics, in Ontario are X-ray and ultrasound clinics. In this legislation, Bill 60, in section 1, the definition of "independent health facilities" is expressly widened, expanded to include surgical and diagnostic centres, thereby expanding the private, for-profit clinics—98% of the independent health facilities in Ontario are for-profit according to the Auditor General. It's expanding the cut of independent health facilities, or private clinics, into, now, the core services of our local public hospitals. This is, without question, a privatization of our local public hospitals, their vital services, and really goes, as I said, against a hundred years of effort by our communities to build these up as public services that operate for the people, in the public interest, not in the private interest or for profit.

I think the main point to make about this legislation, and the policy push which is actually under way before the legislation has even gone through the Legislature, is that it is completely unneeded. Ontario has operating rooms in every public hospital across the province that are under-used. We have operating rooms in virtually every hospital that are closed for days, weeks, months at a time—even permanently—due to underfunding of those hospitals. Most hospitals would have most of their operating rooms operate only from 9 a.m. until 4 p.m. They close at night. They close on the weekends. Just by expanding the use of the existing public operating rooms, this government could, in a very short period of time, clear the backlog of surgical delays—and obviously also by increasing the use of the MRI and CTs in our public hospitals to their capacity. So this is not needed, and to claim that this is the only option to deal with the surgical and diagnostic backlog is utter nonsense; it is completely false.

So why, then, privatize? In whose interest is it to hand over these vital services from our public not-for-profit hospitals to private for-profit entities? Well, the only people who benefit are those private for-profit companies, which begs the question: Is that why this policy is being followed?

The government has said that the status quo is unsustainable. The status quo is unsustainable. However, this government has been in power now for five years and has been a large part of creating the current status quo. For example, Ontario went into the pandemic funding our hospitals at the lowest rate in the country. We have the fewest hospital beds left per capita of anyone in Canada, of any province in Canada, by far. When this government took power, it again pursued a policy—

Interjections.

Ms. Natalie Mehra: Sorry, it's very distracting. There is something going on—this is a public hearing, no?

The Acting Chair (Mrs. Lisa Gretzky): Carry on.

Ms. Natalie Mehra: Okay. When this government took power, it adopted a policy of austerity, cutting hospital funding to below the rate of inflation—this in the context of hospitals that were already funded at the lowest rate in the country. During the pandemic, the government has chosen to underspend the COVID funds each year and underspend on its projected health care spending each year.

The Acting Chair (Mrs. Lisa Gretzky): One minute.

Ms. Natalie Mehra: Last year, it was underspent by $860 million; this year to date, by $1.25 billion. So could we afford to fund our public hospitals and support them to expand their services as public not-for-profit hospitals? Of course we could.

I hope that in the questions we can get into the quality and safety regime. In the public hospitals, there is a robust public safety and quality-of-care regime. That does not exist in this legislation at all. In fact, there are no standards at all in this legislation. They're all left to either the director or directors, who can be a third party for the first time—not even an employee of the ministry. There are no protections against conflicts of interest, or they're left to regulations to be written or not written at the choice of the government by cabinet alone without ever going back to the Legislature. None of the protections that were promised prior to the introduction of the bill—

The Acting Chair (Mrs. Lisa Gretzky): Thank you.

1310

Before I move on to the next presenter, I just want to say that it takes a lot of time out of people's schedules to come and present, so if we could ensure that everybody is paying attention during the time that the presenters have—they don't have a lot of time to present—that would be much appreciated, I'm sure. It wouldn't be so distracting.

I'll move on to the next presenter. Ms. Labelle, please state your name for Hansard before you begin.

Ms. Sara Labelle: I'm Sara Labelle. I am a medical laboratory technologist by profession. I have a licence to practise in the fields of chemistry, hematology, transfusion science, pathology and microbiology, and I also have a specialty in genetics technology and a licence to practise in the field of molecular cytogenetics. I'm also—for full disclosure—the chair of the hospital professionals division for the Ontario Public Service Employees Union. We represent 28,000 health professionals across the province who provide services in our hospitals: radiation therapists, medical radiation technologists, pharmacists, respiratory therapists and, of course, lab professionals.

I'm here to speak specifically around the pieces of the act that make changes to the Regulated Health Professions Act—in particular, around the Healing Arts Radiation Protection Act, 1990, which changes the definition of who can operate an X-ray machine; the Medical Laboratory Technology Act, 1991, which changes the definition of who can provide lab testing; and the Respiratory Therapy Act, which changes the definition of who can provide respiratory therapy services.

If the intent of this government is to allow more people and to enable them to work in their professions, there is a way and a mechanism to do that. There are national certification bodies that we are accountable to. We have to write a certification exam. That was done decades ago. So if that was the intent, that happened 30 years ago, when we all were brought under an umbrella of a national body in order to ensure that there was mobility across Canada.

I want to talk specifically around the services of laboratory technology and the implication for surgeries and diagnostics in private clinics. I have practised for 23 years now as a medical laboratory technologist. I started my career in New Brunswick, where all lab testing is performed in public hospitals, including all of the testing that is done through private clinics, through doctors' offices. They collect the samples, and they send them to the public hospitals, and what that has meant is that we provide better patient care. We know exactly what someone's normal results look like, so when they come in and they have some kind of process happening that is causing them to be ill, we know immediately what their normal results look like and what that means.

We have years of experience. I have five and a half years of training. We have medical radiation technologists who do four years; MRI technologists who do five years of training; respiratory therapists who do three years. There's a reason we've specialized in our fields: Because we are experts at that role, we bring a value to patient care in that we bring our expertise to the field and we provide better diagnoses, better treatments and better therapies.

If we are opening this up now so that anybody can do the job—and that is my concern: that it is anybody. I'm going to relate to the construction industry, because the Conservative government seems to be very focused on the labourers and plumbers and electricians. I would say to you, would you ask a plumber to do your electrical work in your home? If the answer to that question is no, then there is nobody else that should be providing the services in hospitals that have those protected titles and licences, and we should not expand it.

Under surgeries and diagnostics: Opening up and running two parallel systems puts the public hospitals at risk. Every single surgery, every patient who comes into our public hospitals—a lot of them require blood work. For every single one of them, we do that. We do ECGs, we do X-rays, we do blood work on those patients coming in. We crossmatch units of blood for every single patient who comes through the doors no matter what the surgery is, because if it goes bad on the table, if something happens and they require emergency interventions, we are there to provide that service. There is a nationwide shortage of blood products. If you open two parallel systems that will be competing for those same blood products, somebody will go short, and who will that be? Whose grandmother, whose mother, whose father, whose child will be on the table and will not get blood products because we don't have enough?

We have a very strict regulatory regime in hospitals around transfusion products. Transfusion safety officers ensure we are being careful and diligent. They have to be kept at certain temperatures. We cannot just release the products to private clinics and expect that they're going to know how to handle those products and that we won't be wasting them or that someone won't end up with a hemolytic transfusion reaction. There are so many things that we do in our jobs and in our professions, and we do not want the duplication of a public and private system where we are competing for health and human resources.

I want to talk about the 1970s. I was born in 1973. The Johnston commission was struck because hospitals—just hospitals; we're not talking about private clinics that now are competing for the same resources. Public hospitals were paying people and poaching workers, in particular in the GTA. But it is a problem now in Ottawa. It is a problem in London. It is a problem in Hamilton, and it is a problem northern Ontario—

The Acting Chair (Mrs. Lisa Gretzky): One minute.

Ms. Sara Labelle: —and the recruitment and retention problems will not be solved. The private clinics will poach. There is no other way to expand those services into private clinics without taking away. Anesthesia assistants are required to do surgeries. We need access to respiratory therapists. They will be poached. We already see that happening in Ottawa, and it will happen. That is why the Johnston commission was struck. Recruitment and retention was that everybody got paid the same wage. If you now open it up to private clinics, they will poach the workers.

This is also about driving down the wages and 50 years of history of achieving pay equity for a predominantly female workforce. We're not going back. We're not rolling back the time in order to allow this government to take away the gains in a female-dominated workforce that have happened over 50 years, since the 1970s, of central collective bargaining and also of pushing for pay equity. I would urge this government it reconsider and expand public hospitals.

The Acting Chair (Mrs. Lisa Gretzky): I appreciate the two presentations.

We'll go to questions. We'll start with the independent member, then the government side, then the official opposition. You have four and a half minutes.

Mr. Adil Shamji: Thank you, Natalie, for the amazing advocacy work of your organization and, Sara, for all of the incredible work that the members of the hospital professionals division do for our health care system.

Natalie, I wondered if I could start with you first. It's been an often-quoted phrase that patients will always pay

with their OHIP card, not their credit card. What's your assessment of that?

Ms. Natalie Mehra: The issue is that—

Interjections.

Ms. Natalie Mehra: I think there's a plan from the government side to talk every time I'm speaking. I guess that is the plan.

We have called every private clinic that exists in the country. Across Canada, the vast majority of surgeries and diagnostic tests are done in hospitals, not by private clinics. But where they have moved in, we called every private clinic across the country twice and everyone across Ontario four times. We posed as patients. We said, "How much will it cost us to get services there?" etc. We tried to get an understanding of their business model. We caught the majority of them—not a small number, the majority of them—extra-billing patients, in violation of the Canada Health Act and of provincial laws in their provinces. In Ontario, we receive complaints from literally dozens and dozens of patients a month that they're being charged illegally for their cataract surgeries and so on.

In this act, in addition to the problem of extra-billing that no province has actually managed to control in the private clinics—I should say, in the United States, it's not like they control the private hospital sector or the private clinic sector any better; medicare fraud is the largest category of fraud in the United States. It is their business practice to do what they can get away with, and we don't have a monitoring system. We'll have to pay for some kind of monitoring and enforcement system and so on, which would be unnecessary but for privatizing the ownership of these services.

In the act, in Bill 60, they actually invite the clinics to upsell. Right now, the only area where we really see a lot of upselling—so this is in addition to extra-billing. This is telling patients that they need a medically unnecessary eye measurement test or a medically unnecessary lens or what have you. It's only really right now in cataract surgery. You don't go in for your hip surgery and you're not told, "Oh, you could get titanium screws and they will cost you $5,000 more," or this version of the hip or that version.

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Patients have no way of ascertaining in this dizzying array of options what is actually medically necessary or not, and the information given to them already is incredibly manipulative. They are made to expect that these lenses that are different are better, or that this eye measurement test that is completely medically unnecessary and does not show added efficacy is actually medically necessary.

This is invited in the act. It opens a Pandora's box of extra-billing, upselling, all kinds of manipulation to make patients pay more. It's thousands of dollars, often more than the procedure itself is worth. And these are elderly patients who need surgeries. I mean, they're on fixed incomes—the wealthiest people in the country extra-billing some of the poorest people in the country for access to health care services.

The Acting Chair (Mrs. Lisa Gretzky): One minute.

Mr. Adil Shamji: Sara, you had raised some concerns about, for example, the expansion of the definition of various kinds of technologists. Ostensibly, this is because we need more technologists, more health care workers. In your opinion, what would be a more appropriate way to get more health care workers into our system?

Ms. Sara Labelle: We need more people in programs. We need to open up programs that have closed in medical laboratory technology. We have less programs being delivered currently than we did in the 1970s. We ramp up. We add more seats; we train more people. You fast-track them. You provide incentives for them to take those programs. You educate them about the programs. A lot of people are not aware of all of the different fields. I was not when I applied to community college to take medical laboratory technology; I had applied for respiratory therapy. You do all that work, and you pay them appropriately. You cannot restrict the wages of women.

The Acting Chair (Mrs. Lisa Gretzky): Thank you. We're going to go to the government side now for seven and a half minutes. MPP Martin.

Mrs. Robin Martin: Thank you very much for the question, and thank you for the presentations. During COVID, we didn't run out of any blood products during that time frame. Canadian Blood Services certainly ensures that we have a supply of blood products, and if we had a problem with blood products supply, I would assume that we would have a problem with blood product supply wherever we were using more blood, i.e., in the hospitals if we expanded those and the services there or in clinics if we expanded those.

But that wasn't my question. My question is for Sara. Sara, in the interests of full disclosure, as you said you wanted to start with full disclosure, can you just tell me whether you ran as a candidate for the New Democratic Party in the last election?

Ms. Sara Labelle: Of course I did. I would run as a candidate for the group that supports public health care.

Mrs. Robin Martin: Thank you very much for your answer. That's all I have. Thank you.

The Acting Chair (Mrs. Lisa Gretzky): Anyone else on the government side? We still have six and a half minutes.

Ms. Sara Labelle: On the issue of blood products, seeing as that was the statement—

Mrs. Robin Martin: I didn't ask a question.

The Acting Chair (Mrs. Lisa Gretzky): I'm sorry. You can only respond to a question.

If there are no other questions on the government side, I'll go over to the official opposition. MPP West.

MPP Jamie West: Sara, if you want to finish your statement, go ahead.

Ms. Sara Labelle: Yes. On the issue of blood products, during COVID, we all know we had to cancel surgeries. We did it day in and day out. Up until even the beginning of this year and last year, we were cancelling surgeries because of the number of COVID cases. So if you cancel surgeries, you don't have to utilize blood products.

There is a nationwide shortage of blood products. We hear it every single day, asking for more donors. For cancer treatments, we require blood products. We require them for surgical interventions. So that is not something I'm making up. It is something that is every single day communicated from Canadian Blood Services nationwide, asking for people to donate blood products.

MPP Jamie West: In terms of a question—first, I'm disappointed the government didn't have more questions for you because this is a very important topic. We're talking about health care, and I think one of the reasons they don't is because they don't want to talk about the fact that this isn't a solution. This is a way to reward people—I don't think I'm allowed to say that, so I'm going to withdraw that. But the end result of this is going to be about providing private services.

We saw this with long-term care in the 1990s when privatization of long-term care was expanded rapidly. What people were told back then was, "This will solve the issues with long-term care." Maybe Natalie would have a better perspective on this. Do you believe that privatizing long-term care has made long-term care better?

Ms. Natalie Mehra: No, not at all. It's not even just an opinion; all of the major studies bear that out. The quality is poorer. They have poorer outcomes in the for-profit long-term-care facilities than they do in not-for-profit and public long-term-care facilities, mostly because they don't have as much staff. They have more precarious staff, more temporary and part-time staff, and lower staffing levels, and, of course, there's no care without staff.

I think the implications here are really profound. In the Public Hospitals Act, there's a whole section—the entire act is really built around protecting the public interest. There is nothing commensurate in this bill that privatizes core hospital services. For example, under the Public Hospitals Act, the quality and safety regime is publicly accountable and there are provisions in law regarding patient and public access to information, so we can get quality-of-care information. In fact, we want an amendment to legislation to do that.

Hospitals have boards of directors and quality-of-care committees. They have medical positions and processes for appointments. They have elections to advisory committees. They assess the credentials of their appointments. They have quality regimes for patient care. They have an infection-control regime. They have rules regarding the use of hospital facilities. They have an occupational health and safety program. I just want to get this on the record, because it's important. They have specific requirements around those. They have a health and communicable disease surveillance program, and fiscal advisory committees. They have to ensure that nurses and nurse managers are on their committees.

None of that—zero of that—exists in Bill 60. None of the quality-and-safety governance exists, and yet we already know that private hospitals and private clinics have substantially higher death rates. Even aside from the blood issues that Ms. Labelle was talking about, they have substantially higher death rates than the public and not-for-profit hospitals.

MPP Jamie West: Just one last question, and then I'll pass it on to my colleague: You had mentioned earlier about surgical rooms and availability of surgical rooms. What we're being told is that we need this private option because there's a backlog of surgeries, and that if we do it privately, although we'll pay more through our OHIP cards—taxpayers will pay more, because there's an incentive there; you've got to pay your shareholders, and people need a profit margin on there that the public option doesn't have. But what you were saying is that many of these surgical suites are empty, so wouldn't it make sense to have more people working longer hours?

Ms. Natalie Mehra: It just makes no sense to do this at all. Why would we pay to re-create a system, but owned by for-profit interests, including multinational chain corporations etc., when we have existing public hospitals with ORs and when the threat of this is that we have the worst staffing shortage we've ever seen in the history of the province? There's no exaggeration there; it is really serious. To lose OR nurses, anesthesiologists, health professionals, MRI technologists etc. at this point in time would be devastating.

To lose the surgeries out of the middle-sized and small hospitals—the surgeries that the government is talking about privatizing are most of the surgeries left in those hospitals. To lose the surgeries and staff from those hospitals would devastate those hospitals. It's the antithesis of this 100 years I was talking about of building local hospitals and their services closer to home. It's just devastating.

Across the country, no one has followed the private clinics more closely than we have, I don't think, for decades now. We've done repeated studies on them. They all got their staff from the public hospitals. There's nowhere else.

MPP Jamie West: Just to confirm: When you open a new building for health care, you don't magically double the number of people who are working.

Ms. Natalie Mehra: Exactly.

MPP Jamie West: It's still the same amount of workers as before; they just go to private and—

Ms. Natalie Mehra: Exactly, only you're paying for, as Ms. Labelle described, a duplicate system, only this time run for private, for-profit interests as opposed to in the public interest.

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MPP Jamie West: Thank you. France, did you—or Wayne?

Mr. Wayne Gates: Yes, can I have the time left? Is there any way I could do that, seeing they're not interested in asking these people questions?

Maybe the two of you could answer this, because I don't have a lot of time left, unfortunately. The two of you may answer. What effect has Bill 124 had on staffing in the health care sector?

Ms. Sara Labelle: It has devastated the health care sector. We have people that are leaving and they're retiring early, they're quitting, they're taking other jobs,

they're taking real estate. They are migrating out west because it's a better quality of life and a better province, and they are going south of the border. It has been devastating.

Mr. Wayne Gates: I appreciate that. I'll do this quick.

The Acting Chair (Mrs. Lisa Gretzky): Forty-three seconds.

Mr. Wayne Gates: The government made it very clear during the campaign that health care would not fall into private, for-profit hands. Why do you think they lied during their campaign, either one of you?

Mr. Brian Saunderson: We're going to object to that.

The Acting Chair (Mrs. Lisa Gretzky): I'm going to ask the member to withdraw his unparliamentary language.

Mr. Wayne Gates: What part do you want me to withdraw? "Why do you think they lied during the campaign?" Is that it?

The Acting Chair (Mrs. Lisa Gretzky): I'm going to ask the member to withdraw.

Mr. Wayne Gates: Okay, I'll withdraw that.

The Acting Chair (Mrs. Lisa Gretzky): There's 18 seconds left to answer.

Mr. Wayne Gates: Okay. Again, maybe a little longer question for Natalie.

Natalie, in your discussions, have you heard anything about Bill 124 and what it's done for staffing?

Ms. Natalie Mehra: Yes.

Mr. Wayne Gates: What?

The Acting Chair (Mrs. Lisa Gretzky): Thank you. Time's up.

To the government side of the House, I have a clock here I'm watching. I don't need the armchair quarterbacks. Thank you.

I'm now going to move on to the independent member for another four and a half minutes.

Mr. Adil Shamji: Ms. Mehra, I'm happy for you to finish your answer if you wanted to.

Ms. Natalie Mehra: On Bill 124?

Mr. Adil Shamji: Yes.

Ms. Natalie Mehra: I think it has definitely made things worse. I mean, COVID is a problem. It's been a problem in many jurisdictions, so I think we have to be cognizant of that. But Ontario went into the pandemic with the fewest nurses per weighted case, so the lowest nurse-to-patient ratio in the country. We had shortages already of key health professionals, including MRI technologists, respiratory therapists, CT technologists, pharmacists etc., and then, of course, nurses, registered nurses. Those were, of course, made much worse through the pandemic.

But see, when the government could have stepped in and taken measures to address the staffing crisis—we asked, since the first wave, for the government to do what Quebec did in terms of recruiting. They recruited just over 7,000 PSW equivalents for long-term care, did intensive training for three months and got them into the homes in time for the second wave. We could, of course, have portals to bring people back and pay their licensing fees, to bring back people who have just recently retired, offer some light at the end of the tunnel in terms of hours and workload and those sorts of things for the existing staff.

I think the key issues are impossible nurse-to-patient ratios, really impossible workloads at this point, no time off and no control over their scheduling. Then Bill 124 just took a situation that was bad and made it much, much worse.

Mr. Adil Shamji: Thank you. To both of you, in your esteemed opinions, are there any ways in which Bill 60 can be improved, or is it not salvageable?

Ms. Natalie Mehra: Do you want to go first? Go ahead.

Ms. Sara Labelle: I'd scrap the whole thing. The whole intent of this bill is to open up for-profit operators to make money off the backs of people who are ill and need access to care. Anyone who can read that can read that out of that bill. I mean, it's a lot of words, but you can boil it down to a few key sentences which are about allowing access to for-profit operators to make money off the backs of the ill who need access to surgeries and diagnostics.

If we wanted to fix the problem, we could do it by expanding the services and funding them in the public hospitals. We have the infrastructure. We have the staff in those areas. And recruit the workers back.

Mr. Adil Shamji: Thank you.

Ms. Natalie Mehra: Yes, I mean, the bill should be rescinded. First, the government has no mandate for it. Speaking to the question that was withdrawn, in the lead-in to the election, the ministry spokesperson literally said, "I categorically deny that we are privatizing the hospitals or that we have any intention to expand the private hospitals and private clinics." That was two months before the election, and then two months after the election, the government announced their plans to privatize the hospitals. That is not acceptable. This is a democracy—still. Public hearings are fundamental to parliamentary democracy. It matters. Most governments actually amend legislation after hearing from people. This has not happened for any of the major health care bills.

I plead with you, don't do this thing. It will destroy the public hospital system in this province. I'm just being completely sincere. Don't do this thing. It will be terrible for our province.

Mr. Adil Shamji: Thank you. One of the criticisms of this bill is that it doesn't address or include the root cause of our underwhelming health care system performance. Do you agree with that?

Ms. Natalie Mehra: Totally. Because the issue is we have the facilities, the capacity. The load-limiting factors for capacity, for hospitals—they were talking surgeries and diagnostics—are funding and staffing; it's not other facilities. It doesn't address the issues at all. And then how do we organize the surgical wait-lists, you know? And, of course, disintegrating the system in this way—this is the opposite of integration; it is fragmentation. Fragmenting the system in this way actually will be far more difficult to manage. There will be way more duplication and much higher costs, if there's any enforcement at all.

The Acting Chair (Mrs. Lisa Gretzky): Thank you. Time is up.

Now to the government side for seven and a half minutes. MPP Saunderson.

Mr. Brian Saunderson: Thank you, both of you, for coming today. My question is this: Are you aware of the BC Court of Appeal decision that found that wait times in Canada violate section 1 of the human rights in our Charter of Rights and Freedoms?

Ms. Natalie Mehra: You're talking about the Cambie case?

Mr. Brian Saunderson: Yes.

Ms. Natalie Mehra: Yes, so, the Cambie case actually came down against Dr. Brian Day and the private clinics—

Mr. Brian Saunderson: I'm aware of that. My question is, though, they found that the wait times violate section 1 of the charter, right?

Ms. Natalie Mehra: Right. I don't know, actually. I would have to go back and read the ruling. But I'll accept what you're saying on that because I think we're on the same side if we're worried about people waiting too long. I mean, we advocate for patients. We don't want them to wait too long either. But what we're saying is the solution is not private clinics; the solution is to expand the capacity in the public hospitals.

Mr. Brian Saunderson: Well, and I guess that's where we differ, because we see this $78 billion as our biggest line item in the budget in Ontario. We've got increased funds from the federal government, which must mean that we're complying with the five principles of the Canada Health Act. What we see as of utmost importance is cutting down wait times and getting people the treatment they need, where they need it, when they need it. This is a problem right across the country. So I take exception to some of your comments that we're now privatizing health care. We're opening accessibility. I don't know why you would be resisting that, given you understand the wait time issues.

Ms. Natalie Mehra: Thanks for the question. I'm just going to take it very sincerely. When you expand the capacity, the question is who owns it and operates it, and in whose interests. We have phoned every private clinic in the country. They do violate the Canada Health Act; there's no question. The last time we did it, we did it in partnership with the Globe and Mail. They did a five-part front-page series in which they showed these private clinics across the country violating the Canada Health Act—extra-billing of patients, a number of them double-billing patients.

The Cambie case that you're talking about in British Columbia, in the government's audit of those private clinics in BC, they found $500,000 of extra-billing of patients in one month of records and $60,000 of suspected double-billing—that's billing twice for the same service. I mean, this is the business model of the private clinics.

It happens in Ontario. The reason why, in the annual report from the federal government, Ontario did not face a clawback is that it relies on self-reported information. So your government reported to the federal government that you're not doing it, and the federal government dutifully reported it back. But that is not the truth. The truth is patients in Ontario are being extra-billed all the time in the existing private clinics, most of which, right now, are ophthalmology clinics. If you want to see that expand, then do this. Pass this piece of legislation. But we're telling you, based on 20 years of experience, no one has been able to stop the private clinics from extra-billing patients. That is their business model.

And it's not small amounts of money; it's massive amounts of money. They literally charge 10 times the cost for shoulder surgeries, they charge four times the cost for cataract surgeries, they charge four times the cost for MRIs and so on.

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Interjections.

Ms. Natalie Mehra: Someone's telling you not to ask me questions, I think.

Mr. Brian Saunderson: No, I thank you. I appreciate your answer, but the starting point, I think, for all of us around this table is that our current wait times across the country violate the charters rights of our residents, and that needs to be addressed.

Ms. Natalie Mehra: I think we agree. We agree for sure.

Mr. Brian Saunderson: We agree on that. Thank you.

Ms. Sara Labelle: We agree on that, but if you have two houses that require plumbing and one plumber to do the work, they can't do the work of both at the same time. That is the point of the health human resource issue, that if the private clinics poach the workers, the workers are not in the hospitals. You're not doing double the work; that does not happen. We're not multiplying overnight. The health professionals take time to train, and that will not happen overnight. Private clinics will poach; that has been proven. We see that across the country. They have no other area to draw the resources from.

Mr. Brian Saunderson: Thank you. Those are my questions.

The Acting Chair (Mrs. Lisa Gretzky): Any additional questions from the government side? You have two minutes and 46 seconds left. No? Okay.

We'll go to the official opposition for seven and a half minutes.

M^me^ France Gélinas: Thank you to both presenters. I truly enjoyed listening to what you had to share with us. I take from what you shared with us that the health care system as we know it, where care is based on our needs, not on ability to pay, where everybody is treated the same based on their needs, not on their ability to pay, is about to be changed forever with the piece of legislation that we have in front of us, where the people who have means, the people who have money, will get faster care, and everybody else will suffer. This is not something that I could ever support and this is not something that is supported by Ontarians or Canadians.

When you started your presentations, you talked about how we have the infrastructure right here, right now in Ontario that sits idle for hours, days and weeks at a time,

yet once the government allows Bill 60, we will see private, for-profit corporations build up new surgical suites, not for catching up on COVID-related—but forever on end. What do you see as the long-term effect on the people of Ontario of having for-profit clinics offering care to the healthy and the wealthy?

Ms. Natalie Mehra: Well, I think two things. Because the model of the for-profit clinics is to do the profitable cases—they do the patients who are the easier care, faster, the profitable patients. They don't do the people who are hooked up to all kinds of tubes and things who can't walk in and walk out of their surgery. The Shouldice Hospital, for example, does not do people who are obese or who have COPD or heart arrhythmia who might code on the operating table or are at higher risk. They take the light, easy, fast patients—and staff and funding—out of the public hospitals.

The model is fast, high volumes, so in small and rural communities across the province, all of the medium-sized hospitals down to the small ones—this is my worry: This is a model of care that you might do in the middle of downtown Toronto in a Kensington eye clinic or something like that if you want a factory of fast cataract surgeries, if that's the model you want. But it's not going to work for the vast majority of Ontario where there's a small population scattered over a wide area. They lose their surgeries. They lose the doctors. They lose the nurses. They lose the health professionals. That is a class of income in the community that is serious. It's also doctors who provide other vital functions. As you know, when the community loses its doctors, it's a vicious spiral down.

When the Premier was asked by the media, he said 50% of the surgeries were of the easy sort that could be privatized to these. Those are the surgeries that are left in the medium and smaller hospitals. If they go to high-volume centres in Windsor, Kitchener, Ottawa, Toronto, what have you, the large cities which could sustain a high-volume centre, then they lose their hospitals. That is the end of the community hospital in Ontario. I don't think that is what even the government MPPs would want if they thought it through.

So, (1) disaster on the staffing and on the funding of the local hospitals; (2) it's a centralization model that would be extremely damaging; and (3) they run for profit. They locate in neighbourhoods where they can upsell and charge people lots of extra money. So they only locate in the wealthy areas of urban centres.

M^me^ France Gélinas: Some of those surgeries will now be done in the community. I understand that they will pick the healthy and the wealthy cases, but sometimes things go wrong.

To you, Ms. Labelle, what do you foresee could happen if a hip surgery done in the community in one of those fast—we can turn around a hip surgery way faster in the community than we can in the hospital, but things go wrong. What could happen?

Ms. Sara Labelle: A patient could die.

M^me^ France Gélinas: What makes you say that?

Ms. Sara Labelle: Right now, we have operating rooms that are literally down the hall from labs, and we keep the blood products because we have transfusion safety officers, and they are the ones who make sure—and the lab techs who have crossmatched the units. So if there is a bleed and they require the blood products, they call the lab, and we run it down the hall. It's quick intervention. We don't have time—if they're at a private clinic off-site and they code or they bleed, then they could die. With hips and knees, you can hit a major artery—we're talking about the femoral artery. That is a very real possibility. You hope it doesn't happen. But if you happen to be that one patient, you want to know that you have blood products. So now we're going to be tying up paramedics to come to a private clinic to pick someone up, to take them then to the public hospital, and hopefully they don't bleed to death before they get them to the public hospital and get them blood products. That's the reality.

Ms. Natalie Mehra: Didn't that happen at a liposuction clinic in Toronto?

M^me^ France Gélinas: Yes, it did, and the lady died.

When you talked about the change in the scope of practice—I take it that those private clinics, those for-profit clinics will need laboratory technologists. Is it my understanding that the bill would allow somebody with not the full competence of a laboratory technologist to do the work of a laboratory technologist once the bill is passed as written?

Ms. Sara Labelle: As written, it speaks to them being able to designate others. The title "medical laboratory technologist" is a protected title. There is strict criteria that you need in order to practise. Under this, under regulations, they can change who can practise as a medical laboratory technologist. So, yes, it's a problem.

The Acting Chair (Mrs. Lisa Gretzky): One minute.

M^me^ France Gélinas: You're making reference to schedule 2 of the bill that changes the title?

Ms. Sara Labelle: Yes.

M^me^ France Gélinas: My colleague has a quick question.

Mr. Wayne Gates: Finally, somebody is coming out and saying exactly what's going to happen. If I'm off-site getting knee surgery, somebody like myself who may—I'm not saying I do, but I could—have heart trouble, if I have a problem off-site, I'm going to die before I get to the hospital. We know that it's taking a long time for paramedics—sometimes they're sitting at hospitals for a long time. They're not going to make it there. I think it has to be said clearly what's going to happen. Something can happen. I was with a nurse on Saturday night, and she works in the operating rooms, and she told me exactly what you did, and I was a little surprised. She said it happens all the time. She's not saying it happens once in a while. It happens all the time. So they are going to die. That is in the bill. That's what this bill is going to cause—same as it did with long-term care.

The Acting Chair (Mrs. Lisa Gretzky): The time is up.

I'd like to thank the presenters for their participation.

If you'd like to submit any written materials to the committee in addition to your presentation today, the deadline for written submissions is 7 p.m. Eastern Daylight Time on Monday, March 27, 2023.

Seeing the time on the clock, and since the next group isn't due in until 2 o'clock, we'll take a recess until 2 o'clock.

The committee recessed from 1349 to 1400.

ONTARIO COUNCIL OF HOSPITAL UNIONS/CUPE
ONTARIO MEDICAL ASSOCIATION

The Acting Chair (Mrs. Lisa Gretzky): All right, we're back in session. We have the next group of presenters virtually, joining us on Zoom. Sorry, I have to switch out—take my glasses off; these are for distance.

I will now call on the Ontario Council of Hospital Unions/CUPE, Michael Hurley and Doug Allan. I want to welcome you virtually. As a reminder, you'll have seven minutes for your presentation, followed by questions from the committee members. I'll provide reminders of the remaining time during the presentations and questions, so usually at about the one-minute mark, you'll hear me say, "One minute." Before you begin speaking, please state your name for Hansard and then you can begin your presentation. Thank you. You can go ahead.

Mr. Michael Hurley: Thank you very much. It's very much appreciated that we can present to you on this piece of legislation. My name is Michael Hurley. I'm the president of the Ontario Council of Hospital Unions of CUPE. With me is Doug Allan, a senior research officer with the Canadian Union of Public Employees.

Just a bit of background about the Ontario hospital system: It currently has a staffing shortage of 37,000 vacant positions and an annual attrition rate or turnover rate of 15%, or 40,000 positions. It's running on very threadbare staffing and, of course, this staffing shortage is driving the closure of ERs and other services, which the Toronto Star reported there were 145 of last year.

We have a number of what we consider to be significant concerns about this legislation. First of all, it will draw down staff from the public system, and it's easy to see how that happens when the consortium that's going to be performing surgeries at the Ottawa Hospital is offering staff RNs $750 a day and clerical staff $600 a day to work on the weekends. Of course, this is double their current hourly rates. And any staff who volunteer to work for the consortium doing the surgeries on the weekend or booking them are not available to be redeployed elsewhere in the Ottawa Hospital to deal with their massive staffing shortages.

So although the minister has said this bill will not impact staffing and will not draw down staff, in fact, that isn't proving to be true. It will be more expensive. Although it will take the simplest procedures and leave the hospital system with the most complex, in fact, it's going to be paid much more: 30% and more for cataracts, $650 a day—versus $450 a day—at the Ottawa Hospital and the Herzig Eye Institute contract. CBC says hips will be $28,500 in the private clinics versus $10,000 in the public hospitals.

We're concerned about oversight in the private clinics. To protect profits, commercial confidentiality will be assured, and regulation is less than was provided for in the independent health facilities legislation. We're concerned about the inability of the private clinics to deal with emergencies that may arise—and they do arise—and the fact that, for example, at the Ottawa Hospital Riverside Campus, they don't have an emergency unit on site. You have to go down the road to Ottawa General to reach one. And it's in those sorts of situations that people bleed out if they have a misfortune during the surgery, and that's responsible for the higher death rates that we see, which are well documented in British and Canadian studies around the private clinics.

We are concerned—and we know you're going to hear a lot about this from the Ontario Health Coalition, which has done great work and original research contacting these clinics across the country. Extra-billing and private clinics charging for extra-billing and inadequate protections for the public from extra-billing are all features we see across the country in terms of these private clinics.

We want to raise with you the threat to rural, northern and isolated hospitals. As surgeries are pulled out and relocated in freestanding, larger, major urban centres, the impact on rural Ontario is going to be, we believe, devastating. That's something that we're hoping that you're alive to because we have reason to be quite concerned, particularly as the less expensive procedures are pulled out and we're left in those communities to do the more expensive procedures with fewer resources.

We wanted to raise with you quality-of-care issues. There are studies, and we've cited them, where the quality of care in these clinics is of a lower quality than in the public hospitals and, as I mentioned earlier, the mortality rates are higher as well. This despite the fact that these private facilities are receiving 30% and more per procedure than the public hospitals are receiving, and the public hospitals are doing much more complex cases and ones where people have complex medical conditions.

We're concerned about duplication. Here we are, working in a health care system where there aren't enough resources, and yet we can finance the construction of, in some cases, duplicative operating room facilities—

The Acting Chair (Mrs. Lisa Gretzky): One minute.

Mr. Michael Hurley: —and we can afford to pay 30%, 40% more to do the same procedure, using the same staff that are already working for the public hospital systems. This makes no sense to us.

We note with great concern the overspending on private clinics, which has already begun. The public hospitals are in financial trouble. They were budgeted for cuts in the last budget. When you removed the COVID funding, their funding was down on an operating basis, and they've already begun to lay off in communities, like at Stevenson Memorial. But at the same time, we see spending on the private clinics over 100% of what was originally budgeted.

We've raised these issues repeatedly. All these concerns we raised in the last provincial election, and we were reassured that there were no plans to introduce these private clinics—

The Acting Chair (Mrs. Lisa Gretzky): Thank you. Sorry, your time is up.

Just to the members in the committee room, I know we have the volume up as loud as we can here. So if you're having some issues, I believe everybody has an earpiece they can plug in if you're having troubles hearing the presenters.

Now I'm going to call on the Ontario Medical Association. Just a reminder, you have seven minutes. Then, once your presentation is up, we'll start the question rotation. Please don't forget to state your name, too, before you start your presentation.

Mr. Allan O'Dette: Can you hear me okay? There we go. How is that?

Good afternoon, everyone. Allan O'Dette from the Ontario Medical Association. I'd like to thank the members of the committee for providing the OMA with this opportunity to present our views on Bill 60, Your Health Act, 2023, and we'll follow this presentation up with a written and more detailed submission. I'm joined today by—although you can't see her sat beside me—Dr. Rose Zacharias, who is the president of the OMA. There she is.

We welcome the government's proposed legislative framework for new community, surgical and diagnostic centres. It's the right thing to do. It helps reduce wait times, which is critical both for the health of patients and for the health of the system that cares for them. We believe it will free up hospital resources to focus on emergency, acute and complex cases while relieving some capacity issues that are big, and they're real.

The Auditor General's recent report on outpatient surgeries in Ontario emphasized the experience in other Canadian jurisdictions that community surgical centres can treat 20% to 30% more patients within the same amount of time. They can do this because these centres, their staff and equipment focus on a more narrow range of procedures.

The OMA is encouraged by the proposed legislation because it aligns with our recommendations and some key principles for establishing integrated surgical and diagnostic centres. Those principles need to be protecting the stability of human resources, doctors, nurses and other health care workers at public hospitals and other health care settings; ensuring community health service centres operate within the publicly funded health system paid for by OHIP and do not allow and protect against queue-jumping; ensuring that the quality of care and patient safety levels are at and above the standard of any hospital setting; and ensuring that these centres are fully integrated with hospitals and other health care settings. We request again directly that we be fully engaged along with some other stakeholders in the implementation.

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I'd like to quickly take the opportunity to raise just a couple of concerns around two proposed amendments. The first is how we define a physician, and the second is with regard to pharmacist scope of practice. We understand the intent of these amendments and we raise concern in the spirit of avoiding any unintended consequence. The bill proposes to expand pharmacist scope of practice to include assessment of conditions for the purpose of providing medication therapies. We continue to have concerns with the government's decision to authorize pharmacists to prescribe for common ailments. Again, our only north star is patient safety, and that's our utmost concern.

I'm going to pass it to Dr. Zacharias. I know she's keen to share her thoughts with the committee, and I appreciate the time.

Dr. Rose Zacharias: Thank you so much. My name is Dr. Rose Zacharias. I'm president of the Ontario Medical Association. I'm also a family doctor who has worked in the emergency department for 20 years. Every day, I see first-hand the challenges in our health care system and the impact they have on our patients.

Thank you for the opportunity to speak on Bill 60 and to try to bring in the views of Ontario's 43,000 physicians. We're eager to collaborate with the government on Bill 60's implementation, specifically proposing assembling an expert panel of physician leaders to provide clinical advice to the ministry.

Doctors have been strongly advocating for solutions to eliminate surgical backlogs and reduce wait times, which were a major concern even before the pandemic. No patient should be waiting months or years for a surgery that they need. In 2022, we called on the government to create integrated ambulatory centres for outpatient surgeries and procedures. We support Bill 60's [*inaudible*] feature to move lower acuity surgeries and procedures out of hospitals. This is an important step in reducing wait times.

As Allan mentioned, community surgery centres can treat patients in numbers that could never be achieved in a hospital setting. Patients also recover faster and experience lower infection rates. We have seen this. That's good news for patients. It's also good news for our health care system because it means hospital resources can be freed up to focus on emergency, acute and complex cases, which relieves strain on capacity. We look forward to working with the government on implementation to ensure community surgical centres adhere to four critical principles that Ontario's doctors believe must be followed with respect to a human health resource strategy, also public funding through OHIP, quality of service and patient safety, of course, and integration with other health care settings.

With regard to the definition of "physician" and pharmacist scope of practice, we support the intent of the change in the definition of "physician." However, as Allan noted, we're concerned that permitting regulation-making

authority to include others within the definition of "physician" creates a risk for future misinterpretation which could lead to including non-physicians.

We recommend that "physician" be defined as a member of the College of Physicians and Surgeons of Ontario or another person who is lawfully entitled to practise medicine in Canada as a member of a provincial or territorial medical regulatory authority subject to conditions prescribed by the regulations.

The Acting Chair (Mrs. Lisa Gretzky): One minute.

Dr. Rose Zacharias: We believe this amendment is consistent with the intent of the proposed legislation and is necessary to offer clarity and ensure public trust in the "physician" title.

Lastly, with regard to pharmacist scope of practice, we urge the government to reconsider the bill's wording to ensure that it reflects the stated intent of the amendment and avoid the term "assessment," which is uniquely a medical term with respect to the physician scope of practice under the Medicine Act, 1991.

The OMA's written submission provides more details and once again, we are very, very grateful to have a say on this important piece of legislation and provide the best patient care possible to all Ontarians. Thank you so much.

The Acting Chair (Mrs. Lisa Gretzky): Thank you. Now we'll move on to questions from committee members. I just want to remind the committee members to wait until you're recognized by the Chair to speak. It gives the broadcast folks an opportunity to turn your mike on so we can hear you the whole time.

With that, we'll go to the government side to start, for seven and a half minutes. MPP Wai.

Mrs. Daisy Wai: Thank you to all the presenters. I would really like to ask a question and also thank Allan and Rose for coming to do your presentations.

I said to the minister this morning that we are very happy that Bill 60 is going to reduce wait times, which is exactly what you've just mentioned, as well as handle that surgical backlog that we have been struggling with even before the pandemic. I'm happy that Bill 60 is addressing that and I know that you are in full support of that.

My only question is, are the physician standards of practice that registrants are expected to meet to provide safe, ethical and quality patient care consistent across Canadian jurisdictions? Either Allan or Rose can help me with this.

Dr. Rose Zacharias: We do support the notion of pan-Canadian licensure. Indeed, we believe that this would help with our physician shortage [*inaudible*] and we want to support interjurisdictional mobility and efforts to increase human health resources. We do trust the physician regulators of other provinces and indeed we look forward to working with government on regulations that would make clear how OMA would represent all physicians who work in the province, of course, regardless of where they are regulated.

Mrs. Daisy Wai: Thank you.

The Acting Chair (Mrs. Lisa Gretzky): MPP Pierre?

Ms. Natalie Pierre: My question is to Allan and to Rose from the OMA. Do you have any additional suggestions on how the expansion of community surgical and diagnostic services can be successfully implemented?

Dr. Rose Zacharias: We do believe that community-focused surgical centres could be implemented well in our communities and reduce the wait times and catch up on that surgical backlog. Patients are getting sicker—I see it in our emergency departments—and they need to have these elective surgeries that have been put on hold.

Adherence to key critical principles needs to happen. There needs to be an integration with the current hospitals. A scheduled staff plan around human health resource strategy also needs to come forward. "Publicly funded" needs to be a key principle here and always ensuring patient quality and safety.

With these key principles in mind, we do believe that patients would be getting the care that they are waiting too long for now. As physicians we look forward to working with the government, even with an implementation committee, so that we can bring our clinical expertise to the decision-making table as to how these focused surgical centres would be implemented in various regions across the province for our patients.

The Acting Chair (Mrs. Lisa Gretzky): MPP Martin?

Mrs. Robin Martin: Thank you to the presenters. Dr. Zacharias, you had said that the OMA supports moving lower-acuity surgeries out of hospitals and you gave a few factors as to why. Could you just repeat those? I was trying to write them down, but I think I only got two.

Dr. Rose Zacharias: Moving lower-acuity procedures and surgeries out of hospital would free up hospital resources for those higher-acuity, complex cases that hospitals are doing now. Also, those elective procedures, which are so important for patients to be scheduled for and to follow through on, are less likely to be cancelled when a hospital OR, for example, has to deal with something that's come through the emergency department door—a multi-vehicle collision or another trauma of some sort. So not cancelling those procedures, protecting them and also, then, freeing up the hospital spaces, always with a human health resource strategy in mind—we know of the doctor shortage and nursing shortage in Ontario, and we need to have a human health resource strategy to protect those elective surgeries that have been waiting too long and to cover hospital emergency complex cases that would be going on all the while.

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Mrs. Robin Martin: Did I also hear you say, Dr. Zacharias, that these out-of-hospital clinics can do numbers that are higher than could ever be done in hospitals and less infections have been recorded in the data available?

Dr. Rose Zacharias: I'm happy to bring forward an example. In London, there's a surgery centre at London Health Sciences Centre, a hospital, where the OR was pared down to only what's needed for those elective, ambulatory cases. Costs there were reduced by 50%, and

staff were able to see 30% more patients, and there were lower complication rates reported.

It's also supported by the Ontario Auditor General report in 2021 and in a few studies that were published emphasizing specifically the efficiency when we focus on elective procedures in operating rooms that are dedicated to them and able to see more patients.

The Acting Chair (Mrs. Lisa Gretzky): You have 1:19 left, if you have another question.

Mrs. Robin Martin: I have another question, if nobody else wants to jump in.

We're talking for the first time about having out-of-province doctors. I think you said you support pan-Canadian registration so they could be practising here while still registered, I guess, with the college back in their originating jurisdiction—British Columbia, for example—and then they're coming here.

Has the OMA discussed whether they would be representing physicians who are here and not yet registered with an Ontario college? How would you deal with that innovation?

Dr. Rose Zacharias: At this point, the OMA represents only those physicians registered with the Ontario college. We know that physicians who may indeed move to Ontario or are regulated by their provincial bodies elsewhere would be adhering to those strict regulations, which we believe are quite robust, and we are committed to working with government on regulations that would make it a bit more—

The Acting Chair (Mrs. Lisa Gretzky): Thank you. Sorry; time's up.

I'm going to move to the official opposition for 7.5 minutes. MPP Gélinas.

M^me^ France Gélinas: My first question is for the Ontario Council of Hospital Unions.

You opened by telling us that there are presently 37,000 vacant positions within our hospitals, with a turnover rate of 40,000.

How do you see Bill 60 improving those health human resource shortages that we're facing right now?

Mr. Michael Hurley: It won't. It creates an incredibly unfair competition for the public hospitals as they try to compete with and pay for RNs, RPNs, clerical staff, cleaners etc. As you can see in the case of Ottawa, they're prepared to offer two times the normal daily rate of hospitals, which are all precariously balanced on the edge of a deficit—if they're not in deficit—and are not in a position to compete on that basis.

There have to be measures taken to improve conditions in the hospitals to retain people, to have nurses and other workers stay. That has to be a priority for this government. Unfortunately, this legislation doesn't do that. So it's going to make worse a situation which is already critical and most critically felt particularly in northern Ontario and rural Ontario.

M^me^ France Gélinas: I fully agree. So the healthy and the wealthy will be able to go to the for-profit clinic, and everybody else will suffer because of the lack of staff.

Dr. Zacharias, I really thank you for bringing forward the example of what happened at the London hospital. The London hospital built a surgical suite more or less across the street from their main campus, so they are able to provide 30% more surgeries at 50% of the cost. It's a real success. It is run by the hospital, and it is the hospital staff who rotates there. That is, one week you get to work steady days, Monday to Friday, in the outpatient surgical suites that they built; and the following week you have your regular schedule of night shifts, evenings, weekends etc., so they roll through.

My first question to OCHU: Do the staff, nurses, cleaners and everybody else who works in that surgical suite run by the London hospital—do they get paid twice their salaries when they go work across the street?

Mr. Michael Hurley: No, they don't. The phenomenon that you're seeing in Ottawa is a private organization which is staffing up, and it's doing that by actively recruiting staff away from the Ottawa Hospital and away from the availability to work other shifts in other areas of the Ottawa Hospital, which is often critically understaffed. So, no, that's not a feature at that. And I would say, that's an important distinction you're making, Ms. Gélinas.

M^me^ France Gélinas: Dr. Zacharias, I have kind of the same questions to you. Do you see the example that is right here, right now in Ontario? London built an outpatient surgical suite across the street from the hospital. They're using it for low-acuity surgery—costs 50% less; does 30% more surgeries; uses the staff, the oversight, the linkages. Is this what you had in mind when you put your program forward that says it needs to be integrated with the hospital?

Dr. Rose Zacharias: Absolutely. Thanks, France, for highlighting that. Integration with the hospital is key, and also that detailed staffing schedule so as to know—in that regional plan, that would then be bringing in a focused surgical centre. There would be integration with the hospital and the health human resource strategy to see that these focused elective surgeries are happening as well as that the hospital is being staffed adequately to run when acute emergency cases are required to be done. So, yes, that is what we had in mind.

M^me^ France Gélinas: So the bill as it is written right now would allow for-profit corporations to set up—yes, the physicians will have to have privileges in the hospital, but that's it; that's all. Is this enough integration for you, that the physician has privileges but everybody else has no relations, no oversight? I'll leave it up to you. Is that enough integration?

Dr. Rose Zacharias: This is where an implementation committee is key, so that we continue working with government and bring our clinical advice forward as these surgical centres would be developed in each region, adhering of course to those four key principles. Integration is key, and the human health resources strategy, but what we are eager to do is to continue our relationship with government, specifically with an expert advisory panel going forward, so that we can bring our physicians' expertise into each model that is developed.

M^me^ France Gélinas: Back to OCHU: Were you consulted? Given that you represent most health care workers, were you consulted before Bill 60 was put forward?

Mr. Michael Hurley: No, we were not.

M^me^ France Gélinas: Back to the OMA: Was the OMA consulted before Bill 60 was put forward?

Dr. Rose Zacharias: We have been urging governments to implement integrated ambulatory centres. It's been part of our Prescription for Ontario. We know that the wait-time issue is huge. Prior to the pandemic, already patients were waiting far too long, and now the surgical backlog—COVID causing more than a million surgical procedures to be backlogged. So we were happy to see such a model being presented, once again adhering to those key principles, and physicians are committed to seeing the implementation through.

M^me^ France Gélinas: In your prescription for change, you do mention though that you want them to be not for profit. This is not in Bill 60. The for-profit corporations will be allowed. Do you stand by what you had put in your proposal, that it be not-for-profit?

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Dr. Rose Zacharias: Our official position is not-for-profit. We do believe that what is most important to emphasize here are those four key principles around integration, HHR strategy, publicly funded—every medically necessary surgery and procedure would be funded and covered by OHIP, and patient safety and the quality of care would be ensured.

M^me^ France Gélinas: Are you afraid of queue-jumping with the model that's in Bill 60?

Dr. Rose Zacharias: There should be no queue-jumping—

The Acting Chair (Mrs. Lisa Gretzky): Thank you. Sorry, time is up for that round of questions.

We'll now move to the independent. MPP Shamji.

Mr. Adil Shamji: To everyone presenting today, I do want to acknowledge the incredible work of all your members. That's on the part of the OMA as well as CUPE. Thank you very much for your service during the pandemic and for joining us this afternoon.

I just wanted to follow along the theme of MPP Gélinas in regard to the earlier OMA position, which was that—the initial position, I understand, was that the OMA was agnostic as to whether integrated ambulatory centres would be for-profit or not-for-profit, or they could be agnostic on for-profit versus not-for-profit. I know that it eventually evolved to favouring in a not-for-profit model exclusively. I wonder if you could elaborate just a little bit on how and why that position evolved?

I think you're muted.

Dr. Rose Zacharias: Thank you for unmuting me.

Our official position is not-for-profit. However, the emphasis here is around the principles of integration and an HHR strategy and the assurance of quality and safety of each surgery and procedure for patients and the publicly funded nature of every medically necessary service. These key principles being adhered to in any model, we would be committed to seeing through by way of that implementation committee.

Mr. Adil Shamji: I wanted to touch briefly on the points that you made about adding the word "assessment" to the pharmacist scope of practice. I was curious to know—one of the reasons that this has been a proposal that has been put forward has been because it has become more difficult to access clinical care and primary care than ever before. If we don't expand the pharmacist scope of practice, what are the alternatives that the OMA would recommend so that we can ensure that we have that kind of access for people in Ontario?

Dr. Rose Zacharias: We have proposed solutions around the doctor shortage. We want everyone in Ontario to have a family doctor—not just a family doctor, but an entire health care team connected digitally, someone to have that trusted relationship with to access the rest of the health care system. We need to work on that. Licensing internationally trained physicians is an immediate solution that we want to work with government with. But a long-term, stable health care system is going to require more doctors, more medical schools, more junior trainee positions.

We need to address burnout amongst our doctors. We need doctors to train doctors. We need to retain our doctors, addressing burnout around the documentation burden. Documentation right now is ridiculous for the amount of time. A physician can spend, on average, an entire day each week documenting. It takes doctors away from patients.

The Acting Chair (Mrs. Lisa Gretzky): One minute.

Dr. Rose Zacharias: [*Inaudible*] doctors to be doctors, and so focusing on retention of our current physician workforce as well as recruitment of future doctors, who I know want to be inside of this valuable profession, is where we want to continue our focus.

Mr. Adil Shamji: Are there any steps that you might recommend in terms of bringing in more foreign-trained workers?

Dr. Rose Zacharias: Practice-ready assessments are an expedited way. That involves important scrutiny to make sure that internationally trained physicians would have the expertise and be on par with what we would expect a doctor to have as far as competence inside the system. But these practice-ready assessments would be three-month periods of—

The Acting Chair (Mrs. Lisa Gretzky): Thank you. Sorry, time is up for that round.

Back to the government side: MPP Martin.

Mrs. Robin Martin: Thank you to all the presenters for your contributions to this.

There was a question, I think from the opposition, about queue-jumping. Dr. Zacharias, I think you had started to say there's no queue-jumping in the legislation. Is that a concern you have with Bill 60, just to clarify? Because I don't think you finished your answer.

Dr. Rose Zacharias: I think what we want to emphasis is that every medically necessary service would be covered by OHIP and no one would be paying out of

pocket to jump first in line. Indeed, patients need to be triaged as to who is at most need for their hip replacement, knee replacement, hernia repair, and then go first, so that there's nothing that would preclude a patient who needs that surgery or procedure from having it done and have it be done by a physician who is able to do it. Inside one of these focused centres certainly is a way to go about it sooner, because now patients are just continuing to wait. We need a better plan.

Mrs. Robin Martin: Okay. Thank you. And I think, as I recall, what the minister was saying this morning is that's part of the virtue of having the community clinics integrated with the hospital so that there can be centralized wait-list management, which I know is also something the government's been investing in.

Mr. Odette—it's mister not doctor, is that correct? I just wanted to make sure I didn't offend. You talked about how the proposals in Bill 60 align with the OMA's recommendations. I was wondering if you could elaborate on what ways the proposals in Bill 60 align with OMA recommendations.

Mr. Allan O'Dette: Yes. Thanks for the questions. The OMA, about 16 months ago, went out to roughly 2,000 physicians, over 10,000 Ontarians, about 110 other allied health professions, including the business associations etc. The consensus was really to focus on wait times, expand mental health and addiction services in the community, improve and expand home care and other community care, strengthen public health and pandemic preparedness and give every patient a team of health care providers and link them digitally.

This bill figures quite prominently in many of our recommendations and, as Dr. Zacharias has repeated a couple of times, it aligns principally with ensuring that nobody is able to jump the queue, that safety and access are critically important, that we are aligned with community and hospital and that the two are working hand in hand, not unlike the surgi-clinic in London. The final piece is that these centres have to be publicly funded. If we were to roll it all up, we're really quite aligned, principally, with what the government is intending to do on behalf of our families, our neighbours and our communities to improve access to procedures. They ought not to be waiting six months, 12 months or two years, in some cases.

Mrs. Robin Martin: Thank you. Yes, that is certainly a concern for all of us, I think, is to make sure that people get care sooner. How we go about doing it is, I think, to get people to work together. We have a lot of great health care providers, many of whom you represent, of course, and we want to make sure that we're getting the right care to people as quickly and safely as possible so they don't have to wait. That's part of what the government is trying to do with this proposed legislation really to help reduce wait times and free up the hospitals to focus on the most acute kinds of matters.

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You mentioned the pharmacist scope of practice, that concern you had, and you also mentioned the definition of "doctor," which I was trying to find—or "physician" I guess you said. Where was that? Dr. Zacharias, if you could point to it.

Dr. Rose Zacharias: Yes. We are referring to the definition of "physician," and we recommend that there just be no ambiguity there, that "physician" defined as a member of the College of Physicians and Surgeons of Ontario or another person who is lawfully entitled to practise medicine in Canada as a member of a provincial or territorial medical regulatory authority, subject to conditions prescribed by the regulations. So we're just getting ahead of that definition and wanting to be very clear.

Mrs. Robin Martin: Then the only other question I wanted to ask was—you mentioned the London Health Sciences Centre. It has got a clinic which it set up opposite the hospital for these kinds of low-acuity surgeries. Is that kind of clinic something that you think could happen under Bill 60, that these kinds of clinics could also be set up in the future by other hospitals?

Dr. Rose Zacharias: Absolutely. This is what we do see. There is an example of a really good integrated model with a focused surgical centre, that health human resource strategy is implemented there and these patients and their procedures are being protected from being cancelled, which can happen in a hospital operating room when there are emergency and acute and complex surgeries that are required to be done.

The Acting Chair (Mrs. Lisa Gretzky): One minute.

Dr. Rose Zacharias: Yes, this is the type of focused surgical centre that we see being developed across Ontario.

Mrs. Robin Martin: And just to be clear then, you would see the integrated community surgical centres as an improvement on the independent health facilities for this very reason of integration?

Dr. Rose Zacharias: Yes.

Mrs. Robin Martin: Thank you.

The Acting Chair (Mrs. Lisa Gretzky): You have about 26 seconds left.

Mrs. Robin Martin: I'll pass on my 26 seconds, unless someone else wants to jump in.

The Acting Chair (Mrs. Lisa Gretzky): Over to the official opposition, MPP Gélinas.

M^me^ France Gélinas: Thank you. I just want everybody to know that the outpatient surgical centre that exists across the street from the London hospital does not need Bill 60. With the laws that are in place right now, any hospital in Ontario can open up a community-based surgical centre, run it for 50% of the cost, 30% faster. We don't need this bill. This bill is only there so that for-profit corporations can own those. Hospitals are allowed to own them already, and I'll let my—

Mr. Wayne Gates: Yes, what am I?

M^me^ France Gélinas: My neighbour or my second neighbour.

The Acting Chair (Mrs. Lisa Gretzky): You're MPP Gates.

Mr. Wayne Gates: I'm trying to figure that out myself some days.

Listen, those points are well taken. I think our position, very clearly on this side of the House with all my colleagues, is that whatever we do in how we go forward, London is a good example of how this can work, but it should all be not-for-profit, period. There should be no discussion about that.

To the doctor who mentioned the fact that wait times were long before COVID, you're absolutely right, but the reason they were is because they were underfunded for a number of years with no additional funding for close to 13 years, at 0% funding, which starved the hospitals of the problem.

What we're seeing now—and I'll read my next question and I'll send it to Mike from CUPE—is the FAO announced that the current government is underfunding our health care system by over $21 billion over the next five years—that's with a B. Do you think the province is purposely underfunding our health care system to allow for their corporate friends to come in and privatize more and more of the system? I'll send that off to the CUPE reps.

Mr. Michael Hurley: I'd have to agree with you profoundly. The hospitals were budgeted for a cut when you remove the additional COVID funding in the April budget. They're already experiencing deficits that are enormous. They're besieged by an aging and growing population, and yet where you see growth is in these private clinics. They're over 100% budgeted, and we're anticipating that there are going to be more and more pressures on the hospital side as we go forward into 2023 and 2024. In fact, the FAO, as you know very well, is predicting that health care in Ontario will be significantly underfunded for the next five years in the hospital sector.

So we're predicting an ongoing crisis and at the same time an explosion of resources for these private clinics and also a willingness to pay sums which—with a health care system or hospital system which is struggling financially, who would decide, if they didn't have to, to spend $18,000 more on a hip replacement or a third more on a cataract? Who would do that? Where did the money come from to pay RNs twice as much as they are earning now to staff up a private clinic, which is going to get 40% more, 30% more to do the same surgeries? We're burning money in an oil drum in the backyard here at the same time as the hospitals are in financial crisis.

Mr. Wayne Gates: I agree 100% with you.

You did mention something that has happened in my area too. On the weekends, they were paying time and a half and double time for nurses to come in, particularly in the emergency rooms. So my question, to follow up on that: If we can afford to pay the staff on the weekends time and a half and double time—has Bill 124 hurt your members at all with CUPE, around staffing levels?

Mr. Michael Hurley: Terribly. First of all, there's a tremendous disconnect between all of the praise that has been lauded on these workers in the hospital system and the health care system generally and the restraint that has been put on their wages. Their wages haven't doubled; they've gone up by 1% at a time when inflation has been 3.4% or 6.8%. So they've had real wage cuts.

We survey people and ask them, "What would make you stay? Why are you demoralized?" One of the reasons they're principally demoralized is because they're losing ground financially, they're at high risk of getting sick, they're not provided with the proper protective equipment, and it's as though no one cares about them in any real way. If that could be addressed, they would stay. From the government, we see no meaningful measures, like increasing salaries—not 200%, MPP Gates; 5%, 6%, inflation. We don't see anything like that. People are very, very unhappy and bitter about that.

Mr. Wayne Gates: I think that's a fair response.

I think the one thing that you should be saying, as well, about your members is that they have been doing an incredible job over the last three years, under incredible stress—every day, going to work, watching people die, particularly with COVID. Even the young nurses who came in and did the jobs are overwhelmed; they're suffering some mental health thing. You would think the last thing they would have to worry about is fighting Bill 124 in the courts and feeling not respected. It's awful, what they're going through, yet they go every day.

My next question—and then I'll pass it on to my colleague—is, how would you describe the current state of health care in Ontario? Do you think it has gotten worse under the current government since 2018?

Maybe Doug can answer this. Doug has been there for a while and paid attention.

Mr. Doug Allan: There has been a very significant decline in the quality of health care. There has not been the needed increase in staff that has been promised. We're falling significantly behind. The result of that is further decline in the quality of health care, which has now become a very significant crisis.

I'd like to also note that we have a very aggressive push by the for-profit clinics across Canada to remove services from the publicly funded system—

The Acting Chair (Mrs. Lisa Gretzky): One minute.

Mr. Doug Allan: —and to charge extra costs on these systems. It's very confusing to us why the government would say that it's opposed to anything but OHIP payments when we know for a fact that these for-profit clinics have been at the forefront of pushing extra charges onto our system. They have gone about this in extremely inventive and creative ways, including ways that will allow them, under this legislation, to encourage queue-jumping.

There is nothing in this legislation that would prevent a clinic from giving preference to its clients willing to pay extra for upgrades over its patients who do not wish to do so when it comes to accessing services, as long as it doesn't charge or accept payment for the benefit of doing so and as long as it doesn't refuse services to its non-paying patients altogether. That's completely unacceptable to us, but it's the sort of manoeuvre that we see again and again coming from these for-profit clinics across Canada that are now challenging—

The Acting Chair (Mrs. Lisa Gretzky): Sorry, that's all the time we have.

Now to the independent. MPP Shamji.

Mr. Adil Shamji: To Mr. O'Dette and Dr. Zacharias: I wanted to return to your earlier comments about schedule 2 and the definition of "physician." I note what you have proposed as changes that would be considered acceptable. We know that these changes have been proposed as part of the government's as-of-right proposal for interjurisdictional, essentially, credentialing of physicians. I was curious, in the regulations that will follow, are there specific protections or items that you are looking for the regulations to specify?

Dr. Rose Zacharias: Thank you for the question. We do want to work with government to see this implemented, and so that's where we want to continue our work, because it's important that we continue to work together. When it comes to the regulations, that expert advisory panel, physicians are really putting up our hand and saying we want to be part of an implementation committee to see certain assurances adhered to.

Mr. Adil Shamji: Great. Thank you. I know, also, in the same way that you have expressed a need for more clarification in the definition of what is considered to be a physician, there is similar ambiguity around what is a registered nurse and what is a registered practical nurse. Do you have any reservations about those definitions or about overlap in tasks or scope of practice amongst all three of those professions?

Dr. Rose Zacharias: No comment.

Mr. Adil Shamji: Okay. Now I wanted to turn to—one of the challenges that has been brought forward, ostensibly, has been around the concern of upselling and upcharging in for-profit models. I wonder if you have any comments on the protections we should be looking for and the adequacy of the protections as described in Bill 60.

Dr. Rose Zacharias: I would say every medically necessary service needs to be assured for a patient through the OHIP funding and that never would there be a patient denied the next appointment in line because they choose not to go for an additional expense. We actually do see this in cataract clinics, that patients have a choice between different lenses. We see it also when patients are admitted to hospital. They can choose to stay in a private room or not, but never is a patient denied a medically necessary service because they choose not to spend extra. That's for sure a critical component of health care going forward.

Mr. Adil Shamji: Great, thank you. I have no further questions.

The Acting Chair (Mrs. Lisa Gretzky): No further questions? Okay. That's it for the questions, then.

I'd like to thank the presenters for their participation today. If you'd like to submit any written materials to the committee in addition to your presentation today, the deadline for written submissions is 7 p.m. Eastern Daylight Time on Monday, March 27, 2023. Thank you all.

Our next round of presenters is at 3 o'clock, so we'll take a recess until 3 p.m.

The committee recessed from 1454 to 1500.

CANADIAN DOCTORS FOR MEDICARE

DR. BERNARD HO

The Acting Chair (Mrs. Lisa Gretzky): We will resume committee hearings. I will now call on Canadian Doctors for Medicare and Bernard Ho. We'll start with the Canadian Doctors for Medicare. I want to welcome you all.

As a reminder, each of you will have seven minutes for your presentations followed by questions from the committee members. I will provide reminders of the time remaining during the presentations and questions. Usually at about the one-minute mark, you will hear me say, "One minute." Both of you will get your opportunity to present, and then we'll go around and do the questions.

We'll start with the Canadian Doctors for Medicare.

Dr. Melanie Bechard: Hello, everyone. Thank you very much for the opportunity to speak today. My name is Melanie Bechard. I'm a pediatric emergency doctor in Ottawa and the current chair of Canadian Doctors for Medicare. CDM is a national non-partisan member-based physician organization whose mission is to strengthen Canada's universal publicly funded health-care system.

Bill 60 provides a necessary opportunity to rethink health care in Ontario. It is clear that the status quo is not serving us well. In the hospital where I work, sick children and families sometimes have to wait more than 15 hours to see me. My own fiancé has been unable to find a family doctor since moving to downtown Ottawa two years ago, and he is only one of the two million patients without a family doctor in Ontario.

Unfortunately, I worry that the changes proposed in Bill 60 will not significantly reduce wait times or improve access to care. In these resource-limited times, anything that isn't actively helpful risks becoming a harmful distraction. Creating more community health service centres provides more places to do health care, but it does not provide more people. These centres will compete with our existing hospitals for a limited number of doctors, nurses and health care providers. This is probably why other initiatives to contract out surgeries to private for-profit providers have generally not been successful. For example, in 2010, the Saskatchewan Surgical Initiative did not result in any long-term reduction of wait times after contracting out to for-profit providers. I recognize that independent health facilities are currently permitted within our existing legislation, but I am worried that Bill 60 will lead to more for-profit providers and a greater human resource drain on our health care system.

Research also suggests patient safety could be at risk in for-profit settings. During the early stages of the COVID-19 pandemic, long-term-care facilities in Ontario that were for-profit and had chain ownership were more likely to have COVID-19 outbreaks and more deaths. A study in the United Kingdom that was published in the Lancet medical journal in 2022 found that contracting out health services to for-profit centres was associated with more preventable deaths. And a study comparing for-profit to non-profit hospitals in the United States found that with all

other things being equal for-profit hospitals had higher mortality rates. Even if these risks are small, I think we should avoid expanding aspects of our system that may compromise patient safety, particularly when there are better solutions for addressing our health system issues.

One of the first steps should be to maximize the efficiency of our existing hospitals and health facilities. Hospitals often receive a global budget for a specific number of procedures. This means there is no incentive for hospitals to be more efficient. If they perform more than their allotted amount of procedures, they will essentially end up doing them for free. Funding arrangements with hospitals should be re-examined to ensure that they provide opportunities for real innovation in efficiency with our existing infrastructure.

We also need to create centralized intake referral systems wherever possible. Right now, primary care providers often refer patients to a single specialist or surgeon. They often don't know how long that specialist's wait-list is or whether that specialist is the most appropriate physician for the job. In a centralized intake system, patients refer patients to a group of specialists so they can be seen by the first available provider. This really simple innovation and has been shown to reduce surgical wait times by up to 57% and internal medicine wait times by 40% in multiple studies across North America and Europe. We believe the government of Ontario is well positioned to work with health care facilities and providers to create these more efficient referral pathways wherever possible.

Automatic referrals can also streamline the process. A program at the Women's College Hospital in Toronto reduced the average wait times to see a cardiologist from 100 days to seven days after creating an automatic electronic referral for patients who had abnormal heart imaging angiogram results.

Future health care initiatives should also focus on creating and funding more multidisciplinary teams as a way to tackle our health care issues. The Calgary Acute Knee Injury Clinic employed non-physician experts, like athletic therapists, to help care for patients with knee injuries. This helped to ensure that only patients who truly needed surgery remained on the wait-lists and saved, on average, $4,400 per patient.

I and my colleagues at Canadian Doctors for Medicare hope that future legislation can focus on more evidence-based solutions.

I also believe there are other issues with Bill 60 that should be carefully considered and perhaps further investigated. It seems that Bill 60 removes the stipulation that directors need to be public civil servants. The director has significant control over overseeing the creation and licensing of new health facilities, and we worry that a private individual or corporation in the director role would not be subject to the same strict regulations regarding conflict of interest and financial disclosure for public servants. It is important that this is examined to ensure health care decisions are made based on the highest need and best available evidence. These are—

The Acting Chair (Mrs. Lisa Gretzky): One minute.

Dr. Melanie Bechard: —that I was hoping to discuss with you today, and I thank you very much for your time and attention. I'd be happy to do my best to address any questions you might have about the physician perspectives on Bill 60 or the health care system at large. Thank you, everyone.

The Acting Chair (Mrs. Lisa Gretzky): Thank you.

Mr. Ho, you have seven minutes.

Dr. Bernard Ho: Thank you all for the opportunity to speak today. My name is Bernard Ho. I am a family and emergency physician based in downtown Toronto.

As Dr. Bechard said, our health care system is currently facing an unprecedented crisis, and I think we can all agree that the status quo is no longer working. But the provisions under Bill 60 will not fix the gaps they're intended to and may actually worsen our crisis. I strongly believe that, if passed, Bill 60 will have serious consequences for Ontarians and Canadians, undermining the principles of equity and universality that are the foundation of Canada's public health care system.

Part of what Bill 60 proposes to do is to expand and create what are termed "integrated community health services centres," which, at the root of it, are for-profit, investor-owned private clinics. But at the crux of the health care crisis is a national staffing shortage of physicians, nurses, PSWs and other health care workers.

In my own emergency department, senior and experienced nurses are leaving or retiring early every few months, leading to longer wait times and worse patient care. We unfortunately don't have it pool of health care workers ready to staff these new for-profit facilities at a moment's notice. They take years to train. What will happen is that these new clinics will siphon away existing health care providers from our public system, further worsening our human resource crisis.

I'm also concerned that these new facilities will pose a safety risk to our patients. These proposed facilities will operate independently of any hospital or oversight committee. There's currently a lack of detail and transparency for what safety standards these clinics will need to meet and how these will be regulated or monitored.

We already saw the effects that lax standards had in our long-term care homes during the first few waves of the pandemic. For-profit homes had significantly worse patient care and a higher number of patient deaths, [*inaudible*] requiring military intervention as some of our most vulnerable population were left sitting in their own soil.

For-profit facilities are also legally bound to deliver profits to their shareholders. They exist to turn a profit, with patient care a second priority, and there are two main ways to increase profits: either by cutting down costs by running a lean operation or by charging more for services rendered. The former lends itself to increased risk. If something goes wrong, there are less staff and less resources to appropriately treat the patient. And the latter lends itself to upselling where clinics charge patients out of pocket for uninsured health services.

We see this commonly for cataract surgeries, and I worry that with the expansion of these private clinics, this

will creep into diagnostic imaging and hip-and-knee surgeries. One of my patients in clinic was charged $500 for an upgraded set of cataract lenses that, when I looked into it, cost only $300.

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Patients depend on us as medically trained providers to give them the most accurate information that's in their best interests, but when the profit motive is introduced, there is now an incentive to try and sell patients medically unnecessary services and to upsell them. This poses a significant risk to equity and access to care for patients.

I lastly wanted to address the myth that for-profit care will save our system money by increasing competition and creating efficiencies in our system. In fact, we know that the opposite is true: A multi-payer system is more complex and costlier to administer. You see this in the US, where 31% of all health care expenditure is spent on admin costs, compared to Canada, where we spend only 16.7%. Private delivery of care also comes at a steeper price through a profit margin, capital costs and often higher labour costs. We've seen evidence of this in BC, where knee surgeries cost nearly four times more in a private clinic compared to a public hospital, or with MRIs costing almost double in a for-profit clinic compared to the public system.

What we should be doing instead is reinvesting in our public health care system by strengthening our primary care system, by developing a robust HHR strategy, by removing wage restraint legislation, by opening up OR times, and through so many other public solutions that have been shown to work. We have an opportunity here to innovate and to create a system that truly benefits all Ontarians and directly addresses the causes of our ongoing crisis. The proven solutions are in front of us. All we need is the political will to implement them on a provincial scale. Thank you very much for your time.

The Acting Chair (Mrs. Lisa Gretzky): Thank you both.

So we'll start the questions with the official opposition. MPP Gélinas.

M^me^ France Gélinas: Thank you to both the presenters. We had the honour of having the Minister of Health present this morning at this committee, where she said that there is no difference between for-profit and not-for-profit, and that for-profit is not a bad thing.

Do you believe that for-profit ownership of health care facilities leads to better health outcomes? I will start with Dr. Ho and then Dr. Bechard.

Dr. Bernard Ho: So I'm not too sure what she meant by no difference between for-profit and not-for-profit. I mean, there are clear differences even in just the definition of both.

But to answer your question more directly, we have already seen the effects that for-profit ownership has had on patient care and long-term-care homes in the first few waves of the pandemic. We know that for-profit long-term-care homes had worse patient outcomes, had increased patient mortality, had a higher rate of COVID transmission, had a higher rate of COVID deaths, and more for-profit homes required further intervention because they weren't able to provide the necessary care for their residents. So I would say that there is a big difference in whether a for-profit or a not-for-profit home has a difference in health outcomes, and this translates not only to long-term-care homes, but also to clinics and to hospitals.

M^me^ France Gélinas: Dr. Bechard?

Dr. Melanie Bechard: To build on that, I would say that, all other things being equal, for-profit health care is unfortunately at higher risk of worse patient outcomes. This is based on research evidence, like Dr. Ho mentioned, when we look at long-term care in Canada. But also, as I mentioned, when we compare for-profit to non-profit hospitals in the United States, the for-profit hospitals do tend to have higher mortality. That was published in a Canadian Medical Association journal article back in 2002. Then also that more recent study published in the Lancet medical journal in 2022 found that in the United Kingdom, the more they were contracting out to for-profit providers—that was associated with a higher patient mortality from avoidable causes. So it's not to say, of course, that these facilities are incredibly dangerous, but when we look at all other things being equal, there does tend to be worse patient outcomes. So I'd be very reluctant to expand upon this aspect of our system.

In addition to the differences in patient safety, as Dr. Ho expanded upon, we do tend to see that for-profit health care tends to be more expensive. When we look at imaging and surgeries done in for-profit settings compared to public settings in Canada, they do tend to have higher costs associated with them.

And this makes sense. When you introduce a profit motivation, you're likely going to want to have higher revenue. This is particularly true when you build in shareholders, because now that health care facility is not just accountable to its patients; it's also accountable to shareholders.

If you run a lean operation, there can be less staff available when things go wrong, so this is a possible mechanism by which patient safety can be compromised. I would say, unfortunately, based on the research evidence, there is a significant difference between for-profit and not-for-profit providers, particularly when those facilities are investor-shareholder-owned.

M^me^ France Gélinas: We're going to start to do hip and knee surgery in private, for-profit surgical suites in Ontario, something that we have never done before. So when you talk about risk to the patient, how far do you take that risk? Are we talking risk of an ugly scar or are we talking risk of death?

Dr. Melanie Bechard: The studies that I've looked into have looked into risk of death and have found higher mortality. When it comes to other complications, I'm not sure if we have as much research.

Another potential issue too is, when you have these more siloed operations, if they are not closely associated with a hospital, the patients can also be at possible risk of harm if they're having to go to emergency departments at

hospitals where the electronic medical records are not connected to these facilities. Perhaps patients will have fairly common complications like post-operative infections or post-operative pain. If they show up in an emergency department where the physicians are completely unable to access their records, they're not entirely sure how the operation went, they're not entirely sure if there's any complications in the operation—this is also a possible risk to patient safety.

So as much as possible, we need to look at ways to integrate these facilities into our existing infrastructure, even if they are stand-alone facilities. One way to possibly mitigate some of these patient risks is to ensure that the records are accessible to other health care providers.

M^me^ France Gélinas: Dr. Ho, would you describe the risk to patients in the same way as Dr. Bechard did?

Dr. Bernard Ho: Yes, I would. Just based on my own experiences as an emergency physician, I see this not uncommonly, where patients come in with some sort of post-operative complication, and the surgeon who did the operation is not affiliated with my hospital at all. So the surgeons at my hospital have no record of this patient, have no record of how the operation was done, have no record of if there were any complications at all associated with this operation, and so they have very little information to work from. A lot of times, their advice is to tell the patients to go back to their own surgeon, and so this was a waste of an emergency department visit, a waste of resources, a waste of funding—which is why we need to have these clinics affiliated with the hospitals, so that the surgeon doing the operation can go between the clinic and the hospital to have better continuity of care for the patients.

M^me^ France Gélinas: I represent a riding in northern Ontario. We've had difficulty recruiting physicians and difficulty recruiting anesthesiologists to keep our surgical suites open. Do you think that Bill 60 will make it harder or easier for the northern rural community that I represent to recruit and retain physicians?

Dr. Bernard Ho: I think it would make it harder to retain physicians. I think Bill 60 will make it harder to retain physicians in any community or any jurisdiction within the public health care system. As I mentioned earlier, I think it will siphon away resources from the public health care system, from any jurisdiction, into the private system. We know that the majority of these private clinics are in urban centres. So if we have more physicians, more nurses, more staff in these private clinics, that means we have less of them in our public system and, subsequently, less of them in these rural jurisdictions.

M^me^ France Gélinas: Dr. Bechard, do you agree?

The Acting Chair (Mrs. Lisa Gretzky): Sorry; time's up to be able to answer that.

Moving on to the independent: MPP Shamji.

Mr. Adil Shamji: Dr. Bechard, Dr. Ho, thank you very much for joining us today.

During some earlier public hearings, we heard an argument that an expansion to for-profit models would improve accessibility in our health care system. Do you have any thoughts on that statement?

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Dr. Bernard Ho: Yes. I am not sure that I agree with that. I think what will improve accessibility are several things: implementing and investing in public solutions that we know work. The reason why I don't think that Bill 60 or these for-profit clinics will improve accessibility is sort of what we've already described. We know there is a limited amount of staff and resources in the public system, and so if we move staff from our public system to the private system, we aren't actually improving accessibility for the patients. All we're doing is moving the surgery or the treatment from the public system to the private system.

What we actually need to do is invest in our public system and invest in public solutions that work; as Dr. Bechard said, things like improving our primary care system, things like decentralized referral pathways, things like multidisciplinary teams where we don't focus solely on the surgery, for example, or the surgeon, but we also focus on physiotherapists and occupational therapists. That way, through those partnerships and collaboration, we can actually improve accessibility for our patients because not all patients actually need knee surgery. Patients sometimes just need rehabilitation, need physical therapy. So by incorporating our allied health into the discussions and into our solutions, we can actually decrease wait times that way and can improve accessibility.

Dr. Melanie Bechard: Yes, to build on that, I have heard that one of the hopeful outcomes of this plan is to allow patients to receive surgery closer to home and in more community settings. In my mind, if we're going to be building these facilities in communities closer to where people live, sure, there will be more geographic accessibility, but my question is, what does all that have to do at all with having these facilities being for-profit? The for-profit nature of these facilities is a problem. Of course, if you are going to build facilities closer to where patients live, they will have better geographic accessibility, but that's just by the nature of the facilities themselves.

I think if we wanted to have patients have surgery closer to home, it would make more sense to build off our existing hospitals and infrastructure, maybe create some satellite clinics that are affiliated with these hospitals, so that there is that interoperability of staff, of records and lower risk for patient safety.

I think one of the other hopes, too, is that having for-profit facilities will make these surgeries more efficient, thereby decreasing wait times and improving accessibility, but it is a bit of a myth that for-profit necessarily becomes more efficient. Where a lot of the efficiencies come from is having the centres becoming very specialized and doing one thing over and over again. That can happen in our existing public hospitals. That can also happen in a not-for-profit setting. The Kensington Eye Institute is one example of that, where there's very specialized eye surgeons who tend to do repeat procedures over and over, so they do tend to become very efficient. It is not necessarily profit that is motivating that—

The Acting Chair (Mrs. Lisa Gretzky): One minute.

Dr. Melanie Bechard: —it is simply becoming very specialized. That's how we can increase accessibility without involving profits in any sort of way.

Mr. Adil Shamji: Thank you. One of the concerns that I think both of you articulated was inadequate oversight in the for-profit model generally. A counter-argument we've heard to that from the government is that Bill 60 has protections in place. Based on your review and what you've also heard from patients, do you find that Bill 60 implements adequate protections? Is there anything more it can or should do?

Dr. Melanie Bechard: It's difficult to say. It does seem as though there are some protections and regulations for licensing for these facilities, which is very important. My hope is that they will be held to exactly the same standard as our existing hospitals and infrastructure, and it does seem to me that that is the intent. My concern is that we're still opening up a possible pathway for risk—

The Acting Chair (Mrs. Lisa Gretzky): Thank you. Sorry, we're out of time.

Over to the government side. MPP Rae.

Mr. Matthew Rae: My question is for Dr. Ho. Thank you both, obviously, for your presentations today. As you may be aware, Dr. Ho, in the legislation, Bill 60, it outlines how we would establish as-of-right—is how the government's terming it—legislation for health care professionals. I was just wondering, in your opinion, do you support one national licence for physicians? If you could answer and speak to that. Thank you.

Dr. Bernard Ho: Yes, I fully agree and support a nationalized licensure system. I mainly work in Toronto, in Ontario, but I also work in the Northwest Territories and in BC. I do emergency department work there. It has been quite onerous to try to get licensure in both of these other jurisdictions. It's expensive and it's time-consuming, with lots of paperwork for both the province and the territory—as well as hospital privileges. I've heard from many other colleagues that that is a barrier for them to try to work in other jurisdictions. One of the reasons why, especially in rural jurisdictions, we have trouble recruiting physicians and other health care workers is because of a lack of a national licensure. I think that having one system makes a lot of sense, because the medicine is the same. If I can treat diabetes in Ontario, I should be able to treat diabetes in BC. The medicine is not different because the person is from BC or from another province. So if we eliminate those costly barriers and the time barriers, I think it would go in long way to helping our current health care crisis.

The Acting Chair (Mrs. Lisa Gretzky): MPP Martin.

Mrs. Robin Martin: Thank you to the presenters.

Just to follow up on that point, Dr. Ho: You do support that part of Bill 60, then, which is the as-of-right licensure for professionals who are recognized professionals in other parts of the country. It can be helpful, as you said, with making sure that we have adequate health human resources in all kinds of situations.

I heard, during COVID, that there were times when Ontario had a number of COVID cases, for example, and, say, Manitoba didn't have many COVID cases at that time. Do you think that having that kind of as-of-right national licensure for health professionals, like doctors, would be a good thing to allow for responding to situations like a pandemic, if that were to ever happen again? It might happen at some point.

Dr. Bernard Ho: I hope not, but who can say?

Mrs. Robin Martin: I hope not, too.

Dr. Bernard Ho: I think having that flexibility would be very helpful in any pandemic measure, but it would also be helpful for normal times—for physicians and for health care workers to be able to travel and to work across jurisdictions without all the onerous barriers that are currently in place. So, yes, I would say that in a pandemic situation having that flexibility would be important.

Mrs. Robin Martin: Thank you.

Dr. Bechard, you talked about the Kensington clinic and how that's an efficient model because they do one process or procedure over and over again, and so they can become very efficient at it.

Are you aware that Bill 60 would enable other clinics like the Kensington clinic to open? And, in fact, Bill 60 says nothing about whether the clinic should be for-profit, not-for-profit, and is neutral on that point. We're just trying to ensure that we have more access. From what you said, I take it that you would support the Kensington-model kind of clinics.

Dr. Melanie Bechard: I think a better question is to look at where we are going to get the health professionals to address these wait times. Even if we're creating a bunch of non-profit centres like the Kensington Eye Institute, I would worry that ultimately we're going to be drawing away from health care providers who are currently working in hospitals and other settings. We might be able to gain some traction by creating these non-profit, standalone facilities that do become very specialized, but, at the end of the day, the impact can only go so far because we only have so many doctors and nurses in Canada. So I do hope that we're able to look into some of the other innovations mentioned to decrease wait times. Having very specialized centres is one way to do that. I know that it's currently permitted with existing legislation and would continue to be permitted with Bill 60.

I think my main concern with Bill 60 is that it will open up more opportunities for the for-profit motive to come in there, which has been shown to risk patient safety. But I think we could probably gain something from having more facilities like the Kensington Eye Institute—

The Acting Chair (Mrs. Lisa Gretzky): Dr. Bechard, sorry—

Mrs. Robin Martin: Thank you, Dr. Bechard. I just wanted to go on to another question.

I understand what you're saying, and the Kensington clinic, I think, is a good model that has been a successful model and provided a lot of eye care to people.

One of the differences in the legislation we put forward, Bill 60, is to make independent health facilities into integrated community surgical centres, with a view of trying to integrate it as part of our health care system.

I think you mentioned in your comments that centralized wait-list management was a good idea. Are you aware that the government has funded innovations in centralized wait-list management so we can do just that, as well as innovations in digital electronic medical records, which you also said was extremely important so that doctors have the information when somebody comes to see them, as well as the largest health human resource recruitment, retention and training initiative in Ontario's history—not all of which of course is in Bill 60, but it's part and parcel of some of those things. Are you aware that the government is doing those things?

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Dr. Melanie Bechard: Yes, and I believe they are very important steps. Like all things, the devil is in the details in the implementation. From my perspective, being a practising health care provider—fortunately, we have some great local examples of where the centralized referrals are working, but there's a lot of room to roll them out more widely. So I'm hopeful that this funding will translate into more on-the-ground centralized referral systems.

The Acting Chair (Mrs. Lisa Gretzky): One minute.

Dr. Melanie Bechard: Hopefully a year from now, we'll have a very different perspective on this conversation. But even last night when I was working in the emergency department, I was struggling to find referrals for patients to see otolaryngologists in the community. So I really hope that the funding—

Mrs. Robin Martin: Well, I would certainly agree there's much room for improvement in that regard, and what we want to do is make sure we're using everybody to their fullest potential.

I wondered if either of you have physician friends who work in clinics or have operated clinics. I'm aware that a lot of these physician clinics are operated by physicians who just want to get their patients quicker access to care, because I know doctors really want to make sure they give the best possible care to patients. The one I'm thinking of provides care to patients by the doctors foregoing half of their OHIP fee to cover the other costs. Are you aware of examples like that amongst your colleagues—

The Acting Chair (Mrs. Lisa Gretzky): Thank you. We're out of time.

Back to the official opposition: MPP West.

MPP Jamie West: Thank you both for your presentations. It was an interesting set of questions because some of the stuff they were talking about had nothing to do with Bill 60. For example, these stand-alone clinics that we're talking about are currently existing, the London one that is connected to one hospital, for example, doesn't require Bill 60 to happen. Bill 60 actually opens the doors to allow more for-profit ones. It's an interesting comment to say that we just want more clinics. It's very clear what they want are more private clinics.

Dr. Bechard, when you started, you talked about for-profit long-term care having more preventable deaths and that, in the States, the for-profit hospitals have higher mortality rates. What we're looking at are two systems that are very similar, but one is a public system and one is a for-profit system. What I'm hearing from the deputations today, including both of you is the public option seems to have better results and is more cost-effective. The for-profit one has less effective results—the results we want to stay away from—and also costs more money because you have to have the layer of profit on top of it.

What about this bill makes sense in terms of increasing the number of for-profit health care clinics? Is there something I'm missing?

Dr. Melanie Bechard: Well, it's hard for me to say, not having been an author of the bill. From my perspective, one of the few benefits I can foresee from having this for-profit incentive is that if you do have investors contribute some of the capital early on, there might be a lower financial barrier to creating more of these clinics. However, as mentioned, because we do have these health human resource challenges, creating more places to do the surgery and to do health care doesn't necessarily tackle the biggest issues we have. I think leveraging our existing infrastructure to make it as efficient as possible is likely going to take us further.

MPP Jamie West: I'm glad you talked about staffing challenges as well because we know Bill 124 has been a challenge. There are staffing challenges. I was at a convocation for a variety of different courses, and one lady I spoke to had graduated as a nurse, and I said that's great because we need a lot of nurses. She said, "I will never, ever work in that field. I was just partway through my program. I wanted to finish the program to have my degree. But, on placement, I learned how terrible it is. I'll never work in that field."

The Conservative government very often will talk about trying to attract people to health care, but I don't think they talk enough about the importance of retaining people in health care. I always think about, as a kid, trying to fill a bathtub with the plug out of it. If you don't have a plug in and you don't watch how much water is leaving, you're never going to fill that tub to capacity. If we all of a sudden have more for-profit clinics, are there magically going to be more workers showing up who are qualified as doctors, nurses, RNs or PSWs into our health care field? Is it a magical solution?

Dr. Melanie Bechard: Unfortunately, probably not. If anything, these clinics might draw health care providers away from those who are currently working in other clinics and hospital settings, so I do worry that having them might actually worsen the situation for the majority of patients.

I think it is really important that we do look at retaining health care providers, particularly nurses. I know that my nursing colleagues have been very strong in advocating for what they hope to see for their profession, and I have full support. I am absolutely useless for patients without a nurse. So we absolutely need to work together and make sure that we're working to recruit and retain our health care providers.

MPP Jamie West: Okay. And then similarly, I've been hearing a lot from long-term care and health care clinics about the use of nursing agencies, and what I hear from

them is that the full-time staff are working there every day, and the nursing agencies get about two times the amount of money. They sometimes get housing. They, I believe, get a stipend for food as well. In northern Ontario and Sudbury, they get paid for transportation to come up. All of that somehow is able to be covered in a budget, but hiring a full-time nurse or a full-time PSW to work who actually lives in the area doesn't seem to be available.

I always think about the old saying "There's only one taxpayer." When we're looking at health care and we have a finite amount of money to spend, does it make sense at all to include in that pool of money a little slice for profit so that people are profitable, or does it make sense to have that small slice go back into health care so it gets back to the front line and the people who need it?

Dr. Melanie Bechard: Speaking both as a physician and as a taxpayer, I think it's very important that my taxes and public funds go toward services that will serve myself and the community rather than towards private profits whenever possible.

MPP Jamie West: Okay. Did you want to—

Mr. Wayne Gates: I'll do one if you want.

MPP Jamie West: Go ahead.

The Acting Chair (Mrs. Lisa Gretzky): MPP Gates.

Mr. Wayne Gates: How much time have we got?

The Acting Chair (Mrs. Lisa Gretzky): Just over two minutes.

Mr. Wayne Gates: Just quick, you talked a little bit about long-term care—actually, quite a bit about long-term care. I want to kind of take you through where my head's at on Bill 60. We had 5,400 deaths in long-term care. That would be our moms, our dads, aunts, uncles, brothers and sisters. Approximately 78% of all those deaths died in for-profit care. I don't know if you guys are aware of that, but that's a big number.

So my question to you is, if we already were told a lie, quite frankly, under a different government—

Interjections.

The Acting Chair (Mrs. Lisa Gretzky): I am going to just caution the member on his language.

Mr. Wayne Gates: If we already know that a different government brought in long-term care—well, a Conservative government, but a different leader—and this is the result of what happens when you take it from a public system to a private system, then why would we ever decide to support Bill 60, which is going to take—the same thing is going to happen. It's going to go from being publicly delivered and not-for-profit into a profit situation. And you've already said that the outcomes are proven around the world, quite frankly, on what those outcomes are.

Can you just give maybe your thoughts on what I just provided to you and how that would happen under Bill 60?

Dr. Melanie Bechard: As physicians, I think a lot of what we do is try to mitigate risk for our patients, and I do worry when we see ourselves set up for more risky situations. To me, it's almost like riding without a seat belt. Most times, you'll probably be okay, but you are putting yourself in a riskier situation based on research evidence.

I think it's hard for any of us to entirely predict the future. We have to go by the best available evidence, and if the best available evidence is suggesting a risk, I suggest we steer away from those models.

Mr. Wayne Gates: Go ahead, Dr. Ho.

Dr. Bernard Ho: Yes, I agree with Dr. Bechard. I agree with what you said. We know the 78% figure in for-profit homes, and I agree, why would we want—

The Acting Chair (Mrs. Lisa Gretzky): Thank you. Sorry, time is up.

I have to move to the independent member, MPP Shamji.

Mr. Adil Shamji: One of the arguments we have heard in favour of for-profit models is that in for-profit business models, there's greater opportunity for innovation. What are your thoughts on that?

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Dr. Melanie Bechard: To me, it hasn't been borne out in research. I think that we've seen tremendous innovations within our public system. At my own hospitals, I've seen some great innovations for central referrals, for intake, with new clinics being created. We created the first virtual pediatric emergency department in Canada, which has been very popular amongst patients and providers. We believe we saved a few funds early on in the pandemic, and all of this was done within the context of a publicly funded, not-for-profit system. So I think that linking for-profit to innovation is a little bit of a myth. I think that there's a lot that we can be doing and have done within our existing system.

To me, the problem is with scale. We need to scale up these innovations. We need to make sure that these things that are happening at the local level are scaled up and are implemented at the provincial level.

Mr. Adil Shamji: I must admit, that has been my sense, as well. When I think about many other jurisdictions around the world, there are just so many examples of incredible amounts of innovation in publicly funded systems—everything from virtual internal medicine wards to central diagnostic wait-lists—and it isn't the exclusive purview of the public sector. But it's good to hear another perspective on that, as well.

Can you highlight for us just one more time some of the more prominent examples of how for-profit long-term care has led to inferior health outcomes for patients in Ontario, or, more broadly, across the country?

Dr. Melanie Bechard: There was a study published, I believe in 2020 or 2021, in the Canadian Medical Association Journal, by Dr. Nathan Stall, that looked at differences in mortality in COVID-19 outbreaks within Ontario during the pandemic, and that did find that not only were the outbreaks more extensive in for-profit facilities, but the deaths and mortality were also, unfortunately, higher. It's believed that a lot of this is because when you have a for-profit setting and you're trying to run lean staff, oftentimes the staff in the facilities would not have access to full wages and full benefits and would need to work in different facilities to make ends meet, thereby transmitting infections from different facilities. It's also believed that

because there were fewer staff in a lot of these facilities and fewer staff per resident, when infections did occur, they wouldn't have the same capacity to respond and to isolate patients as well as you could if you had a more full complement of staff and weren't running such a lean operation.

Mr. Adil Shamji: Another concern that has been identified in the for-profit model and specifically in what is being proposed here in Ontario is that equivalent surgeries offered in for-profit, out-of-hospital centres, it appears, will be remunerated at a 20% or 30% premium compared to in the public sector. Is there a good reason for that?

Dr. Melanie Bechard: It's hard to say, when the service rendered is the exact same, why we would tolerate paying more for it. Of course, when you have the for-profit motivation and you are accountable to shareholders, you do need to generate extra revenue—there's only so fast you can go without completely compromising patient safety, so one of the only ways to make more revenue is to charge higher prices.

The Acting Chair (Mrs. Lisa Gretzky): We'll move over to the government side. MPP Martin.

Mrs. Robin Martin: Thank you again for your testimony here today and coming to join us.

I think both of you indicated that you're working in emergency, but do either of you also run a family practice? Have you ever run a family practice? No?

Interjection.

Mrs. Robin Martin: Dr. Ho, you have?

Dr. Bernard Ho: Yes, I also work in a family practice.

Mrs. Robin Martin: And I take it that both of you do not just work for free; you get paid.

Dr. Bernard Ho: Correct.

Mrs. Robin Martin: So, in a sense, you have money to take home; you have a profit; you have money to live on, as it were. Is that correct?

Dr. Bernard Ho: Correct.

Mrs. Robin Martin: You earn money as a doctor?

Dr. Melanie Bechard: I personally am salaried, but I do earn money, yes.

Mrs. Robin Martin: Yes, okay—which a lot of people would consider something similar to profit.

When I was asking you questions last time, I was talking about a clinic I know of in the city of Toronto where the doctors want to get patients care quicker and want to provide low-acuity surgery quicker, and so these doctors, selflessly, instead of taking their whole OHIP fee for themselves, give half of the OHIP fee to cover the costs of the clinic—which have shareholders, I guess, but it's them. So they give half of the fee to cover the cost of the clinic and the other things they would need: equipment, rent and the nursing staff.

I asked if you have any personal experience or if you know of any other such selfless doctors or if they're all rapacious capitalists trying to earn 20% or 30% profit, as was indicated by the members opposite and the independent members.

MPP Jamie West: Not even close—

Mrs. Robin Martin: Do you know of any doctors who provide services who aren't rapacious capitalists and who might care about their patients?

MPP Jamie West: Chair?

The Acting Chair (Mrs. Lisa Gretzky): I'm going to caution MPP Martin with the language. It sounds like it's going in the direction of some personal attacks—

Mrs. Robin Martin: On who?

The Acting Chair (Mrs. Lisa Gretzky): Towards doctors—

Interjections.

The Acting Chair (Mrs. Lisa Gretzky): Order, please. Order.

Mrs. Robin Martin: I'm just suggesting that doctors—

The Acting Chair (Mrs. Lisa Gretzky): I'm asking you to please be careful with the language because that's what it's starting to sound like you're implying.

You still have five minutes to finish your question.

Mrs. Robin Martin: Thank you. I was just trying to ask if you know of any doctors who are selfless and who want to provide services to their patient lists and who are anxious to get them services quicker and trying to find ways in our system to make that happen or if they're all just interested in earning a lot of money, which I suspect is not the case. Certainly not the ones I've met.

The Acting Chair (Mrs. Lisa Gretzky): I'm sorry, I'm going to interrupt here because that was heading in the same direction as I had cautioned you on asking before, implying that somebody making an income, such as all of us around this table do—that people should be giving up their salary, and if they don't then they're a bad person, I think is taking this in a very wrong direction.

So I'm going to ask if there is another question you would like to ask using different language or I'm going to move on.

Mrs. Robin Martin: Thank you, Chair. Sure. Let me try to rephrase this.

I know of a clinic where doctors provide half of their OHIP fee, get no funding from government, but are able to see more patients using this clinic. They have 15 to 18 colonoscopies per day, as opposed to what can be done in the hospital, but they fund it by using half of their OHIP fee to do so. I was asking if you know any other such doctors who have entered into some arrangements like this so that they could provide more surgeries for their patients so their patients don't have to wait?

Dr. Bernard Ho: I guess my question or my concern is if we have the public funds available—we know that the government is sitting on quite a bit of public funds for health care—to implement these public solutions and to implement public measures that have been shown to work—

Mrs. Robin Martin: Sorry, can I just interrupt, Dr. Ho? What I was asking was—these people get no money from the government except for their OHIP fee. So I'm not asking about any government-funded solution. I'm just asking you if you know of other people, other doctors, who provide services like this just to make sure their patients have access to timely care?

Dr. Bernard Ho: Yes, I have many colleagues who work in public clinics that provide timely care to patients.

Mrs. Robin Martin: Public clinics? So they're paid through the public system and aren't sacrificing any of their own earnings to do that. Okay, that's one example.

Dr. Bechard, do you know of any like the example I gave?

Dr. Melanie Bechard: I think that's actually how the majority of outpatient clinics work, where physicians will essentially be running a small business where they charge OHIP and, from that revenue, need to pay for the rent of their building, need to pay for their staff. So that's how a lot of outpatient medicine works.

It is, in theory, for-profit. I think a really important distinction is for-profit when you have the physician running a small business versus where there are external shareholders and investors which the physicians are accountable to. That seems to be where the research evidence suggests we might see some higher risks.

Mrs. Robin Martin: Okay, so just to be clear: Your evidence is that it's okay if it's a small doctor running a clinic kind of thing, like the example I gave, but what you're concerned about is the larger institutions, perhaps. Is that right?

Dr. Melanie Bechard: Yes, the research evidence seems to suggest that corporatization of medicine, the chain ownership of long-term-care facilities tends to be the higher-risk situations and settings.

Mrs. Robin Martin: Okay. But you're okay with it being a few doctors who are running an outpatient clinic and making, perhaps, a small profit, or not, to provide more services?

Dr. Melanie Bechard: I think that's how the majority of outpatient medicine currently happens in Canada.

The Acting Chair (Mrs. Lisa Gretzky): One minute.

Dr. Melanie Bechard: To rethink that model would be quite a significant rethinking of our whole health care system—

Mrs. Robin Martin: Sorry, I didn't catch what you said there.

Dr. Melanie Bechard: —I don't know if everyone necessarily would be.

Mrs. Robin Martin: I didn't catch what you said there, Dr. Bechard. Could you say it again?

Dr. Melanie Bechard: Yes. The majority of health care in Canada is privately delivered right now; the difference is that when it is in for-profit settings, it often is physicians owning and operating small businesses. I think where we're seeing greater opportunity for risk is when we have investor-owned, for-profit delivery, where there are external investors who are not involved in the patient care and who are expecting a return on their investments. That seems to be where we have the riskier situations coming up in research evidence.

As to whether or not this current setting, where physicians are independently owning and operating small businesses, is the ideal model for health care—I think it's a very good area open for debate, but that is the way that health care in Canada has been set up since the 1950s.

The Acting Chair (Mrs. Lisa Gretzky): Thank you. That's all the time that we have.

I'd like to thank you both for your presentations today. If you would like to submit any written materials to the committee in addition to your presentations that you did today, the deadline for written submissions is 7 p.m. Eastern Daylight Time on Monday, March 27, 2023.

Dr. Bernard Ho: Thank you very much for having us.

The Acting Chair (Mrs. Lisa Gretzky): The next group of presenters is at 4, so it looks like we're going to take a recess until 4 o'clock.

The committee recessed from 1552 to 1600.

The Acting Chair (Mrs. Lisa Gretzky): We'll resume committee. Before I call on the next set of presenters, I want committee members to know we do have TFO here that are going to be recording. They're not going to be recording MPPs or anything on the desks, but they are here recording.

Also, one of the presenters, Mr. Cashman has indicated that he will be doing his presentation in French. So, for those who need it, if you plug your earbuds into the mike, there's a switch at the top. If you need the translation service, you can do that.

ONTARIO FEDERATION OF LABOUR
UNIFOR
COALITION DE LA SANTÉ D'OTTAWA

The Acting Chair (Mrs. Lisa Gretzky): I'm going to now call on the Ontario Federation of Labour, Unifor and the Ottawa Health Coalition for their presentations. I want to welcome you all.

As a reminder, each of you will have seven minutes for your presentations, followed by questions from the committee members. Once all of you have done your presentations, that's when we'll go around the room with questions. I will provide reminders of time. It's usually around the one-minute mark that you'll hear me say, "One minute." I know that kind of interrupts sometimes for some folks, but it's necessary so you get all your thoughts out.

Before you begin your presentation, please state your name for Hansard, and then after you state your name, you can begin your presentation.

First up is the Ontario Federation of Labour.

Ms. Patty Coates: Good afternoon. My name is Patty Coates and I am the president of the Ontario Federation of Labour, representing 54 unions and one million unionized workers. I'm joined by Thevaki Thevaratnam, OFL director of research and education.

Ontarians have had enough. This government created the crisis in our health care system, and Bill 60 will make it worse. Permanently moving publicly funded surgeries and diagnostic procedures into private, for-profit clinics does not solve the problem; it creates new and more dangerous ones.

The 250,000-surgery backlog is a manufactured crisis caused by chronic underfunding and shortage of health

care workers. Hospitals in Ontario have operating rooms that are underutilized or are permanently closed. This is a political choice.

Over the next six years, health care will see a funding shortfall of $21.3 billion, according to the FAO. Government spending comes down to priorities, and the Ford government has the wrong ones.

Ontarians don't want their health care system privatized. Recent Environics polling shows that 59% of Ontarians oppose private, for-profit health care providers to solve the health care crisis. In fact, most Ontarians oppose the government's plan to pay private companies to provide surgeries and other health care services. Ontarians know the main objective of for-profit health care companies is to make money and that government is leading Ontario to two-tiered health care and they don't seem to care. The legislation hasn't even passed and they are already moving ahead with their plan.

Just a few weeks ago, an Ottawa hospital leased operating and recovery rooms to a private corporation on Saturdays to perform orthopedic surgeries. Why is a private corporation being allowed to use publicly funded operating rooms instead of the hospital extending its own operating hours? It doesn't make sense.

Bill 60 is problematic for several reasons:

(1) It fails to protect patients. Extra-billing and user fees are banned under the Canada Health Act. A patient cannot be charged for a medically necessary surgery or charged necessary diagnostic tests, no matter what facility performs it. It means private clinics cannot manipulate patients into paying by pretending unnecessary services are necessary, but this happens. In 2021, the Auditor General found add-on fees for OHIP-covered cataract surgeries ranging from $450 to $5,000 extra per eye for non-OHIP lenses, and some being told the specialty lens is mandatory. Data from the Canadian Institute for Health Information shows that knee-replacement surgery in a public hospital costs about $10,000, whereas in a private clinic it can cost up to $28,000. Violations of the Canada Health Act will continue under this government.

(2) Bill 60 means spending more public dollars. In January, it was confirmed that the Herzig Eye Institute will receive $150 more per cataract surgery than public hospitals, costing taxpayers an extra $750,000 for their 5,000-cataract surgery contract. Unsurprisingly, the owners of the company lobbied to expand privatized eye surgeries and donated thousands to the Ontario PC Party.

(3) Bill 60 will worsen the staffing crisis. Both for-profit centres and hospitals recruit from the same limited pool of health care workers. Private clinics that offer higher pay and better hours are alluring. Just look at Ottawa Hospital: RNs are offered $750 a day to work with the doctors on Saturdays, with clerical staff earning $600. That's twice the rate of an RN on a regular eight-hour shift in a hospital. Already stressed public hospitals must compete with private clinics for staff. The government's own briefing documents admit that low wages and Bill 124 created the hospital staffing crisis. The FAO projects that by 2027, there will be a shortfall of 33,000 nurses and PSWs, jeopardizing Ontarians' access to care.

(4) Privatization means worse patient outcomes. Studies from the UK and the US have shown that for-profit care is linked to higher death rates. There's no doubt that private surgical centres will cut corners as they put profits ahead of patients. During the height of the pandemic, for-profit long-term-care homes in Ontario had outbreaks with nearly twice as many residents infected and 78% more resident deaths than in publicly run ones. And that's not the only example. The research shows that patients treated at for-profit dialysis centres are less likely to receive a kidney transplant or even make it on the list compared to patients getting dialysis at non-profit facilities, because for-profit clinics have an incentive to keep patients on dialysis. That is shameful.

(5) Bill 60 is an attack on our public health care system. Privatization is the theft of public tax dollars for private profit. It creates two tiers of care. Those who can afford to pay will receive faster service, and increasingly, patients who need care are faced with extra charges. Meanwhile, underfunded public hospitals are pushed beyond the breaking point with underpaid, overworked, burnt-out health care workers.

The Acting Chair (Mrs. Lisa Gretzky): One minute.

Ms. Patty Coates: Who you are, how much you make and where you live shouldn't determine your ability to access high-quality health care, but in Doug Ford's Ontario, it does. We say enough is enough.

Withdraw Bill 60, properly fund public hospitals so they can increase capacity and meet patient demand, address the staffing crisis by stopping the appeal of Bill 124, and treat health care workers with dignity and respect. The crisis in our health care system demands real solutions now.

The Acting Chair (Mrs. Lisa Gretzky): Thank you.

Now I'll call on Unifor. Please state your name before you begin your presentation.

Ms. Kelly-Anne Orr: My name is Kelly-Anne Orr. I'm the assistant to Unifor's national officers. I'm joined today by our health care researcher, Mike Yam. He's joining us virtually.

Unifor welcomes the opportunity to share our views with the committee regarding the proposed Bill 60. Thank you for the invitation to appear.

Unifor is Canada's largest private sector union, with 315,000 members working in virtually all sectors across this economy. Over half of our members live and work in Ontario, making Unifor one of this province's largest and most important trade unions. Despite our footprint in various private industries, Unifor represents a significant amount of workers in the public services, including health care. We represent more than 30,000 health care workers in Ontario who work in hospitals, long-term-care homes, retirement homes, ambulance services, home care and health clinics.

Bill 60 has been tabled during an unprecedented time—a time when our health care system and health care

workers have been stretched to the limit. But this legislation is not going to solve these problems—problems that have been exacerbated by starving the public system of its health care resources.

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Ontario continues to provide the lowest per capita funding for public hospitals and health care in Canada. The state of our health care system, including the issue of wait times and backlogs for surgeries and diagnostic procedures, is a result of a systemic underfunding of public hospitals and government policies that have exacerbated staffing crises in this sector. There continue to be underused operating rooms and testing capacity in our public hospitals that can improve access to surgeries and procedures, if the government chooses to do so. With this bill, the government has clearly chosen to go in a different direction by seeking to expand privatization of hospital services to for-profit entities. This is a political choice that is not in the best interest of Ontarians or our health care system.

This government is going down a dangerous path. Health care workers, unions, community groups and the media have all warned of the downsides of privatized health care services. For example, there is a significant concern around private clinics upselling patients for services. This includes payments that accompany common procedures like cataract surgeries, MRIs and diagnostic services. While one section of the legislation requires private clinic applicants to describe uninsured services, charges for these services and the planned method of obtaining consent, this reporting requirement does not ensure accountability for service providers. This legislation does not prevent the predatory practice of upselling and does not set any standards regarding the upselling of services. This would leave Ontarians financially vulnerable when receiving services from a for-profit, private clinic.

As this government pushes resources towards private clinics, there will be a negative impact on human resources, especially with the public system. With the expansion of privately delivered services, there will be more competition for skilled workers across two different systems amid a staff shortage across the health care sector. Several organizations and regulatory bodies for health professionals have pointed out that the private expansion will create challenges for hospitals which already are struggling to keep up with patient volumes. We cannot afford to siphon critical care workers away from our public system.

We also need to talk about profit. Instead of public funding going to services provided within our public system, this legislation is further enabling public tax dollars to line the pockets of private clinic owners. With profit as a motive, the reliance on private clinics will create more inefficiencies in our health care system. Profit motives inevitably lead to cost-cutting measures. That could include reducing staff or other measures that impact quality of care. Profit motives will also lead to Ontarians paying more through their tax dollars or through the upselling of services.

Bill 60 raises some very concerning questions around public accountability for service providers. Section 3 of the legislation enables the minister to appoint a director who "may be an individual or ... entity." This is a notable departure from the current requirement for the director to be an employee of the ministry. This outside individual or entity is being given vast powers to approve new private clinics and licences; however, a third-party director would not be subject to the conflict of interest and ethics guidelines for public servants. They would not be subject to requirements related to financial disclosure or public access to information.

Unlike the existing legislation, section 5 of Bill 60 would give the director sole discretion over the approval of private clinic licences. There would be no requirement for the minister to make a determination in this process, and thus these decisions would not be subject to public notice nor require cabinet approval.

The Acting Chair (Mrs. Lisa Gretzky): One minute.

Ms. Kelly-Anne Orr: Bill 60 does not contain provisions for public oversight by elected representatives. For example, there is no measure related to public notices, requirements for cabinet approval or a notice period. In other words, this legislation will enable the rapid expansion for private clinics with very little oversight for public consultation.

The lack of transparency around private clinics is very concerning in this legislation. Section 19 of the bill states that the information related to licence application will remain confidential and not available through the public freedom-of-information legislation. This exemption for licensed applicants from public access to information is harmful to the integrity of our health care system.

With these measures, there will be no avenue for the public to challenge a licensed applicant, nor will the public know who has applied and what services are being outsourced to private clinics.

In general, there appears to be no public—

The Acting Chair (Mrs. Lisa Gretzky): Thank you. Sorry, that's your time.

Up next is the—I'm going to try this—Coalition de la santé d'Ottawa. Was that close?

M. Ed Cashman: Oui, merci. Je m'appelle Ed Cashman et je représente la Coalition de la santé d'Ottawa. Mesdames et messieurs les députés, madame la Présidente, permettez-moi d'abord de vous souhaiter bonne fête internationale de la Francophonie.

Le danger d'être le dernier à parler, c'est que les bons points ont déjà été soulignés. Je ne veux pas me répéter. Par contre, je veux me concentrer sur des exemples concrets à Ottawa. Les trois grandes préoccupations pour nous, c'est le manque de qualité, le manque de surveillance et les problèmes de dotation.

Alors, les exemples à Ottawa : depuis peu, nous connaissons trois cliniques privées qui se sont ouvertes bien avant que cette loi soit adoptée. D'ailleurs, je dois me poser la question, pourquoi êtes-vous là si M^{me} Jones et M. Ford se permettent d'agir comme si la loi existait déjà? Ces trois cliniques sont Academic Orthopedic Surgical Associates

au campus Riverside de l'Hôpital d'Ottawa, Herzig Eye Institute sur le boulevard St. Laurent à Ottawa et Focus Eye Centre sur l'avenue Carling, également à Ottawa.

Dans ces trois cas, de l'argent public a été alloué pour des services publics, mais dans des cliniques privées. Aucun détail n'a été partagé avec le public. Le public a le droit d'être au courant de la dépense de l'argent des contribuables. Dans le milieu de santé, il existe une expression : on dit toujours que la transparence, c'est le meilleur désinfectant. Et nous n'avons pas de désinfectant dans ce cas.

Alors, ce projet de loi aurait des conséquences négatives sur les hôpitaux en région. Pour ceux de vous qui représentent les régions, vous avez à vous inquiéter.

Permettez-moi de vous expliquer un petit projet que nous avons entrepris dans notre région. En utilisant la loi sur l'accès à l'information publique, nous avons déposé des demandes auprès de 14 hôpitaux publics à Ottawa et dans l'est de l'Ontario. J'aimerais partager avec vous quelques exemples. Dans le cas de l'Hôpital Montfort à Ottawa, l'Hôpital Montfort nous confirme que 92 % des chirurgies ont lieu du lundi au vendredi de 9 h à 17 h. Très peu de chirurgies ont lieu le soir. Aucune chirurgie n'a lieu le week-end. Je précise que Montfort, bastion fier de la communauté francophone en Ontario, a été réduit à une vulgaire clinique de jour.

Je veux aussi vous parler des hôpitaux—monsieur Jordan et monsieur Quinn, dans vos régions. Je parle des hôpitaux de Kemptville et de Winchester. Ces hôpitaux ont réussi à garder leurs portes ouvertes parce qu'ils utilisent la surcharge de travail de l'Hôpital d'Ottawa, et s'ils risquent de perdre ce chiffre d'affaires, vous risquez de voir Kemptville et Winchester fermer leurs portes. Alors, comment allez-vous pouvoir retourner dans vos comtés et expliquer à vos électeurs que vous avez permis à ces hôpitaux de fermer leurs portes?

La perte de 50 % des chirurgies aura un impact négatif sur plusieurs hôpitaux à travers la province. La perte de ces chirurgies aura aussi un impact négatif sur le niveau de dotation des hôpitaux en région. Les gens viendront vers les grandes villes pour trouver les emplois meilleurs qui paient plus. Les communautés de Kemptville et de Winchester, dans l'exemple d'Ottawa, ont travaillé très fort sur de longues années pour bâtir et assurer la survie de leurs hôpitaux. Maintenant, ils risquent de tout perdre.

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On a vu cette semaine une belle annonce du gouvernement Ford et du ministre Clark. De l'équipement MRI sera prochainement alloué à Smiths Falls et à Brockville. C'est une excellente nouvelle pour ces communautés. C'est le genre de bonne nouvelle qu'il faut avoir davantage.

On a vu la semaine dernière et la semaine d'avant le ministre de la Santé fédéral, Jean-Yves Duclos, envoyer une lettre à la ministre, M^me^ Jones, lui donnant un rappel à l'ordre sur la Loi canadienne sur la santé pour ces services privés.

Nous constatons un manque flagrant de normes dans ce projet de loi. Aucune mention d'inspections. Aucune mention de normes de qualité. Aucune mention de surveillance. On a vu l'exemple des soins de longue durée, tristement et tragiquement, mais aussi de la privatisation dans les soins à domicile dans cette province. Ne laissez pas ce qui est arrivé aux foyers de longue durée ni aux soins à domicile se répandre aux réseaux pour les hôpitaux publics.

The Acting Chair (Mrs. Lisa Gretzky): Merci. Now we'll begin the rotations for questions, starting with the independent member, MPP Shamji.

Mr. Adil Shamji: My first question is to Ms. Coates. You finished your deputation by saying that Bill 60 is not the answer to the crisis in our health care system. Could I invite you to articulate what you think are the solutions?

Ms. Patty Coates: Thank you for that question. I also have Thevaki here, so Thevaki, feel free to jump in. The solution is to properly and adequately fund our hospitals and our health care system now. We know that they've been underfunded. We know that they need resources, they need staffing, retention of our health care workers—those are the things we need in our health care system. We've talked to many of our members, we know the crisis that is happening, but on top of that, a lot of Ontarians do not want their tax dollars to go to for-profit companies and organizations and clinics.

Thevaki, do you want to add to that? Please feel free to.

Ms. Thevaki Thevaratnam: Sure. So as Patty mentioned, the issue right now is that every hospital in Ontario has operating rooms that aren't being used in the evenings or on the weekends or that are closed for weeks or months per year, or that are permanently closed. And as she said, this is a political choice because Ontario funds its hospitals at the lowest rate in Canada. In 2019-20, more than a third of Ontario hospitals failed to use their operating rooms for 90% of their available time because of a lack of funding and qualified staff. And also, in a 2022 internal government document, it shows that surgeons were only completing about 80% of the non-urgent procedures they did before COVID-19.

So instead of using the operating rooms that Ontarians paid for, the government wants to rebuild them in private, for-profit clinics at a significant public expense. We don't need to do that. We should use the operating rooms that we already have, because the reality is it's about how you choose to spend the money, and the government isn't making the right choices.

Mr. Adil Shamji: Thank you very much. And thank you also to the important work that your members do in supporting our health care system and our economy.

Ms. Orr, I wonder if I could ask you a question. Thank you, also, for the important work of your members. As you mentioned, Unifor is the largest private sector union in Canada—I think something like 68,000 members in Ontario, roughly—with an unparalleled view on the ground of some of the challenges that we face in especially private health care. I was wondering if you could share any of the experiences that your members may have noted in long-term-care homes or in any of the other places that they work in health care.

Ms. Kelly-Anne Orr: Thank you for the question. Certainly, we have members in long-term-care homes that are municipally run, not-for-profit, as well as for-profit. Of

course, during COVID, we saw significant staffing shortages, but this happens all the time in long-term care. There is no minimum standard of care, so we see the—

The Acting Speaker (Mrs. Lisa Gretzky): One minute.

Ms. Kelly-Anne Orr: —especially the for-profit corporations, they don't replace staff. They work too short before they start calling in people. Our members are left to continue to get the same people up—so they're very overworked, and the overtime is unbelievably hard for them. They want people on the ground to help them.

Mike, can you add anything to that?

Mr. Mike Yam: Yes. I think the lessons from long-term-care privatization really should be taken into account here. We've seen the devastating impact over COVID and the differential impact between COVID deaths in for-profit homes versus those in government-run or not-for-profit homes. It's pretty much a given, where there's profit, these corporations—

The Acting Speaker (Mrs. Lisa Gretzky): Thank you. Sorry, that's all the time to answer that question.

We're going to move on to the government side. MPP Rae.

Mr. Matthew Rae: Thank you to all the presenters. Merci beaucoup aussi to my colleague.

My question is for the Ontario Federation of Labour. You mentioned the Ottawa clinic—the partnership. Just to highlight for the record, they'll do 120 OHIP-covered joint replacement surgeries in their four-month program. My question is simple: Why do you think those individuals who require these surgeries should have to wait?

Ms. Patty Coates: Thank you very much for the question.

It's not a matter of waiting. What we're saying is that these should not be farmed out to for-profit companies; it should be done in the hospitals or in conjunction with the hospitals, integrated with the hospitals, and I know the doctors who have spoken before today have also said the same thing. It's about keeping our tax dollars in our public system and not going to for-profit, because we know that drains the system. That will mean that our hospitals will get less funding and they will then, of course, have to lay off staff. That's already happening now in community hospitals. At Stevenson Memorial in Alliston, they're laying off 12 nurses because they don't have the funding from the government that they need to keep the hospital running. So it's about where the dollars go. It's about the choices that are made: publicly funded health care versus private for-profit health care.

Thevaki, if you'd like to add to that, please do so.

Ms. Thevaki Thevaratnam: Thank you. I totally agree with what Patty just said, and I want to reiterate that the premise that wait times are actually faster in private, for-profit care is a misconception. That argument doesn't hold. The latest data from CIHI shows that Ontario actually had the shortest waiting times in Canada for hip and knee replacement surgeries in 2021-22; 73% of Ontario patients received knee replacement surgeries within six months, but when you compare it to patients from provinces outsourcing surgeries to for-profit clinics, they waited longer—in Alberta, only 53% of patients received knee replacement surgeries within six months, and in Quebec, it was 48%. So to reiterate, the premise that for-profit care is better or faster is simply not true. In fact, it's more dangerous, and you end up waiting longer.

The Acting Speaker (Mrs. Lisa Gretzky): Any additional questions from the government side? MPP Martin.

M^me^ Robin Martin: Monsieur Cashman, je vais essayer de demander une question en français parce que c'est le jour pour ça. Savez-vous que le gouvernement a fait des investissements récemment en 49 machines d'imagerie magnétique dans les hôpitaux ruraux, même dans les circonscriptions des membres de Perth–Wellington et aussi Lennox and Addington?

1630

M. Ed Cashman: Oui, je suis au courant, et d'ailleurs, j'ai cité dans ma présentation les exemples de Smiths Falls et de Brockville. Ce sont des projets à venir. Donc, ce sont de beaux projets.

M^me^ Robin Martin: Alors, le gouvernement fait des choses pour faire les investissements dans les communautés, les hôpitaux comme ça.

M. Ed Cashman: Oui, et je les félicite.

M^me^ Robin Martin: C'est tout.

The Acting Chair (Mrs. Lisa Gretzky): Any additional questions from the government side? You still have three minutes left. MPP Martin.

Mrs. Robin Martin: For Patty Coates, are you aware that the government provided almost a billion dollars to hospitals to help recover from the surgical wait-list backlog? The minister had given evidence this morning that the hospitals have not used all of that funding, that it's still available to hospitals should they be able to use the funding to operate their operating rooms on weekends or evenings to help move that backlog. Are you aware of that?

I can't hear you. Sorry, Ms. Coates. Maybe you're on mute.

Ms. Patty Coates: Thank you. Yes, I was muted.

Again, I will call on Thevaki, because Thevaki has our numbers. But we know that overall, Ontario funds our hospitals per patient lower than any other jurisdiction in Canada, whether it's provincial or territorial.

Now I'll pass it over to Thevaki to add more to that.

Ms. Thevaki Thevaratnam: Thanks, Patty. I'm not sure if the member is aware of an FAO report that came out recently on health care spending—

Mrs. Robin Martin: Thank you. The member is aware of the FAO report—

Ms. Thevaki Thevaratnam: I'm sorry; I thought it was my turn to speak.

Mrs. Robin Martin: What I had asked about was not the FAO's predictions of what the government might do in the future, which is what that report says. My only question to the witness—and she can pass it to the other witness. My only question is, are you aware that the government provided, almost at the beginning of COVID and continues to provide, a billion dollars to hospitals to run their operating rooms more so they can help clear the

surgical backlog and that hospitals have not spent the money, as the minister said this morning in evidence, to do that?

Ms. Thevaki Thevaratnam: But you recognize that it's $21.3 billion—

Mrs. Robin Martin: I'm not asking about that; I'm asking about the billion dollars. Can you just answer that question?

Ms. Thevaki Thevaratnam: No, but I think we have to talk about the difference in the numbers, right? You're talking about—

Mrs. Robin Martin: But you're talking about a future prediction.

Can you just direct the witness to answer the question, Chair?

The Acting Chair (Mrs. Lisa Gretzky): I believe she's trying to answer the question.

Ms. Thevaki Thevaratnam: May I speak?

Mrs. Robin Martin: Are you aware of the billion dollars that the government gave to hospitals to run their surgical facilities on evenings and weekends at the beginning of COVID and continues to provide? And are you aware that hospitals have not used all of that funding, and therefore we still have a surgical backlog of some 207,000 cases?

Ms. Thevaki Thevaratnam: As Patty mentioned at the onset of the deputation, the reason we have a backlog, which is a manufactured crisis, is partly because of provincial funding. But it's also—

Mrs. Robin Martin: Thank you. I don't want your theories as to why we have a backlog. I wanted to know if you're aware of the government funding.

Ms. Thevaki Thevaratnam: I'm speaking—

The Acting Chair (Mrs. Lisa Gretzky): I'm going to ask all members to be respectful when speaking to the witnesses. Watch what you say and how you say it.

Mrs. Robin Martin: Was I disrespectful? I said, "Thank you."

Ms. Thevaki Thevaratnam: I'm just simply trying to say that there is a staffing crisis in this province, and Bill 124 is the reason for it. When you cap wages for nurses at 1%—

Mrs. Robin Martin: Thank you. I don't want any more information from the witness.

The Acting Chair (Mrs. Lisa Gretzky): There are five seconds left.

We'll move on to the official opposition. MPP West.

MPP Jamie West: Did you want to start?

The Acting Chair (Mrs. Lisa Gretzky): MPP Gates.

Mr. Wayne Gates: I apologize that you weren't allowed to tell the truth on what's going on in our hospitals. But I want to ask a couple of questions to both the Ontario Federation of Labour and UNIFOR. I agree enough is enough, by the way. I thought I'd get that out as well.

I'm going to ask Patty first. How many members do you represent?

Ms. Patty Coates: We represent over a million workers, many that are in the health care sector.

Mr. Wayne Gates: Knowing how this bill is going to change health care maybe forever if it gets passed, I would think that you, representing at least a million members—I think it's 1.2 million, in that area—in every sector of the economy, but lots in health care, had lots of consultation with this government. So maybe you can explain what those meetings were like and give us a little input on how much consultation you got from the Conservative government on Bill 60.

Ms. Patty Coates: I appreciate your question. As the president of the Ontario Federation of Labour, I have on many, many, many occasions asked for meetings with the Premier, with this government, with the Minister of Labour, and in five years have yet to be able to meet. We've never been invited to any consultations. There have never been any consultations with front-line workers in the health care system.

Mr. Wayne Gates: I appreciate that. I saw some bill come across my table while I've been sitting up here for the last number of years—there's a bill that's called Working for Workers. You would think—and again, I'm just guessing—that if the government is working for workers, they would talk to the Ontario Federation of Labour on important legislation that is being discussed at Queen's Park. I'm really, really sorry that they've chosen not to speak to you for such a long period of time.

I'll turn my question over to Kelly-Anne Orr. You represent over 315,000 members across the country and 68,000 here in the province of Ontario, many in long-term care. So I'm going to ask you a question that I think is fair and reasonable, and I'm sure you'll have a different answer than Patty did.

Knowing the size of your union and how important your union is to health care, whether it be in long-term care, not-for-profit, retirement homes, home care, how many times has the Conservative government reached out to your union to talk about Bill 60, on something that's going to change our workforce for maybe generations if it goes through?

Ms. Kelly-Anne Orr: Never.

Mr. Wayne Gates: Let me get this straight: You represent over a million workers, and you represent 315,000 from coast to coast to coast and 68,000 here, and this government has chosen not to talk to any of you over an important bill like Bill 60? That's correct?

Ms. Kelly-Anne Orr: Yes, that's correct.

Mr. Wayne Gates: Wow. It's not surprising. You would think that a government that stands up in this House on a daily basis—the labour minister, Monte McNaughton, says he's working for workers, yet he has never talked to you. That's absolutely terrible. I just want to be very clear.

I'm going to ask the two of you another question—because I think you know. You both represent long-term-care facilities. We had 5,400 of our moms, our dads, our grandparents, our aunts and uncles die in long-term care, and 78% of those died in for-profit long-term care. For-profit was brought in under the Harris government, I think around the 2000s. Here, we've had an example, to say, "How does profit work? Is it going to be better for our

moms, our dads, our seniors who are getting older?" When you have 5,400 of them die, would that not be a good example where you could say, "Why would we ever want to privatize our publicly funded, publicly delivered health care?" It makes absolutely no sense to me. So I'm going to ask—because I heard some of the questions over here talk about staffing levels and why you're not operating your operating rooms. Well, you're not operating because there's no staff. They were taking staff and, quite frankly, closing down operating rooms so they could operate their emergency rooms, and closing urgent care centres—they're doing all kinds of that. The number one thing that I think caused all that—and I'd like the two of you guys to answer that—is Bill 124.

So maybe the two of you can answer how Bill 124 has affected our hospitals, our outcomes in our hospitals. Really, at the end of the day, Bill 124, because there wasn't enough staffing—I believe that a number of our parents, grandparents and them could still be alive today if we had staffing, and I think Bill 124 is the biggest question. So please answer that. I appreciate it.

Ms. Patty Coates: Thank you for that question.

1640

Just yesterday, I spoke to a number of workers who worked in long-term care—and I hope that I don't tear up, because their stories are horrific.

I also know the health care system intimately. I have a mother who is in her eighties, and I often have to take her to the emerg for her conditions. I talk to the nurses, I talk to the health care staff, and I hear their pleas. Many of them are on the brink of a mental health breakdown. They're doing double and triple shifts. There was one person who retired and has come back. People are retiring, and they're leaving for other professions where they are respected and there's dignity. They're moving to the States or other countries. These are the stories that we hear every single day from the front-line workers. Bill 124 has had a huge impact on this.

Let's also remember, this government talks about—

The Acting Chair (Mrs. Lisa Gretzky): One minute.

Ms. Patty Coates: —how they're responsible for taxpayers' dollars, but they're spending taxpayers' dollars to appeal Bill 124. That's millions of dollars that are going to the court case. They could be putting that back into the health care system, back into the long-term-care system. That is what needs to happen.

That's why we're here; that's why we're so passionate about this—because health care affects every single one of us at many, many points in our lives.

The Acting Chair (Mrs. Lisa Gretzky): You have 25 seconds.

MPP Jamie West: I'll wait till the next round.

The Acting Chair (Mrs. Lisa Gretzky): Moving to the independent: MPP Shamji.

M. Adil Shamji: J'ai une question pour M. Cashman.

Forgive me; my French is not strong enough to ask the question in French. If there are challenges in health care access in the province for those of us who speak English, I know that the challenges are only greater for those who are francophone. Does Bill 60 help those individuals, and if not, what could be solutions that would be better?

M. Ed Cashman: Non, le projet de loi 60 n'aide pas. D'ailleurs, c'est le contraire. Le projet de loi causera des problèmes pour les communautés francophones à travers la province parce que les services des minorités et les services en région sont menacés par ce projet de loi.

Mr. Adil Shamji: Merci.

Ms. Orr or Ms. Coates, can I ask you to expand a little bit about concerns on upselling or up-charging, which we've heard quite a bit about?

Ms. Kelly-Anne Orr: Again, I can speak to what happens now, for example, at the Shouldice clinic. I think it was Premier Ford who gave an example about the Shouldice clinic and the fact that it's free. It's not free. The surgery is free, but if you don't have private coverage or semi-private coverage, you have to pay out of pocket. The Shouldice clinic also makes you stay a minimum of three days, if not five days. That is a cost to the taxpayers' dollars, because all that is billed to the government. If you go to the hospital to have hernia surgery, you are in in the morning and out that evening. But at the Shouldice clinic, you have to stay a minimum of three to five days, so that's all nursing and doctors' care that you're under, so that's billed to the government. Also, it's discriminatory, at the Shouldice clinic, because you have to be healthy. You can't have any underlying conditions. You can't be a diabetic. You have to be a certain weight in order to have the surgery. And if there are complications in any way during your surgery, you'll wake up in a hospital, because they'll only deal with your hernia. They cannot deal with—if you have a possible stroke on the table, you'll wake up in a hospital. So that's upselling. I can get in quicker if I pay for private coverage—$350 for a semi-private room. I don't know what a private room would cost—$600? If I have ward coverage, I'm paying that out of pocket, and you multiply that times five. That's the upselling, and that's what we're worried about.

My father paid $1,500 for cataract surgery—83 years old—because they thought maybe it would help his vision. He has macular degeneration, and he had to pay $1,500 for that service in Kitchener.

Mr. Adil Shamji: Thank you.

The Acting Chair (Mrs. Lisa Gretzky): One minute.

Mr. Adil Shamji: Ms. Coates, did you want to add anything?

Ms. Patty Coates: I agree with the previous speaker. We're hearing of a number of upselling, and that's a concern, especially for cataract surgery, for elderly people who may not really understand which lens is best for them, what procedures are best for them.

There's also the concern about some diagnostic tests or even blood work that is not covered under OHIP. This whole idea of "You just use your OHIP card"—we know that these clinics have to make profits. That's all part of it. That's what happened in long-term care during COVID. Saying that they purchased PPE—yes, they purchased PPE, but it's sitting in a locked closet, and you're only allowed to have one set per shift—

The Acting Chair (Mrs. Lisa Gretzky): Thank you. That's all the time to answer that question. Moving to the government side, MPP Martin.

Mrs. Robin Martin: Thank you. I'll just ask Ms. Jansen a couple of questions. Ms. Jansen, you were talking about Shouldice earlier. Are you—sorry, is that your last name? It says here, "Kelly Jansen." Sorry, what is your last name?

Ms. Kelly-Anne Orr: Orr.

Mrs. Robin Martin: Orr. I'm sorry; I couldn't see. My apologies. All I had was "Kelly." It's Kelly Orr.

So you were talking about the Shouldice example. Are you aware that Shouldice is a private hospital, not an independent health facility?

Ms. Kelly-Anne Orr: Yes, I'm aware.

Mrs. Robin Martin: Okay. So you're aware that Bill 60 does not apply private hospitals, that it just applies to independent health facilities and the future integrated community clinics?

Ms. Kelly-Anne Orr: Yes. I think the question was about upselling though, and that was an example.

Mrs. Robin Martin: But it doesn't apply to this bill. Okay. Thank you.

The Acting Chair (Mrs. Lisa Gretzky): Any other questions from the government side? You have six and a half minutes. No? Okay.

We'll move back to the official opposition. MPP Gélinas?

M^me^ France Gélinas: I would like to thank the Ontario Federation of Labour as well as Unifor for their presentations.

Je vais commencer avec vous, monsieur Cashman. Lorsque vous avez fait votre présentation, vous avez commencé en nous disant que le projet de loi n'adresse pas le manque de qualité, le manque de surveillance et le manque de dotation. Je suis allée sur le site de l'Hôpital d'Ottawa, puis là, je peux vous dire qu'il y a cinq postes d'infirmières en chirurgie, 26 postes d'infirmières aux soins intensifs, 51 postes d'infirmières à l'urgence, et la liste continue comme ça pour au-dessus de 400 postes.

Pensez-vous que pour nous, les francophones, une clinique privée à profit va nous aider à avoir des services en français?

M. Ed Cashman: Si vous cherchez les derniers chiffres pour l'Hôpital d'Ottawa, c'est 525, actuellement.

M^me^ France Gélinas: C'est 525, OK.

M. Ed Cashman: Uniquement au côté infirmier-infirmière. Mais votre question concernant la communauté francophone : ces cliniques privées ne seront pas assujetties aux lois et aux règlements sur le respect du français. Donc, vous pouvez imaginer que ce ne sera pas le cas non plus. Si elles ne sont pas obligées de le faire, elles ne le feront pas.

M^me^ France Gélinas: Je suis parfaitement d'accord avec vous. Vous avez également mentionné l'effet domino que ça l'aura sur les petits hôpitaux. Vous avez donné l'exemple de l'hôpital de Kemptville, l'hôpital de Winchester. Moi, je viens du nord de l'Ontario. Pensez-vous que le même scénario que vous avez décrit à Ottawa où ces deux petits hôpitaux restent ouverts parce qu'ils font des chirurgies—pensez-vous que ce scénario-là va se répéter dans d'autres régions d'Ontario?

M. Ed Cashman: Sans connaître votre région, je peux vous dire—permettez-moi de vous rappeler ce qui s'est passé dernièrement à travers la province pour les salles d'urgence. Nous avons vu beaucoup de salles d'urgence fermer, dont une à Carleton Place le week-end dernier, par manque de personnel. Ce n'est pas un phénomène unique à Ottawa. La seule différence, c'est que, drôlement, M. Ford et M^me^ Jones nous ont choisis comme cobayes pour ces projets pilotes. Donc, ça commence à Ottawa et dans l'est de l'Ontario, mais ça va se répandre parce que le modèle est là.

1650

M^me^ France Gélinas: Oui. Je dirais, pour les hôpitaux qui sont capables d'offrir des services en français, on risque de tout perdre, parce que si, eux, ils ne sont pas capables d'offrir les services en français, ça ne sera pas les cliniques privées qui vont les offrir. Qu'en pensez-vous?

M. Ed Cashman: Non, exactement.

M^me^ France Gélinas: Mon collègue Jamie West a d'autres questions.

The Acting Chair (Mrs. Lisa Gretzky): MPP West.

MPP Jamie West: Thank you to everyone who has presented today. Just because of the limited time, I'm going to start with Ms. Orr. Thank you for your deputation and speaking to us today.

We have had a lot of conversations about long-term care, and one of your members in my riding, Melissa Wood—I met her more than 10 years ago when Unifor was doing the six-minute challenge, the hard work that PSWs do, and can you get ready in six minutes? That was a long, long time before now. So when people talk about for-profit long-term care, they don't really see it as saving long-term care. What I hear a lot is that a lot of people got rich and care got worse.

My colleague Mr. Gates talked about 5,400 deaths and 78% in private long-term care. That reminded me that the RCMP had to come in and help with long-term care during COVID-19. I cannot, for the life of me, imagine why we'd want to take a model that has failed that badly in health care and duplicate it in a health care system with private clinics. There is no line that I can see in there. Is there anything outside of "a lot of people will get rich" that you can think of?

Ms. Kelly-Anne Orr: Well, yes, a lot of people will get rich. The other thing is that the Premier has allowed that home to have a 30-year licence and expand their building. So there was no accountability, no recourse. Mike, help me out here, if you've got anything else to add.

Other than the rich getting richer, it certainly doesn't help the workers, because I know lots of people in the for-profit nursing homes that are leaving in droves, and they're not leaving because they don't love their jobs or they can't handle their jobs. They're leaving because they're fed up with being unable to do their jobs properly.

I'm an RPN; I was a PSW and went back to school and got my RPN. There's this model that you learn in school on how you're supposed to take care of patients properly.

But when you get into the private, for-profit long-term-care business, it's not like that. A reality is hit and that's why people are leaving. It's not like working in a factory where you make widgets and if somebody doesn't show up to work, you make less. You've still got to get 30 people out of bed and feed them and dress them and care for them each and every day, and so if you work short, you have to just work harder to get those people up. And things get missed.

MPP Jamie West: During the March break, I shadowed some workers in long-term care and one of them talked about moving from PSWs to the cleaning facility because she said you had more time to spend with the members they took care of and able to talk to them and hold their hand, so it resonates with me.

President Coates, I saw you nodding your head while she was speaking. MPP Gates talked about how there's been no consultation with the OFL or Unifor, very large worker representative organizations, for these bills—and I know from conversations we've had, for any bills related to workers, as well.

Now, one of the things we hear about very often is the government will stand up and answer every question with, "You will pay with your OHIP card." What I hear in that is there's OHIP, a giant piggy bank, and now people who are wealthy will have access to it because—as I hear these stories about the overcharging and the upselling—you will pay with your OHIP card. Does this make sense to either of you as a financial model, where you'll be able to pay nurses twice as much for a private clinic, or there will be upselling, or that—

The Acting Chair (Mrs. Lisa Gretzky): One minute.

MPP Jamie West: —the more expensive cataracts will be charged, but you'll pay with OHIP? Does this make any sense to you in terms of providing more and better care to the people of Ontario?

Ms. Patty Coates: Thank you very much, MPP West, for your question. I don't think it will. Again, these are our public tax dollars. I'm a taxpayer. Many, many Ontarians are taxpayers and they don't want their tax dollars going to a corporation that finds themselves in the stock exchange. That's not what universal health care is about. That is not the intent of our health care system in Canada or even in Ontario. We need to keep it public. That's what citizens want. There was no mandate with this election to privatize our health care system in any form at all. And I can only see this getting worse and worse. The minute we give an inch, they're going to take a mile. We saw what happened in long-term care—

The Acting Speaker (Mrs. Lisa Gretzky): Thank you. That's all the time that we have for a response.

I'd like to thank all of the presenters for your participation today. If you would like to submit any written materials to the committee in addition to your presentation that you did today, the deadline for written submissions is 7 p.m. Eastern Daylight Time on Monday, March 27, 2023. Thank you all again for your time.

We're just waiting to see if maybe all of the 5 o'clock presenters are here already and we can start five minutes early.

1700

SE HEALTH
INDIGENOUS PRIMARY HEALTH CARE COUNCIL
ONTARIO FEDERATION OF INDIGENOUS FRIENDSHIP CENTRES

The Acting Speaker (Mrs. Lisa Gretzky): All of the presenters are here in the room already, so we're going to go ahead. If the presenters can come take a seat, please.

I'll call on SE Health, Indigenous Primary Health Care Council and Ontario Federation of Indigenous Friendship Centres. If all of you can come forward and sit at the table. I want to welcome all of you. As a reminder, each of you will have seven minutes to make your presentations followed by questions from the committee members. So each of you will get to do your seven minutes, and then we'll do the question rotation throughout the committee.

I will provide reminders about the time. Usually, at about the one-minute mark, you will hear me say, "One minute," and that's so you know to try to get in the last of your thoughts to wrap it up.

Before you formally begin your presentation, please state your name so that Hansard has it on the record.

I just want to point out to the committee members so that I don't forget when we get to this point, the Indigenous Primary Health Care Council and Ontario Federation of Indigenous Friendship Centres did provide print copies of their submission. If you didn't get one, just let the Clerk know, and we'll get one to you.

I'm going to start off with SE Health.

Mr. John Yip: My name is John Yip. I'm the president and CEO of SE Health, formerly known as Saint Elizabeth Health Care.

SE Health is a national not-for-profit social enterprise that employs 8,000 staff across Canada. Founded over 115 years ago, our purpose is to bring hope and happiness to the people we serve. SE Health operates in five provinces and is a trusted partner of government, delivering health and life care services at scale. In Ontario, we provide seven million community health visits every year across 27 Ontario health teams. We provide over 20 post-surgical hospital transition programs. We help build capacity in over 500 First Nation, Inuit and Métis communities through our health career college. We're also a proud member of the Better Access Alliance, which operates Health811, Ontario's telehealth service.

As the head of a large not-for-profit care provider, SE Health believes in a fair, equitable, high-quality system of care that is underpinned by love, kindness and empathy. These are long-established core tenets of who we are at SE Health.

Based on SE Health's knowledge of the national landscape, I'm here to say that Bill 60 is a good start in

eliminating Ontario's surgical backlogs. We are pleased to see this government introduce significant changes to our system that will better serve Ontarians within a publicly funded system. Overall, this bill sets up a good framework to create a system of surgical care that is patient-centred and promotes patient choice.

I do believe I am uniquely positioned to comment on Bill 60 given my previous role as the president and CEO of Kensington Health, a not-for-profit independent health facility which provides over 20,000 procedures in a non-hospital community setting. I've seen first-hand how community-based surgical services can be done safely, efficiently and effectively while upholding the principles of the Canada Health Act.

Based on my experience and SE Health's long-standing service to Ontarians, I want to address three false myths for the benefit of the committee.

Myth number 1: These surgi-centres will work outside of the publicly funded health care system. Bill 60 emphasizes that these new community surgical centres will work within, not outside, the health care system. There is a tremendous opportunity to innovate surgical services in a region to allow for greater equitable access. Take, for example, the ability to create a centralized electronic referral system. Today, one referring physician refers to a preferred surgeon by fax. A future system could be where one primary care physician can refer to multiple surgeons in their local area electronically.

In addition, a centralized wait-list management system can level-set current inequities by evenly distributing surgical volume across many surgeons who may have a shorter wait-list. There is an ability to pool all the available surgical resources in each community to allow for patient choice. For example, patients can choose to wait six months for their preferred surgeon in a hospital or wait a shorter length of time with a different surgeon operating in a surgi-centre. That choice does not exist today. Give patients a choice.

Myth number 2: Non-hospital surgi-centres need to be governed by hospitals. Non-hospital surgical centres do not need to be governed by their local hospitals, but can effectively partner with them. Surgi-centres would benefit by being independently governed by a volunteer board, like we do at SE Health, that is separate and distinct from a hospital. Being autonomous and independently governed allows surgi-centres to be solely focused on delivering on a narrow set of procedures. These centres can be agile and nimble enough to deliver the highest quality of care without being encumbered by the complexity of hospital operations.

In addition, these surgi-centres do not need hospitals to grant physician privileges. By doing this, this would eliminate many surgeons who are not privileged at their local hospitals or who choose not to work at a hospital. This negatively impacts new surgical graduates who cannot get staff positions. In the current health human resources crunch, eliminating a proportion of the surgical workforce would add to, not help, with the crisis.

However, surgi-centres should partner with hospitals. But let each surgical centre determine what is the best way to partner in their local communities based on their needs—for example, coming up with a regional health human resources plan, sharing of best practices in infection protection and control, resource allocation of existing procedures and considering a broader range of procedures that can be done in non-hospital environments.

Myth 3: Bill 60 will create further inequities. Many people face health access inequities across the province.

The Acting Chair (Mrs. Lisa Gretzky): One minute.

Mr. John Yip: We are aware of the concerns that the bill may widen the health care access gap. We share this concern. We acknowledge that without government's continued focus to address these gaps, this myth may indeed be a reality.

SE Health has had a long-standing commitment to support solutions that reduce barriers and close the gap. We fully support the priority for surgi-centres to be in communities that are underserviced or have long wait times for much-needed surgical and diagnostic procedures.

Take, for example, our Indigenous communities. We believe Indigenous health should be in Indigenous hands. We have seen other provinces, such as Alberta and Saskatchewan, where there are emerging models that are Indigenous-led, designed and delivered. I see there are representatives beside me from these communities here today, and SE Health would be honoured and privileged to collaborate with your organizations to better serve your communities.

In closing, as a not-for-profit, our organization has a strong track record of high-quality, safe, efficient—

The Acting Chair (Mrs. Lisa Gretzky): Thank you. Sorry. The time is up.

Next up is Indigenous Primary Health Care Council. Please remember to state your name before your presentation.

Ms. Victoria Marchand: Victoria Marchand. Do I start now?

The Acting Chair (Mrs. Lisa Gretzky): Yes.

Ms. Victoria Marchand: Wonderful.

Kwey kakina kaye mino kijigad. Good afternoon, everyone and members of the committee.

Remarks in Anishinaabemowin.

My name is Victoria Marchand and I work as the health policy manager with the Indigenous Primary Health Care Council. IPHCC is an Indigenous-governed and Indigenous-informed organization. We currently work with 21 Indigenous primary health care organizations across Ontario to prioritize and support the advancement of Indigenous primary health care in the province. Today, we welcome the opportunity to speak to you about Bill 60.

First, we appreciate the provincial government's efforts to create a more connected health care system which prioritizes more convenient care for patients closer to home. IPHCC's member organizations across the province must innovate every single day to meet growing demands with insufficient resources, and these growing inequities must be addressed in this bill.

At this time, IPHCC is very concerned that if this bill passes without important questions and considerations addressed, health disparities will continue to disproportionately impact Indigenous peoples. Specific concerns that must be addressed prior to passing this legislation include: There is absolutely no mention of Indigenous nor First Nations, Métis or Inuit within this act. There is no mention of Indigenous cultural safety. There is no acknowledgement of traditional Indigenous health practices. These are all further detriments to Indigenous self-determination in itself.

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It is also not clear how these amendments will reflect the jurisdictional realities of First Nations like myself living on territory or on-reserve. We do have both bilateral and trilateral agreements that have been signed between federal, provincial and Indigenous governments, which include legal commitments to Indigenous health. These agreements should be reflected in Bill 60.

Prior to making any decisions with respect to passing this bill, IPHCC urges the provincial government to make amendments and commitments that will safeguard and improve our publicly funded system and ultimately save lives.

First, the preamble must include explicit language to address Indigenous peoples and the ability to be involved with the planning, design, delivery and evaluation of health services, also consistent with Ontario's own Connecting Care Act. Additionally, we must consistently include Indigenous traditional healing practices as a main pillar of health care.

Second, the definition of "integrated community health service centres" must be amended and limited to surgical and diagnostic centres. The current draft legislation is very broad and provides the government with significant powers to develop ICHSCs to a more significant level in the future. So we are asking the government to strike out "health facility, including a" from schedule 1 and expand on a definition of "class of health facilities."

Third, the bill and any regulations should include language about the director to be experienced and committed to applying health equity and anti-racism within their lens and within the role.

Fourth, the list of required contents in the licence application must include considerations to address Indigenous health equity, Indigenous patient experience and provisions to culturally safe care before a licence can be approved.

Fifth, the complaints process must include additional language describing a clear, inclusive and culturally safe process, ensuring adequate protocols and resources to address these complaints from Indigenous people. They are Indigenous patients that we need to care about.

And finally, IPHCC wishes to remind the committee about the duty to consult. As per Ontario's own provincial law, "Ontario, as the crown, has a legal obligation to consult with Aboriginal peoples where it contemplates decisions or actions that may adversely impact asserted or established Aboriginal or treaty rights. Ontario is committed to meeting its duty to consult with First Nations and Métis communities." So not only does the duty to consult offer an opportunity for the government to build partnership with Indigenous communities, but also you have Indigenous health in Indigenous hands. We are the experts of our own care.

Any committees that impact the health of Indigenous people must include the IPHCC. We are Ontario's only organization with members providing primary health care services, on and off territory, to Indigenous peoples and their families. If we want to see positive changes towards improved health outcomes for Indigenous peoples and their communities, the government of Ontario must engage in reciprocal relationships with Indigenous people.

I'll take this moment to reflect on two stories that I know, the first being Joyce, an Atikamekw woman whose name we've heard many times over. She died almost two years ago at the hands of systemic racism, a culture which many institutions inherently protect. As a result of this tragedy, Joyce's Principle was created to keep governments accountable and take a strong stance against the systemic racism lived by Indigenous people.

Second, a name you might not have heard: John Boudrias, the former Grand Chief of the Anishinabe Algonquin Nation, an Ottawa resident and my late uncle. He dealt with chronic illnesses his entire life, going in and out of hospitals, clinics, you name it, until his untimely death one year ago. He was a leader in our community. He spoke four languages. He was a brave, intelligent man, and even he was not immune to the oversaturated anti-Indigenous racism and critically underfunded system that Indigenous people continue to experience. As a result, he passed, leaving our family, our community and our entire nation behind.

Now, I recognize the important role that each of you has on this committee. With many other Indigenous people with similar stories to Joyce and my uncle John, I call on you to recognize how the lack of Indigenous inclusion and the lack of duty to consult within this legislation will exacerbate ongoing racism and deaths such as my uncle's—

The Acting Chair (Mrs. Lisa Gretzky): One minute.

Ms. Victoria Marchand: —where investments to Indigenous primary care could have saved his life.

So I say kitchi meegwetch, committee members. We understand the status quo is not working and innovative solutions are needed to address backlogs, improve safe and effective health services. There are some opportunities with this bill, but without the amendments IPHCC is putting forward, the provincial government would be failing to address what is needed. As we are calling for the crown's duty to consult, we are looking forward to the invitation to strengthen that partnership. Meegwetch.

The Acting Chair (Mrs. Lisa Gretzky): Before I move on, I just want to say that I am so sorry for your loss.

Ms. Victoria Marchand: Thank you.

The Acting Chair (Mrs. Lisa Gretzky): Next is the Ontario Federation of Indigenous Friendship Centres.

Ms. Suze Morrison: Good afternoon, committee members. My name is Suze Morrison. I'm the chief engagement officer for the Ontario Federation of Indigenous Friendship Centres. I'm here today to raise our concerns with Bill 60, a bill that will enable the privatization of Ontario's health care system.

Before I begin, I'd like to recognize Chelsea Combot, our director of policy and government relations, and Tessa Jourdain, our health policy analyst, for their excellent work preparing our written submission.

The OFIFC is a provincial organization that represents 29 friendship centres across Ontario. Friendship centres were born out of a nationwide movement and have been serving the needs of Indigenous people who live in towns, cities and rural communities for more than 50 years.

Today, 88% of all Indigenous people in the province of Ontario live in urban centres, off-reserve. This represents an overwhelming majority of the Indigenous population in the province. The friendship centres serve that population. They act as gathering places and as sites of healing, education and culture.

Friendship centres are the most significant off-reserve Indigenous service infrastructure in Ontario and, as we learned during the COVID-19 pandemic, are essential front-line service providers to urban Indigenous communities.

Friendship centres have several decades of experience in delivering a wide array of culture-based health and healing programs. They act as connectors, linking community members to preventive supports, to mainstream health care services, and to culture-based approaches to health and healing. Some friendship centres also offer primary care to ensure culturally safe access to care for their community members. As a result, friendship centres have first-hand knowledge of urban Indigenous people's experiences navigating the health care system, and experience in providing culturally appropriate care for Indigenous people in urban centres.

It's no secret that Indigenous people face significant harm within the current health care system, from medical racism to health outcomes that are far worse than the non-Indigenous population. This harm stands to substantially increase if Bill 60 is passed.

The OFIFC strongly opposes the delivery and expansion of health care services by for-profit providers as outlined in this legislation for several reasons. First, the private delivery of health care violates the statutory duty of government in its relationship with Indigenous communities and is, quite frankly, a violation of the Canada Health Act.

Second, this bill is in direct conflict with the Ontario government's own commitment to the Urban Indigenous Action Plan, which is a document I've provided as supplementary material in the packages. This legislation has been tabled without considering the impacts it will have on urban Indigenous communities and without involving Indigenous communities in co-developing solutions to health care that are responsive to community need, which really, at its core, is part of the Urban Indigenous Action Plan.

Third, the private provisions of care enabled through this legislation will have a disproportionately negative impact on urban Indigenous people, affecting access to quality and anti-racist health care, to mechanisms of accountability, and will lead to worse health outcomes.

Urban Indigenous people already experience significant racism in the health care system that is not only detrimental to health outcomes but is, quite frankly, lethal. The for-profit health care industry has no incentive to address anti-Indigenous racism. This model of care will also impede current, system-wide efforts to combat that racism through further fragmentation of service delivery between the public and private sectors. It will also reduce the ability of the health care system to address and monitor anti-Indigenous racism as well as to enforce culturally safe delivery of services.

Simply put, medical racism kills, and we know this.

I'm reminded of the death of Heather Winterstein, an Indigenous woman who died in the waiting room at the St. Catharines hospital on December 10, 2021, after being sent away the previous day in excruciating pain with nothing but Tylenol.

A year after Heather's death, Jennifer Dockstader, the executive director of the Fort Erie friendship centre, commented in the St. Catharines Standard: "Saturday is the one-year anniversary of the loss of Heather Winterstein to a treatable infection that was missed in the emergency room at the St. Catharines hospital, and we are still waiting for answers. How did a young woman present in excruciating pain and leave with a prescription for Tylenol? How did she collapse on the floor of the waiting room the next day, having been brought in by ambulance, and die so suddenly? What role does our system play in her death? What is taking so long to get answers?"

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Under Bill 60, how will racism in a private system be reported? How will that racism be responded to? What anti-Indigenous racism education will be required for these for-profit providers? We cannot further fragment and obfuscate that accountability for addressing racism in our health care system. We cannot sit by and merely hope that private providers will voluntarily prioritize anti-racism work above profits.

Next, I would like to address how Bill 60 will widen the current health disparities that urban Indigenous people already face. For-profit surgical and diagnostic centres will be motivated to treat easy-to-serve patients as quickly as possible. The risk of for-profit centres refusing and de-prioritizing treatment of urban Indigenous people due to the time that's involved to treat complex cases is a fatal risk within a privatized system. This bill does not offer any protections against the refusal of care based on the complexity of care, and the possible refusal or de-prioritization of care for urban Indigenous people is also contrary to the universality and accessibility criteria of the Canada Health Act.

Additionally, as long as Bill 60 permits the provision of uninsured services, for-profit surgical and diagnostic centres will continue to upsell patients for publicly funded procedures and surgeries. Patients will continue to be misled regarding the cost of procedures and surgeries as well as necessary add-ons. This is particularly concerning considering that 24% of Indigenous people in Ontario have low incomes in comparison to 14% of the non-Indigenous population.

The OFIFC would like to recommend to this committee that Bill 60 be withdrawn from consideration by this Legislature—

The Acting Chair (Mrs. Lisa Gretzky): One minute.

Ms. Suze Morrison: —on the grounds that it contravenes the Canada Health Act and will disproportionately negatively impact urban Indigenous people. Further, we are calling on this government to invest in strengthening the public health care system and to advance Indigenous-led initiatives to eliminate anti-Indigenous racism within our public health care system.

I'd like to thank the committee for the opportunity to present today, and hope that our significant concerns with this legislation will be thoughtfully and seriously considered.

The Acting Chair (Mrs. Lisa Gretzky): Now we'll move on to the questions. We start with the government side for seven and a half minutes. MPP Wai.

Mrs. Daisy Wai: Thank you to all three presenters. Thank you to SE Health, Mr. John Yip. I appreciate how you shared the three myths to clarify a few things for us as well. We really look forward to the hospitals and the community-based providers—how to do the integration.

One thing I'd like to check with you is, we were hearing earlier from another presenter from the OMA and they were saying that community health centres can do more procedures than the hospital ever could. I would like to hear from you and see how that has been done. And if this is true, how can we understand the situation and work together and do the integration even better?

Mr. John Yip: I would have to agree with the OMA. Take, for example, cataracts. At Kensington, about 20 procedures can be done in a day in one room. The equivalent in a hospital: 12 to 14. Turnaround time between procedures: seven minutes, 23 seconds; hospital, 45 minutes at best. So when you define a narrow set of procedures, you get really good at it. When you get really good at it, the patient outcomes are better and the cost drops. This is good for taxpayers. It's good to address the surgical backlog. We do need to address the inequities, though.

Mrs. Daisy Wai: I understand. How would you make sure that the quality is there when we use the surgical centres instead?

Mr. John Yip: Yes, there's a myth that the surgical centres will have poor quality. In fact, we know that with proper oversight from within the facility, that quality can supersede other same procedures being done in hospital. Take the infection rate for cataracts in hospital. On average, it's 2%. In a community surgical facility, it's 0.02%. Because of the narrow range, the smaller facilities, you're not co-mingling patients that are doing trauma, triple bypass heart surgery, orthopedics—all co-mingled into one set of operating rooms. You're purpose-built for those specific procedures and then can overlay a quality regimen on top.

But government does need to provide the guardrails at a provincial level to offer those clinical standards so that there are those levels of quality within the surgical centres that are on par with and similar to ones that are in the hospitals. We think that while the College of Physicians and Surgeons of Ontario may be a third party, it could be housed within Ontario Health to oversee that quality.

The Acting Chair (Mrs. Lisa Gretzky): MPP Rae.

Mr. Matthew Rae: Thank you to all the presenters for presenting. I really appreciated hearing your deputations to the committee.

My question is for SE Health and John. First, I had the opportunity to visit with one of your community care nurses in my riding, and she provides great care—I've heard from constituents there, and the fact that you're able to provide that in communities at no cost, as a non-profit, in Ontario and across Canada, as you mentioned, is great.

My question, since SE Health does operate, obviously, across Canada, is—we've heard a lot today about the human resource challenges in health care. In my riding and much of rural Ontario, this predated COVID. So I was just wondering if you could comment on how you see Bill 60 and the involvement of, potentially, SE Health or Kensington and the human resources working with the hospitals to ensure that we support those services in hospitals still but also have the human resources to do the community care clinics.

Mr. John Yip: Thanks for the question. And thanks, both of you, for visiting our nursing clinics in recent weeks. I forgot to mention that, MPP Wai.

To answer your question around the health human resources question: This is not a hospital issue. I think the media has portrayed this as a unidirectional floodgate, from hospital to community, but those of us in the community know that we've been struggling with health human resource challenges for decades and that it's a bidirectional issue. We do need to address this as a system. I know this government and governments across the country, including the federal government, are working very hard to address the challenges. At a local level, I think there are some interesting, creative opportunities to look at a system of HHR strategy. We saw a glimpse of that during COVID when the emergency orders were enacted, where hospital staff would go into long-term care, and I couldn't tell the difference—who was hospital staff, who was long-term-care staff. They were there to serve. When the orders were lifted, everyone went back into their little sectors, and we didn't see that collaboration. I think with the advent of Ontario health teams, there is an opportunity for local partners to sit down and figure this out so that we're not robbing Peter to pay Paul.

The Acting Chair (Mrs. Lisa Gretzky): MPP Martin.

Mrs. Robin Martin: Thank you to all the presenters for coming today and for giving us your input, and for the materials provided by both of the Indigenous presenters. I've learned some things here just as I was reading, so thank you, and thank you for your presentations.

I had a question for SE Health. I just wondered if you could offer us what your closing was going to be, because we cut you off as you said "in closing."

Mr. John Yip: Thanks for asking, MPP Martin. I almost got there. In my practice run, I was about six minutes and 40 seconds. For some reason, I lost 20 seconds; I don't know where that went.

The Acting Chair (Mrs. Lisa Gretzky): One minute.

Mr. John Yip: The clock is fast in the Legislature.

I was going to say that this is a great opportunity for SE Health to be part of system change. We have a history of innovation. We do care about access to care. We do believe in patient choice. We do believe in improving the system, particularly as we come out of the pandemic with a surgical backlog. Like my presenters here, we do want to be consulted. We want to be at the table to shape this groundbreaking legislation for Ontarians.

The Acting Chair (Mrs. Lisa Gretzky): You've got 18 seconds.

Mrs. Robin Martin: You keep mentioning patient choice. Can you elaborate a little bit on what you mean by that and why that's important?

Mr. John Yip: I think in our system today, patients don't have the choices that they should have. I outlined in my remarks around the surgical referral process—

The Acting Chair (Mrs. Lisa Gretzky): Thank you. Sorry, time's up again.

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Mr. John Yip: It's like the Oscars, except there's no music.

The Acting Chair (Mrs. Lisa Gretzky): It's not personal. Everybody gets cut off when the time is up.

We're going to go to the official opposition. MPP Mamakwa.

Mr. Sol Mamakwa: Meegwetch, John, Victoria and Suze, for your presentations.

I think it's important to bring up the issues of anti-racism within health care. Where I come from, in Sioux Lookout, in 1997, we still had two hospitals: a federal hospital for Indian people, and a provincial hospital for white people. And I think when we talk about the new hospital that's there, when we are off-reserve, when we live in these cities and townships, urban Indigenous—the racism, the needless deaths, the unnecessary suffering that happens, continues to happen.

Thank you, Victoria, and thank you, Suze, for the presentations.

I hope people across the way—when we talk about anti-racism, I think about if you guys are hearing or even listening or understand the issues, what these Indigenous providers are saying. I say this in a respectful way. You are all white people, and I don't know if you understand this. I don't know if you know what they mean, because oppression, colonialism is very evident, even in this room.

What are some examples of some anti-racism efforts that are not in the bill? You talk about engagement with First Nations, Indigenous people—"Indigenous-led." What does that mean for you? Can you elaborate a bit on that?

Ms. Suze Morrison: Thank you for the question.

To elaborate on the consultation process: I think my key message to this committee is to not be restrictive in your consultative approaches. It's important to be engaging with First Nations, Métis and Inuit nations and partners but to not exclude the urban Indigenous organizations that, as Sol said, are on the front lines serving community members, no matter where they live. Your rights to health care as an Indigenous person don't stop at the imagined boundary line of your reserve. You have a right to high-quality health care no matter where you live in this province as an Indigenous person. So I would say, if urban Indigenous partners are not at the table having these conversations with you before bills like this make it to the Legislature, that in itself is a miss.

In terms of the anti-racism efforts, at OFIFC we offer Indigenous cultural competency training. We are working with a number of public sector organizations, ministries, non-profits to deliver that level of training. I know that the publicly funded health system is engaging in that work to ensure that their providers are getting that education. If providers don't have anti-Indigenous racism training, people die, and I don't know how to make that clear to people.

Whether it's the woman I spoke of in St. Catharines or the man in Manitoba who showed up in the ER and died—because he was dying of the results of diabetes and was assumed to be drunk. He was left to sleep it off in the corner of the ER, and he died, over the assumption that he was drunk.

I remember the story of a physician who, when another Indigenous person came in, instead of treating that person—again, for diabetes—he drew this crude drawing of an alcohol bottle on a prescription slip and crossed it out, and handed that to the patient.

I had a surgery a year ago, and when I was discharged from a hospital just down the street here, someone made the decision somewhere along the line that the pain medication I had been prescribed for having a six-hour, substantial surgery—because it said "Indigenous" on my chart, that prescription walked itself away out of the chart, and I was discharged after major surgery without any pain medication because of the assumptions that people make in the health care system about the kinds of care that Indigenous people deserve. And people die from that care.

What I don't see in Bill 60 that I really want the committee members to understand is any protection to ensure that there is any accountability to address anti-Indigenous racism in this new model that you're proposing, and if you can't guarantee that, then we shouldn't be moving forward.

Thank you. Meegwetch.

Ms. Victoria Marchand: Meegwetch. Absolutely, and I think when you talk about the anti-racism education, it's not up to the Ministry of Education, it's not up to different

silos to do this work. It should be specifically embedded within our health systems in the province.

When you look at the indicators, how do we measure racism? How do we ensure that the health care providers that we work with are actually going to be culturally safe? How do we ensure that when I go to the hospital or my son goes to the hospital, I can trust that that health care provider is going to adequately use culturally safe mechanisms to ensure that our care is being delivered safely? I can't trust the system—right now, tomorrow; it doesn't matter. So we need to develop indicators and appropriate measures to ensure that the system that we are working with is being held accountable.

Just as Suze said, we need appropriate protocols in place to address racism against Indigenous people within the system. This needs to be explicit within the legislation, and it's not. We're constantly an afterthought, and I'm tired of it.

The Acting Chair (Mrs. Lisa Gretzky): One minute.

Mr. Sol Mamakwa: Meegwetch.

It's okay for the government side to ask questions to the Indigenous representatives, not just SE Health.

I think I heard a lot of impact on the—it contravenes the Canada Health Act, as well. Again, it has an impact on the lives and the health of Indigenous people, because people pay in full with their lives with that.

I'm just wondering, John, if you have any comments about contravening the Canada Health Act.

Mr. John Yip: First of all, I applaud our fellow panellists. I support your concerns around anti-racism. We at SE Health are early in our journey in understanding that.

In terms of the Canada Health Act, this is well within the parameters—

The Acting Chair (Mrs. Lisa Gretzky): I'm sorry; I'm going to do it to you again. The clock ran out.

Mr. John Yip: I'll just put duct tape on my mouth.

The Acting Chair (Mrs. Lisa Gretzky): We'll move to the independent member. MPP Shamji.

Mr. Adil Shamji: Mr. Yip, I'm going to throw you a lifeline and let you finish your thoughts there. You can rip that duct tape off. Go for it.

Mr. John Yip: With respect to the Canada Health Act, this legislation falls within it, as it's currently written. The ability to generate profits is difficult, I think. Given the capital that's required, the equipment, the consumables, there's very little profit at the end of this.

For SE Health, this is not a money-making venture, as a not-for-profit. We believe in publicly funded health care. In home care—it is privately delivered as well. We came from long-term care; it was privately delivered. Primary care is a private enterprise. We have a private system in this country. But we at SE Health firmly believe, within the confines of publicly funded—and I sit on one side of the for-profit/not-for-profit divide, clearly.

Mr. Adil Shamji: Just as a clarifying remark—and I know you know, but just for everyone—we have a publicly funded, privately delivered system, but the vast majority of private delivery in Canada and in Ontario is within the context of a fiduciary patient-physician relationship, which is fundamentally different from a shareholder/corporate private delivery model in which the shareholder is the legal primary interest.

Earlier, Mr. Yip, you commented on the importance and need for guardrails in our system, and I wondered if you could articulate what guardrails you would like to see and whether they're present.

Mr. John Yip: Well, I think one of the guardrails is to prevent unnecessary death and harm in these facilities, like we do in our hospitals. Currently, within the Independent Health Facilities Act, there are very little guardrails. If this bill moves forward, it does need to have the protections around clinical quality, cultural safety, workplace safety—all the elements to ensure that what this bill is intended to do to relieve surgical backlog accomplishes that. The Ontario health care system does have a number of entities within its purview to create those guardrails, with expert panels, to ensure that the care provided at these surgical centres is world-class.

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Mr. Adil Shamji: Earlier, you also referenced things like centralized surgical wait-lists. You also referred to regional HHR plans. There are allusions to some of these things; not necessarily to all of them. Are there any improvements that you'd like to see in Bill 60?

Mr. John Yip: Certainly the improvements my fellow panellists have indicated.

There are regulatory elements that are very operational, in terms of issuing of licences, who can acquire these, the mobility of licensure, the partnerships with hospitals and what that looks like.

The Acting Speaker (Mrs. Lisa Gretzky): One minute.

Mr. John Yip: So there are a number of detailed elements within the regulations that I would take a very keen interest in shaping.

As it stands now, Bill 60, as I mentioned in my remarks, is, overall, a good start.

Mr. Adil Shamji: Thank you.

And I wonder if I can ask you some questions. In regard to request number 1, to include Indigenous peoples in the Your Health Act preamble, there's a suggestion to include "recognize the role of Indigenous peoples in the planning, design, delivery, and evaluation of health services...."

If Indigenous peoples will be included in the planning, design, delivery and evaluation of health care services, what might a system like that look like?

Ms. Victoria Marchand: How much time do I have?

The Acting Chair (Mrs. Lisa Gretzky): Five seconds.

Ms. Victoria Marchand: Five seconds? Yes, absolutely—

The Acting Chair (Mrs. Lisa Gretzky): Sorry.

Ms. Victoria Marchand: I can't do anything—

The Acting Chair (Mrs. Lisa Gretzky): It will come back around.

Over to the government side: MPP Rae.

Mr. Matthew Rae: My question is for Victoria or Suze, or both.

Bill 60 obviously creates opportunities, potentially, for Indigenous-led health care. So if Indigenous health care partnerships wanted to apply for integrated community health care service centres, do you believe, from your experience, this would be an opportunity for your communities?

Ms. Victoria Marchand: With these centres, I really think that we need to be more clear and explicit that they need to be surgical and diagnostic, because the work that we do as Indigenous primary health care providers—we're already doing this work. We're working with, like I mentioned, 21 of our members across the province, and we're constantly stretched. We're innovating. We're saving lives. Right now, we don't have a lot of support from the provincial government, but we're making do. So imagine if we had the support from the provincial government.

MPP Martin actually brought that up in response to a question received in the pre-budget consultation question period, mentioning that the government is "working collaboratively with Indigenous partners and communities to co-develop programs that will improve access to safe and effective health services. We acknowledge that programs and services must be designed, delivered and evaluated in collaboration with Indigenous partners"—yet we're having this discussion that we were not consulted.

We know, according to research—the Canadian Medical Association Journal, in Postoperative Outcomes for Indigenous Peoples in Canada: A Systematic Review, said that Indigenous patients in Canada are 30% more likely to die after surgery than other patients. So what are we doing to better this?

I really think that we need to build those partnerships, like you're saying. We need to build together, with the Ontario Federation of Indigenous Friendship Centres. We need to work closely with our IPHCCs and our member sites, because we're offering their lifeline.

Ms. Suze Morrison: What I'm hearing you say is, there's nothing stopping Indigenous organizations from—what?—applying to be a private care delivery model ourselves? On behalf of the OFIFC—we're not in the business of doing surgery. We are front-line community service organizations that provide upstream health and wellness programs and services to urban Indigenous communities and support the overall health and wellness of our communities.

What we're saying we're seeing is that the experience of the Indigenous clients we serve in navigating the existing public health system is already fragmented, is already fraught with racism. We have spent the last 50 years working with governments of every stripe to try to make improvements on that work. We are at a place where we are doing a substantial amount of work on anti-Indigenous racism, in partnership with the health care system. What this bill risks doing is further fragmenting that system, making it harder for Indigenous people to navigate, because now they'll have to figure out, "Am I getting care in these private clinics? Am I going through the mainstream system?"—and then navigating that care and ending up in that situation, being told, "Your outcomes might be better if you opt in to these extra services that I may or may not tell you aren't covered.

And by the way, if you experience significant racism in your care, including being denied adequate pain medication because people are making assumptions about Indigenous people being drug users, or crude comments about being Indigenous from someone providing your care, you have no avenue to pursue any accountability for that," because, quite frankly, in the bill, the way that it's outlined, the organizations have to come up with their own processes to deal with complaints. So it's self-managed. Fine. But then the legislation does not specifically name anti-Indigenous racism as a type of incident that can be fed through that process. The only type of incident that can go through a complaints process, as outlined in this bill, is in the case of death or severe disability, where an underlying condition cannot be attributed to it.

So where does that put people who are experiencing significant anti-Indigenous racism? Well, the complaints process, as outlined in this bill, isn't going to handle it. What do those people do, and what is the accountability of this system, outside of our publicly funded system? Why are we defunding the public system that has been working for years to move—we have existing relationships that we're trying to move forward on, to improve the experience of Indigenous people in our public health care system, and if we fragment it and start from scratch with all of these private providers, we have to establish new relationships. There is no mandatory requirement for engagement with Indigenous communities, no mandatory requirement for culturally safe care, no process of accountability or investigation in incidences of anti-Indigenous racism. It will lead to worse health outcomes, and it will lead to death.

Ms. Victoria Marchand: I don't know if there's time to add anything—

Mr. Matthew Rae: I would like to ask another question. Sorry. Thank you very much for that answer.

My question is back to John. Can SE Health elaborate on how making profit is challenging in this current model, and how much capital it costs to actually open a clinic, a community care centre?

Mr. John Yip: The fee schedules have not changed in a decade. The cost of delivering care is a lot more than what the fee schedule provides. The delta is there.

Mr. Matthew Rae: Thank you.

The Acting Chair (Mrs. Lisa Gretzky): About a minute and a half. MPP Martin.

Mrs. Robin Martin: I just want to ask SE Health—and this is maybe along the same lines. We don't know the cost of running a health clinic. Most of us don't have that experience. So I think we'd just like to understand some of the costs that people like yourself, who have run Kensington clinic, face. What kind of costs would you face in setting that up, and how do you make that work?

The Acting Chair (Mrs. Lisa Gretzky): One minute.

Mr. John Yip: The cost of building operating rooms, on average—procedure rooms; not to do trauma surgery,

but for these types of ambulatory procedures—six years ago, would be about $1.5 million to $2 million per room. That's just the room—not including all the external fixtures that need to be done around the gases, the ventilation, to ensure safety; the waiting room and so on. That is a major capital outlay. The operating, 80%—no surprise—is staff and staff-related costs, and the 20% are indirect costs, but those costs, as I mentioned with MPP Rae's question—it is cost-prohibitive around that 20%. Those are just back-of-the-envelope, to be validated, and to go through the proper due diligence around the costs of doing that. So when you put that up front, there are very few organizations—

The Acting Chair (Mrs. Lisa Gretzky): Thank you.

1750

Over to the official opposition: MPP West.

MPP Jamie West: Thank you to the speakers.

It's good to see you again, Suze. I missed your voice here.

Because we have limited time, I just have a quick comment, and then I'll hand it off to MPP Gélinas.

In this deputation—I know it wasn't from you, Suze—what caught my eye was the "30% more likely to die." All through today, there have been a lot of organizations—CUPE, OFL, OHC—that represent health care and represent workers who have not been consulted on this. But I am urging the government—earlier, you were talking about if we're hearing and if we're listening. I want you to know, as a New Democrat, we did hear you today, that this has to be integrated. I believe that my colleagues across the aisle are listening, as well. You'll know if you were heard if anything changes in this bill. So I'm urging them to make that change.

I'll hand it off to Ms. Gélinas.

The Acting Chair (Mrs. Lisa Gretzky): MPP Gélinas.

M^me^ France Gélinas: I would like to thank Victoria Marchand for all the great work that you guys do in primary care.

Just to set the tone a bit: Of the 10 Aboriginal health access centres and all of the centres that you represent—when was the last time you got a base budget increase to do your work?

Ms. Victoria Marchand: I don't think we ever have. We've been here since 2019, working with those members and constantly growing with our members. So I think it's really interesting that you ask that.

I know that we're constantly advocating to be supported, and that looks like financial resources. We need more financial resources so that we can fully be supported. There are all these talks at the federal level and the provincial level of these health equity funds and provincial funds to support Indigenous health, but we don't actually see it.

Like I mentioned in my presentation, we are one of the only Indigenous-led, Indigenous-governed organizations in Ontario that services, through our members, Indigenous primary health care. So the dots are not connecting on my end. I think it's really interesting, because right now, we're advocating with this government for a provincial integrated health hub; we're advocating for a model of traditional well-being. We're here. We're advocating. We're at the tables. I'm right here, right now, asking for amendments. These requests are so clear, and we can't be any more clear as to what we need. So now it's up to you, in this path of reconciliation that we often talk about—to be supported, to be funded. We are the experts in our own care, and I can't stress that enough.

M^me^ France Gélinas: I fully agree.

What the bill does is that it allows private, for-profit, investor-owned corporations to build $2-million-a-room surgical suites so that the healthy and the wealthy can go into those suites to have their surgeries, and the rest of us can wait in the hospital with less staff and less resources and everything else.

What are the chances that there is a private, for-profit, investor-owned corporation that builds something for Indigenous people in our province?

Ms. Victoria Marchand: We absolutely oppose that, inherently. Traditionally speaking, my teachings don't correlate to that.

Just thinking about not even being consulted with this bill, why would we trust a colonial institution and system trying to introduce a new type of health care act once again, when we've already been working so hard to develop the partnerships that already exist? We're on the right path, and now we're being thrown a wrench once again, just to start at zero.

For us, the most important thing is to take care of our people—to take care of people like my uncle, who has been in and out of those hospitals. Even as a grand chief, it doesn't matter how much power you have. You're still Indigenous, at the end of the day. You're still going to die.

So I wonder, what can I do? What's in my power within IPHCC, even as an Indigenous-led and Indigenous-governed organization? What can we do to make sure that there are no more uncle Johns? For me, I think, minobimaatisiiwin—that doesn't fit in Bill 60.

M^me^ France Gélinas: I fully agree.

Would you agree with me when I say that when the government brings forward a piece of legislation like this, we are disrespecting every First Nation person in this province?

Ms. Victoria Marchand: Absolutely. There's nothing more I could say but to confirm exactly that.

Jurisdictional wrangling: We talk about those bilateral agreements between the federal and the provincial government—and so we have those non-insured health benefits that we like to use. They're not benefits. They don't benefit my health. So how can we depend on federal and provincial jurisdictional wrangling? I can't even depend on our provincial health care system. So what can we do?

We're on the right path. We need those partnerships.

M^me^ France Gélinas: Do you have a full network of primary care organizations to serve our province at this point, or do we still have areas of our province that would need an Indigenous-led primary care organization?

Ms. Victoria Marchand: We're doing our absolute best right now. We just need more funding. At the end of the day, we need more money in order to support the entirety of the province. We're working with 21 members to service as many as we can. Since late 2019, we've already serviced over 120,000 Indigenous clients and patients. That's so many, and so we need to think, if we were actually properly funded and supported, how many more can we reach? How many more lives can we save?

M^me^ France Gélinas: Many, many.

I know that Mr. Gates had some questions.

The Acting Chair (Mrs. Lisa Gretzky): MPP Gates.

Mr. Wayne Gates: I just want to say that I was at the celebration of life for Heather when she passed, at the Market Square, and we have taken the hospital to task on racism. It's unacceptable to have that last a year—over a year now.

The Acting Chair (Mrs. Lisa Gretzky): One minute.

Mr. Wayne Gates: Okay.

I also want to let you know, Suze, that I have two friendship centres in my riding. One is in Fort Erie, and we have a very active daycare as well. They do an incredible job there. I have one in Niagara-on-the-Lake as well, and they do a great job at our friendship festivals. I just went to the powwow a week ago, and the number of community members who came out to it was incredible. I also have 5,000 self-identified Indigenous members in my riding who I'm very proud to represent.

My question is, what would you like to see in the bill?

Ms. Suze Morrison: Like I said in our submission, at this point we're calling on the Legislature to withdraw it. We don't think there's an amendable path forward with it. We should not be entertaining further fragmentation of our health care system. We should be adequately funding our existing public infrastructure and doing it in a way that will meet the needs of Indigenous people. And then—

The Acting Chair (Mrs. Lisa Gretzky): Thank you. Sorry. Time's up.

Over to the independent: MPP Shamji, for the last four and a half minutes.

Mr. Adil Shamji: When we left off, we were talking about what it might look like if Indigenous people were involved in the planning, design, delivery and evaluation of health services.

Ms. Victoria Marchand: Thank you for that. As I mentioned briefly, the model of traditional health and well-being—here at IPHCC, we do tremendous work with our community. I think that when we do think about programs and services that need to be designed, delivered, planned and evaluated in collaboration with us, it's all about the first steps. When you come up with that idea, you need to reach out to us. You need to reach out to the Indigenous communities, because we are being affected first and foremost—these disproportionate percentages that we see constantly. That's the reason why we need to be involved in every single step.

And we need to talk about those indicators. They need to be within the legislation. We need to take that extra step, not just put it in the regulations. This needs to be binding. If we want to talk about colonial legislation, we need to at least insert ways that we can indicate and measure anti-Indigenous racism to better support those Indigenous patients accessing health care services.

And the rest—we are submitting a written submission, and I would gladly try to extrapolate more on that and include more examples and ideas.

I do invite everyone to engage with IPHCC. Engage with us. Email us. On the last page of the slide show printout, you have our emails, you have our names, you have our positions. Please, we are looking forward to your emails, because that's what meaningful consultation and partnership is to us. So I hope I hear from all of you.

The Acting Chair (Mrs. Lisa Gretzky): You've still got two and a half—

Mr. Adil Shamji: I'm fine. Thank you.

The Acting Chair (Mrs. Lisa Gretzky): No? You don't want any further—okay.

I'd like to thank you all for your participation today. If you would like to submit any written materials in addition to what you did today to the committee, the deadline for written submissions is 7 p.m. Eastern Daylight Time, on Monday, March 27, 2023. Again, thank you to the presenters for your time today.

This concludes our business for today. The committee is now adjourned until 9 a.m. on Tuesday, March 21, 2023, when we will continue with public hearings on Bill 60.

The committee adjourned at 1800.

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