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SP-11

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Standing Committee on Social Policy

Comité permanent de la politique sociale

Your Health Act, 2023

Loi de 2023 concernant votre santé

1st Session
43rd Parliament

Monday 27 March 2023

1re session
43e législature

Lundi 27 mars 2023

Chair: Goldie Ghamari
Clerk: Lesley Flores

Présidente : Goldie Ghamari
Greffière : Lesley Flores

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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 27 March 2023

Lundi 27 mars 2023

The committee met at 0900 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 to resume 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 tonight, Monday, March 27, 2023, at 7 p.m. Eastern Daylight Time. 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 with you virtually via SharePoint.

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 presentation. Following all three presentations, there will be 39 minutes of questioning for all three witnesses, 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.

To ensure that everyone who speaks is heard and understood, it is 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?

NIAGARA HEALTH COALITION

UNIVERSITY HEALTH NETWORK

The Chair (Ms. Goldie Ghamari): I will now call upon the Niagara Health Coalition to please come forward. Welcome. 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. Please have a seat.

Please state your name for the record, and then you may begin right after. You have seven minutes.

Ms. Sue Hotte: My name is Sue Hotte or Suzanne Hotte.

Good morning. Thank you very much for the opportunity to bring forward our concerns regarding Bill 60. My name is Sue Hotte, and I'm chair of the Niagara Health Coalition. We are a non-profit, non-partisan group whose primary goal is to protect and improve our public health system and to ensure it follows the principles of the Canada Health Act: universality, comprehensiveness, portability, accessibility and public administration. In Niagara, our health services are delivered by three health systems: Niagara Health, Hotel Dieu Shaver and Hamilton Health Sciences, with the West Lincoln Memorial Hospital site in Grimsby.

We strongly oppose Bill 60, as it contravenes the principles upon which the Canada Health Act is based and which the government of Ontario is obligated to follow. Bill 60 for-profit surgical and diagnostic clinics will not be publicly administered. They will not be accessible to all patients who require their services. They are accountable to no one but the owner or the shareholder. There is no transparency, no regulations, no criteria for selection, and they are wide open to abuse by appointed third-party directors who are not bound by conflict-of-interest rules.

We are also extremely concerned that Bill 60 will have a negative impact on the delivery of health services in our region, and I really want to spend a little bit of time with regard to this. It will result in the closure of hospitals in Fort Erie and Port Colborne, and a great reduction of services, if not the closure, of the Welland hospital. It will jeopardize the ability of the West Lincoln Memorial Hospital to provide full services to the 100,000 residents living in its catchment area. The Niagara Falls and St. Catharines sites will be overwhelmed and more over capacity than they presently are.

These private surgical and diagnostic clinics are going to suck money out from our public health system. Our

health systems have been underfunded for decades, but never more so than since 2018. The MOH share of total revenue has dropped from 73% in 2017 to 64% in 2021-22 for Niagara Health, and the same holds true for all the other health systems. Hospital funding is based on the services that they provide, including operations, and the ministry determines which operations and how many for all the hospitals. Private clinics will take the number of surgeries away from the hospital. A decrease in the number will further strain our health system's ability to meet the needs of Niagarans and of Ontarians.

Our public health system will witness a huge brain drain of trained professionals. Already understaffed, the situation has been aggravated by the impact of COVID and Bill 124. There is a huge need for doctors, nurses, RPNs, PSWs, medical technicians and support staff. Surgeons in private clinics will be doing fewer surgeries in the hospitals, and they may decide to focus solely on their clinic. Nurses, especially those who work in the OR, and medical technicians will be enticed to work in clinics because of better hours, salary, working conditions and respect.

Hospitals may lose the specialists they have to do the cataracts and the various hip and knee replacements, and unless they're capable of hiring more specialists, who are few in number, they're going to have a real problem in doing the number of operations they are entitled to. That means an additional loss of revenue, additional long wait times for patients. They're not going to be able to replace all that lost staff. At the present time, Hamilton Health Sciences has allocated West Lincoln hospital a number of spine surgeries, orthopedic scope and eye surgeries. The doctors come from Hamilton. If there's a decrease in surgeries for Hamilton health, those services in West Lincoln are going to be withdrawn.

Presently, our health systems have responded to the financial and staffing crises by closing urgent care, closing operation theatres and reducing hours of operations for surgeries. Hamilton health moved maternal health/obstetrics and surgeries from West Lincoln for a period of time. Presently, the Welland hospital has reduced surgery hours and the hours of operations for the emergency department. Surgeries have been cancelled. People show up, and they say, "Hey, you're going to have to go to Hamilton." They have held back on hiring all the staff they need because of financial constraints.

Did you know that in December 2022, Niagara Health had 659 vacancies? I'd really like to know how many of those they've been able to fill.

The impact on patients has been great: long waits for surgeries, in emergency departments, cancellations. They have to travel further. And do you know what? That's a real problem in Niagara. We've got a canal that bisects our communities. There are only a few places that we can cross over. On top of that, we have a microclimate. On the north shore of Lake Erie, when there's a storm, it gets stopped—

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

Ms. Sue Hotte: Sorry.

The Chair (Ms. Goldie Ghamari): That's okay. I was just giving you a reminder. One minute left.

Ms. Sue Hotte: Okay. Thank you.

Patients who are going to be going to private clinics—not all of them are going to be accepted, only those with no complications. They're going to end up having to pay extra. And those who don't want those lenses, don't want faster time—they're going to be served, yes; they're on OHIP, but they're at the bottom of the list. What about those wait times? Who's going to manage that?

At the end of the day, we have the capability, we have the physical structure, the human resources, and our government should be putting all the money that is necessary into supporting our public health system and not taking our public tax dollars and putting them into private, for-profit surgical and diagnostic clinics. We have—

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

We'll now turn to our next presenter, from University Health Network. Please state your name for the record, and then you may begin. You will have seven minutes.

Dr. Kevin Smith: My name is Kevin Smith. I'm the president and CEO of University Health Network. Good morning to each member of the Standing Committee on Social Policy. I want to thank the committee for allowing me to be here today to discuss Bill 60, Your Health Act.

0910

For your information, UHN is comprised of Toronto General Hospital, Princess Margaret Cancer Centre, Toronto Western Hospital, Toronto Rehabilitation Institute and the Michener Institute of Education, Canada's only in-hospital school of applied health sciences.

At UHN, our primary value underlines all of our work, and that is, the needs of our patients come first. The last three years of the COVID pandemic have meant delivering on the promise is significantly more challenging, as we face unabated clinical, surgical, education and research challenges for the care needed and the continued strain within health human resources in our system. It has also presented opportunities for meaningful reforms to ensure that patients are fully and timely—and can conveniently access the care they want and need, and the care that stressed providers wish to offer.

I believe the overarching goal of Bill 60 is to do exactly the same: to get patients care more quickly, because the status quo isn't working, as each of you know. When I talk to patients, to providers, to policy-makers, to funders here and around the world, we all hear that no one believes that the health care system in on stable ground, without challenge. It's for that reason that we really need to look at and experiment with new models of care.

Currently, the surgical backlog in Ontario is pegged at more than 200,000 surgeries. More than 100,000 Ontarians have been waiting longer than the maximum clinical guidelines for their surgery, dramatically impacting their quality of life and at times potentially affecting the outcome of their illness. From my perspective and the perspective of University Health Network and our board, we must be

willing to consider new models of care that ensure timely access across the continuum of need while maintaining universal access.

I want to underline the issue of universal access, as I've often believed the discussion about public and private blurs that line. I wish to be completely clear for the committee: Protecting universal access is sacrosanct. Canadians rightly cherish their public health system, as do I. As we look at that, that means that no Canadian, no Ontarian, should be affected in terms of receiving care because of their economic circumstance. The principle that how much money you have should affect how quickly you're cared for can and must be completely eradicated from the discussion of working more closely with not-for-profit and potentially for-profit centres. The OHIP card must continue to be the model of payment.

That having been said, when we look around the world, particularly in parts of northern Europe, and look at faster access, choosing direct or indirect benefits and looking at how we can ensure that the preservation of equitable access can be enforced—as it will be, as I read and understand the bill—the importance of an inspection body, which has been outlined in this legislation, with the powers to issue compliance orders cannot be underestimated. And as the bill moves forward, I think that will be an area where we wish to see more work done.

Licensing, of course, will also be a very important ingredient; a detailed description of services provided; the ability to improve patient wait times, to improve the patient experience, to integrate with the health system—and I particularly want to underline that last part: that, as this bill goes forward, the importance of working with hospitals and other providers to ensure access and services to the sickest and most vulnerable will not be compromised, but in fact, we can work together. It also offers a great opportunity for us to think about how we can jointly staff new environments such as these.

As an example, my nursing colleagues, who are extremely stressed and of whom we have too few in Ontario, have the capacity, with a collaboration between hospitals and such centres, to explore joint-staffing models. That might see a surgical nurse, as an example, working part of her week or his week in a centre such as this, as well as part of their month or week in a centre such as University Health Network, thereby allowing them to keep all of their skills, both highly acute and hospital-based as well as high throughput through community centres. It also allows a lower-stress environment for part of that week or month of work. Again, improving quality of work life for health care providers as well as improving access is an important part of the outcome of this legislation, in my view.

The bill, as I read it, also ensures that there are no changes for universal services. The processes for providing information and receiving patient consent in connection with any service will be clear, and the complaints will, in fact, be overseen by the Patient Ombudsman.

I'm also heartened to see in the bill the role of the director, the potential impact on health system planning, availability of health human resources, the potential impact of coordination of health services and the extent to which proposed services are already available in Ontario. The application process will be an extremely important one, and the initial selection of these particularly relevant. I want to remind the committee, as I'm sure you already know, we do have over 800 independent health facilities and approximately 25 or so that are already doing surgical or intense medical procedures. We have an opportunity to build on this and to not harm access to hospital care or—

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

Dr. Kevin Smith: I'll conclude by saying thank you for the opportunity and leave you with one more recommendation. The University Health Network has recommended to the minister and the government of Ontario through the ministry that an expert panel be provided to work with government as Bill 60 moves forward. This would allow people from across the spectrum, including patients, to identify risks, recommend guardrails, improve access and prevent against unintended consequences, which any new initiative in the health system can unfortunately incur. I'm confident, with this and other guardrails, that we can move forward to navigate the change of health care that all are calling for.

Thank you for the opportunity to comment today. I look forward to participating in creative experimentation and improving our system for patients and providers.

The Chair (Ms. Goldie Ghamari): Thank you very much. We'll now turn to our questions. This round will begin with the government. You have seven and a half minutes. MPP Martin, you may begin.

Mrs. Robin Martin: Thank you to the presenters for coming today and coming virtually. We really appreciate you taking the time out to be here to give us your input on our proposed Bill 60.

I just wanted to start with Dr. Smith. Dr. Smith, my understanding is that UHN has an existing relationship with the Kensington Eye Institute. I was wondering if you could tell us how that partnership works right now.

Dr. Kevin Smith: Yes, certainly. We've enjoyed a longstanding relationship since the outset of the Kensington Eye Institute. We are funded for certain eye procedures; in this case, particularly cataracts. Our surgeons are allocated cataract time, and we work with Kensington at a price point to use their physical plant, which is a much lower-acuity environment than the intense operating rooms of places like the Toronto General Hospital and the Toronto Western Hospital, which are literally looking after Canada's sickest people. This model allows us to ensure that those small number of people receiving minor, less intensive eye surgery, are appropriate for the setting. If they're not, they default usually to our Toronto Western campus. The model has worked outstandingly well.

Another initiative: As a very academically intensive environment for research and education, we also see learners accompanying the surgical team in that environment. The model has worked exceptionally well so far, to the degree that we continue to explore further expansion into other low-acuity surgical domains as we think about catching up on—at UHN, we have 5,000 people who are on the waitlist as a result of COVID.

Mrs. Robin Martin: Thank you very much, Dr. Smith. You mentioned that you believe the overarching goal of Bill 60 is to get patients access to care more quickly; I also believe that that is our government's goal. Some people have suggested that providing care in these innovative models will actually provide less access for patients. What is your experience with how access for patients is facilitated by places like the Kensington Eye Institute and the current situation with, I think you said, the backlog of cases here in Ontario of 100,000 waiting more than the recommended clinical period and 200,000 waiting?

Dr. Kevin Smith: Yes. As you know, members of the committee, all roads at the moment lead to health human resources. So I hope that this opportunity for experimentation, as a research and educationally intensive hospital—it also allows us to explore what models of care we offer. If we look around the world—and I would encourage us to look to northern Europe more than south of our border. It's a very polarizing debate when we talk about the United States and a more for-profit oriented system. But there are very good models of care that can address equity and prevent erosion of the public system while expanding care.

0920

The other piece of this is with the Michener Institute of Education. Because of Bill 60, we've already begun looking at what some of those extender professions are that can help doctors and nurses. In my opinion, MPP Martin, we will not educate or immigrate our way out of the nursing shortage. It's a worldwide shortage. No matter how much we increase our educational programming, we won't meet the needs of Canada and Ontario in terms of a growing population and the retirement of the existing profession. So while we should try and we should continue to expand nursing capacity as much as we can, we do also need to think about what some of those other emerging professions are that can help us address the backlog. UHN, Michener and our partner institutions associated with U of T are the perfect place to explore that.

I'm talking about exploring models that are offered at the very best places in the world: places like the Mayo Clinic, places like the Karolinska Institute, places like Imperial College in London. So again, not in any way, shape or form compromising, but looking at new models that will address the health human resource shortage.

Mrs. Robin Martin: Thank you very much. The health human resource challenge is certainly great around the world, and between an aging demographic and the general challenge we have with having enough health human resources, that's certainly important.

I will pass it along to my colleague.

The Chair (Ms. Goldie Ghamari): MPP Pierre? Sorry, MPP Wai. I'll get to you after.

Ms. Natalie Pierre: Thank you, Chair, and thank you to both of today's presenters.

My question is for Dr. Smith. Do you have any additional suggestions on how we can go forward with the integration and expansion of community surgical and diagnostic centres to make sure that they're implemented successfully?

Dr. Kevin Smith: Yes. My experience is a bit rooted in the work we've done in the past on wait times, including seeing some alternative environments. So as I mentioned, I think creating an expert panel is a very important ingredient. I also think a bit of a charter would be helpful, looking at what the intentions of these environments are and what the unintended—or what we do not wish to see as a result of these. I think as we lay out the framework that says we don't want to see other acute health environments more challenged by health human resources, we don't want to see any challenge on equity or access, we don't want to see any push against the quality of work/life of already-stressed providers—the more we lay that out, and then put that expert panel together to advise the minister or ministry. I think we all have examples of every system of well-intended ideas that result in unintended consequences, and—

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

Dr. Kevin Smith: —if we're working together with a diverse group of voices, we will absolutely ensure that those issues come to the table before we make mistakes. And any time we do things as innovative as this, mistakes are possible. Let's fail fast, alter the model and move forward in the goal: more Ontarians getting better access to a high quality of care.

Ms. Natalie Pierre: Thank you.

The Chair (Ms. Goldie Ghamari): There's 30 seconds. Do you want to save it for the—all right. MPP Wai.

Mrs. Daisy Wai: Very quickly, I just am happy to see that you see the status quo is not going to resolve the problem that we're facing with the different hospitals. Can you tell us how this bill can support this? I know we only have 30 seconds left, but tell us a little bit more.

Dr. Kevin Smith: Yes. I think the most important thing this bill can do is ensure that we don't see a—

The Chair (Ms. Goldie Ghamari): My apologies; you'll have to hold on to that question and the answer for the next round because we are out of time.

We'll now turn to the official opposition. Who would like to begin? MPP Gélinas.

Mme France Gélinas: Thank you to both presenters. My first question will be to Mrs. Hotte. Do you know of cases in your area where people have been charged to access cataract surgery?

Ms. Sue Hotte: Definitely—no. I do know where people have been—I don't personally know someone who has, okay? There have been reports of people that have been charged for surgeries, but I can't go and give more details because I don't have them with me right here.

I do know that there has been a case where someone had a liver transplant here in Toronto and needed to get digital imagery with regard to the results. The hospital here in Toronto only did that once a week and so—her name is Barbara—she went to Niagara for that service. She had to provide to that clinic supporting documents from the doctor that she needed to have that, so she went and had her CAT scan or MRI and ended up having a surcharge of $40. That we can attest to.

The Ontario Health Coalition did release a report a few weeks ago with regard to all the charges related to extra costs, extra billing in the private clinics.

Mme France Gélinas: Agreed. I saw the report and I saw many, many people being asked to pay for a second

measurement of the eye for $250, being upsold different lenses when, really, they were never offered the free lens.

My next question will be to Dr. Smith. I fully agree with you that things need to move more quickly and that some surgeries can safely be done in the community and that we need all of the oversight and the transparency that you talked about that exists in our hospitals to continue. Some of those already exist. I take it that you are familiar with what Sunnybrook is doing with their hip and knee. Is this a model that you would support?

Dr. Kevin Smith: Yes. The Holland orthopedic centre is a very, very positive centre, so we very much would see that as an opportunity, again, for a low acuity environment for lower acuity and low-risk patients where we can see high throughput. Increasingly, as you know, Madame Gélinas, we're seeing same-day hip procedures occur so that they can get home and, especially, if we can augment our home care support, really improve our throughput.

Mme France Gélinas: And all of the oversight that applies to a hospital applies to that clinic. Are you also familiar with what London Health Sciences has done for their outpatient surgeries?

Dr. Kevin Smith: I'm not as familiar with the London Health Sciences model. I apologize; I'm not totally familiar with what's happened there.

Mme France Gélinas: No problem. Same idea, where the hospital has an outpatient clinic across the street from the hospital; they see lower acuity, but the wait-list is maintained—as in nobody gets to jump because they are healthier and can go to a lower acuity.

When you talked about how we need to have guardrails and need to have an expert panel, we need to do this right—do you see any of that in the bill right now?

Dr. Kevin Smith: I see much of the work around protections under the purview of the director. So I think that there are many initiatives there, and as I read the bill and interpret it—my expertise is not legislation, I confess, but as I read the bill and look at the application process—how it will affect staffing, how it will affect the local hospitals—I see opportunities there. As important as the legislation will be the regulations that accompany this, should it be passed into law and then be implemented.

That being said, I would see the real strength in bringing together colleagues to ensure unintended consequences don't occur, which I believe all of us wish to prevent.

Mme France Gélinas: Were you consulted before Bill 60 came forward?

Dr. Kevin Smith: Let me think about that. I don't believe I was consulted, no. As it was being developed, I certainly had a lot of discussion with the Ontario Hospital Association. When I heard a bit about it, I reached out to a couple of colleagues in the Ministry of Health to reinforce the importance of ensuring that research and education are not forgotten in these high-throughput environments. Learners are very important to see the future models of care. Of course, learners do slow us down in environments where—obviously, it takes longer when you're teaching someone. So it's really preserving and protecting. And of course, the last piece was reinforcing the importance of looking at joint staffing so that we don't leave the high-acuity environment at risk or result in any unintended consequences.

0930

Mme France Gélinas: When we look at the data that exists around the world, when we look at the private, for-profit, investor-owned corporations—Australia being the last one—a lot of other physicians have come forward and said that it should be at least majority physician-owned. Rather than being investor-owned, a majority of the investors should be physicians. What do you think of that idea?

Dr. Kevin Smith: I'll be very honest; I haven't given that as much thought as I'd like to to answer your question with enough clarity.

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

Dr. Kevin Smith: I see challenges with both models. If I look at the Japanese system, it has been levied that when it's completely physician-owned and physicians are compensated for the work—is there an unintended consequence of driving more activity? Equally, I would say when I look at hospitals in the private sector, we've used public-private partnerships under numerous governments and in numerous provinces where the capital portion—building the building, caring for the building, looking after the heat, light, food and things like that—are within the private sector, while the clinical endeavour, the actual physician services, is reserved for the clinician team. Again, I think there are models there to emulate. Again, I think our concept of an expert panel allows us to look at those and bring the investor community to the table to ensure it's attractive for them.

The Chair (Ms. Goldie Ghamari): Thank you. That's all the time we have for this round. We'll now turn to the independent member for four and a half minutes. You may begin.

Mr. Adil Shamji: Good morning, Dr. Smith.

Dr. Kevin Smith: Good morning.

Mr. Adil Shamji: At the outset, I do want to say I trained at UHN. I've had many of my patients receive exceptional care at UHN. Of course, I know how difficult it has been for all of the staff at UHN, so I just want to acknowledge that and thank you and your teams for all of your service during the pandemic.

Dr. Kevin Smith: Thank you so much. I'll convey that back to the team.

Mr. Adil Shamji: Fantastic. I'm glad to hear that.

One of the things that I was pleased to hear you acknowledge—and I think it's an entirely fair thing to acknowledge—is that in any new venture, there can be unintended consequences. Certainly as we've seen the rollout of virtual care, I have worried that there have been unintended consequences, for example, differential access, pay for access. The genesis of my question is that my concern has been that this government has been slow to address those unintended consequences. So in that spirit, my question for you this morning is, from your read of the bill, what are some of the unintended consequences that you're worried about?

Dr. Kevin Smith: The number one unintended consequence I think we all have is the health human resource shortage. Is it more attractive for a beleaguered health care

provider—our greatest shortage, as we all know, is nurses—to say, "Gee, why don't I hang up my cleats and go across the road to a facility that's open Monday to Friday, 9 to 5, no holidays, no weekends, no on-call"? Doesn't that sound attractive? And, of course, it does.

You know as a health professional that there are a special group of people who love to work in the acute, highly technical disciplines, and our hope is that they'll continue to do so. For me, the greatest worry is people are so tired and burnt-out from COVID that we run the risk of not having adequate people for the true emergency, for the true in-patient stay.

That having been said, with some unique staffing models and, again, some opportunities for us to consider how might we jointly staff a high-throughput ambulatory environment and a highly acute hospital, do I believe we could come to some solution? I do.

Mr. Adil Shamji: Are there any elements that you would like to see in this bill that would reassure you more that we wouldn't see any of those unintended HHR consequences?

Dr. Kevin Smith: I think maybe just being explicit in regulation that the health human resource plan is one that does address adequate numbers for that particular geographic region, and exploring new models of care and new providers. We haven't talked today at all about areas like digital health, but many exciting things are happening in other jurisdictions that I hope we'll bring to Canada, to Ontario, to better look at how we can support people from home post-surgically to prevent people having to return to areas like emergency rooms.

A couple of the areas that I do worry about and I've been vocal on: the itinerant provider—if someone isn't of the community, isn't part of the on-call group at a local hospital. Even in low-acuity procedures, as you well know, there is a small number of people who end up in emergency rooms. I'm hoping that the surgical team, particularly the surgeon, will be from the local community and that if the person needs to go to a hospital, they go to the hospital where their surgeon is on call or the surgical team that includes that surgeon is on call, for continuity of care.

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

Dr. Kevin Smith: There are, of course, also the economics of local presentation as well: the nature of the fee schedule of the physician doing the work, as opposed to those who might have to do follow-up work. Again, those are details that I think, at a table with an expert panel, we could safely work out and put some guardrails in place.

Mr. Adil Shamji: Thank you for sharing that. Certainly, I think there's merit in any and all of the comments that you provided. My ambition in this is to bring as many of those proposals and suggestions forward into the legislation, because certainly at the regulatory stage we as legislators don't have very much opportunity for input. I'd like to see it get as strong as it can before it's passed.

One of the things that you mentioned that you're reassured by is that there will be a director; one of the concerns that I have is, really, there are no parameters around what qualifications a director should have—

The Chair (Ms. Goldie Ghamari): Thank you. That's all the time that we have for this round. We'll have to come back to that thought after.

We'll now turn back to the government for seven and a half minutes. MPP Wai.

Mrs. Daisy Wai: Dr. Smith, I would like to have you continue to say—I understand you say the status quo is not going to work. How does this bill support and help and improve on what we've been working on and resolve those challenges?

Dr. Kevin Smith: Thank you. Obviously, we have to consider how we'll bring more patients to our operating theatres more quickly, and also in these centres, we're looking at imaging; they often go hand in hand. It's very difficult to do surgical care in many domains without strong imaging. Really and truly, it's increasing the denominator of access to care.

As you know, we have about five million new people coming to Canada a year. If I do my math, which I hope isn't flawed, maybe 400,000, if you look at Ontario's distribution—40%—will come to Ontario and 60% of that 40% to the GTA. We seriously need to look at an aging and growing population and how we'll meet their needs, both with physical plan as well as work hours. I know many of my colleagues have mentioned, and I'm very respectful of their view, that when we expand services after hours we could use the public operating rooms that are funded within hospitals. When I look at staffing after hours, our biggest challenge is actually hearing from my nursing colleagues—and on occasion surgical and anaesthesia—who say, "I want to work when my children are in school." So keeping those hours roughly aligned would be helpful.

The last part is the research component. When you're working in a surgical environment that isn't an in-patient environment and the default can't be, "Well, just admit the patient," we are more creative and relevant. We are looking at new models of care. We are looking at care extenders. We are looking at technologies. So I would like to believe that Ontario can and will and should be an environment that is experimenting with the most creative models of care that allow us to preserve access and preserve equity.

A previous question talked about the wait-lists, and in my view this model of care should be drawing from a central long wait-list. By doing so, we eradicate the view that we're basically catering to an individual geography; we're looking at Ontario as a whole for long waiters. When and if we catch up, then we should again look to the local geographies, the regions in which these operate, as to how we can preserve equitable access and innovation.

Last but certainly not least, I think the other component of this is looking, again, at what else we can free up in the hospital setting as new technologies emerge, as new challenges emerge. We know, for example, during COVID, it was very difficult to have things done in a hospital setting. The more surgical environments we have as backup, the greater the opportunity, in the event of an infectious disease outbreak, that we will have the capacity to do work in multiple settings.

0940

Mrs. Daisy Wai: Thank you very much. I'll pass the time to Robin.

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

Mrs. Robin Martin: Thank you again, Dr. Smith and Ms. Hotte, for being here and for giving us your views.

Dr. Smith, I know you have experience with the Kensington Eye Institute. We talked about that before. Just your comments right now about looking at what else in hospital settings that we can free up—the more surgical environments we have, you said, the better, in case hospitals are confronted with major incidents or ongoing problems like COVID. Can you just describe to us why that is important for managing our wait-lists and for making sure patients get access?

Dr. Kevin Smith: Certainly. One, I think, is the anxiety of patients. We saw, sadly, during wave 1 of COVID large numbers of people avoiding presentation at the hospital because of fear of contracting COVID in the early days, when we understood very little about this disease. Sadly, we've seen a number of those individuals presenting to hospital and worsening their illness and worsening their outcome—people who, sadly, have had cardiac events, people who have had a number of other events.

Then, lastly but not least, when we're prioritizing access to surgical care, life-threatening surgeries, urgent and emerging surgeries are the ones that get done most quickly. A cataract, while it has a huge impact on quality of life, is rarely such a procedure. Similarly, a more minor surgery—I won't say minor per se, but more minor relative to a sarcoma surgery. A bone and joint surgery that might be oncologic in nature—cancer-related—would, of course, take precedence. By having environments like these, we can balance the life-threatening illnesses with the quality-of-life illnesses. If you're suffering with an orthopedic problem and you've been waiting two years, the joint has further deteriorated and your mobility decreases, your quality of life decreases, and similarly with your vision.

I actually think this is balancing the urgent and emergent need with the quality-of-life needs of Ontarians as we move forward in looking at growing that denominator of care.

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

Mr. Billy Pang: Madam Chair, through you to Dr. Kevin: There are already over 900 community surgical and diagnostic centres operating in Ontario, and approximately 26,000 OHIP-insured surgeries and procedures are performed annually. Other Canadian provinces, including BC, Alberta, Saskatchewan and Quebec, have successfully reduced their surgical backlog by implementing community-based models for surgical procedures. Alberta and BC perform up to 70% of their surgeries in non-hospital community settings, while Ontario delivers only 3%. How do you think this bill can help to facilitate reducing the surgical backlog?

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

Dr. Kevin Smith: I think overall it is growing the denominator of access to care. If we, at the end of the day, can't say we have more open, available surgical hours to treat more patients in these environments, when accumulated with the hospital environment—it really is staffed operating rooms, both in hospitals and in community-based centres. Of those that exist now, as mentioned, about 25 or 26 of them are already doing more advanced surgical and medical procedures, mostly cataracts, mostly eye surgeries, but also endoscopy and a number of other invasive procedures for diagnostics.

I actually think the more we can increase access, both for patients and providers, while ensuring that we have appropriate staffing, the greater the probability of us getting our wait-lists under control and coming into play such that the quality of life will be equally balanced—

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

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

Mr. Wayne Gates: Good morning, Sue and Kevin. I know both of you extremely well.

Kevin, we've dealt with a number of issues in Niagara when you were brought in to supervise. I've talked to you many times, including about the number of hospitals that we lost in Niagara, including the two in St. Catharines and one in Niagara-on-the-Lake—Port Colborne, services cut; Welland, services cut; Fort Erie, closing and services cut. We've had lots of cuts in Niagara, a lot of it caused by a promise of a hospital that now is going to take 15 to 16 years to get built. We also had the C. diff issue that we had in Niagara where 39 people died, because of a private cleaning company that came in. When we found out what was causing everybody dying in our hospitals—it was because of the private company. We saw the private effect on long-term care, where 78% of the people that died were in long-term-care facilities that were private. So this is all about privatizing our health care system.

But I'm going to ask you questions quickly, because it's not fair that we have two presenters and the government only asks one questions. I think that's not fair to the other person that comes. I will ask you a question quickly: Can you tell me your salary?

Dr. Kevin Smith: My salary?

Mr. Wayne Gates: Yes.

Dr. Kevin Smith: [*Inaudible*] MPP Gates, I'd have to go back and look at it. It was in the sunshine list last week—

Mr. Wayne Gates: I'm a nice guy; I'll help you out. It's $855,000 a year. And this is why I'm going to ask you the second question, Mr. Smith: Do you believe that health care workers deserve a fair wage increased with inflation, running as high as 6.5% to 7%? Yet this government under Bill 124 has capped their wages and benefits at 1%. I believe you've got an obligation being one of the main guys in all of health care, quite frankly, across the province of Ontario, with my dealings. Do you think it's right? This is why we've got a staffing crisis, I believe. Do you think it's right that this government has capped their wages at 1%? Just yes or no, because I want to get to Sue.

Dr. Kevin Smith: The Ontario Hospital Association speaks for all hospitals—

The Chair (Ms. Goldie Ghamari): Sorry, I'd just like to remind the members to keep their questions to this bill specifically.

Mr. Wayne Gates: It is on the bill.

The Chair (Ms. Goldie Ghamari): We're here to ask questions about—

Mr. Wayne Gates: It is on the bill. It is on the bill.

The Chair (Ms. Goldie Ghamari): It's on this bill that's before committee?

Mr. Wayne Gates: And you're supposed to be non-partisan. It is on the bill.

Interjection.

Mr. Wayne Gates: Never mind the question. I know the answer. I'll go to Sue.

Sue, could you briefly discuss what some of the most important issues facing health care in Niagara right now are? What are the problems? What are the solutions? Does this bill do anything to make health care delivery better in Niagara?

Ms. Sue Hotte: So first of all, this bill will do nothing to improve the situation in Niagara. It will only aggravate it. What we have presently is a health system, the Niagara Health System, struggling to find proper staffing, to be able to fund the programs that they actually have. They have huge staffing issues. I did mention at the beginning the reduction in funding—that is huge.

What we're looking at right now is—for example, Dr. Smith did close the Niagara-on-the-Lake hospital. There were promises that they would be getting an urgent care, that everything would be really copacetic, because—guess what?—there's a new hospital that was going to be built in Niagara Falls. And we're still waiting for that hospital in Niagara Falls.

The aging population: It's more than 28% of the people in Niagara-on-the-Lake that are over 65. They do have health issues. They do have to move to try to get the care that they need. The staffing issue for the Welland hospital presently—there are no anesthesiologists, so what's going on? There are not enough, so they have reduced the number of surgeries that are going on. They have reduced the hours of the ER.

If you look at Port Colborne and Fort Erie, what you have there are urgent cares. Once again, both of those communities have more than 25% of their population that is over 65. They have real issues, and they are depending on those urgent cares. Well, at times, the urgent care centres are closed.

If you look at West Lincoln, it is known for having a great maternity and obstetrics program. Well, guess what? It was taken away from them for many, many months, and it went focused into Hamilton. There's close to 1,000 babies that are born in that hospital. So this is a huge problem with regards to people there.

If you look at the staff, at what's going on, all the nurses, the medical technicians—they're working overtime. Nothing like doing another four hours, six hours or eight-hour extended shift. They're tired. And you have huge off-load ambulance times—like, it's unreal. There aren't enough beds that are being opened. And by the way, just to let you know, in 1989, we had 2,000 beds for the Niagara region. In 1999, we were down to 1,000. I wonder why. Then, during Kevin Smith's time, we were down to 680 to 700, and we've been slowly going up and we've had—

Mr. Wayne Gates: Sue, I'm going to have to cut you off because my colleague wants to ask another question, and I want to make sure she gets it, okay?

0950

I'll turn it over to my colleague Lisa Gretzky. Thank you.

The Chair (Ms. Goldie Ghamari): MPP Gretzky, you have a minute and 30 seconds.

Mrs. Lisa Gretzky: I just want to address the question about Bill 124. It was actually mentioned several times about health human resources and nurses potentially being poached to go to work to the private for-profit sector. I think it's interesting that Mr. Smith had mentioned cataract patients with lower acuity would be seen at these clinics and the rest would go to the hospital, which is exactly the point we're trying to make on this side of the House. These clinics are not open; it's not equitable access of health care, and those patients with higher acuity are going to end up in hospitals that are already understaffed—but they're taking nurses and more and more health care professionals out of the public not-for-profit system.

I just want to address one last thing, which is innovation, because I keep hearing it. I heard it last week for two days in hearings. Profitization of health care is not innovation. It's the oldest game in the book. We started off with private for-profit health care. In fact, what this government is doing is the exact opposite of innovative. They like to talk about BC. BC is buying these clinics back and bringing them back into the public not-for-profit health care sector because this model, proposed under Bill 60, doesn't work.

With that, I'll give it back to my colleague from Niagara Falls if there's any time left.

Mr. Wayne Gates: I'll go real quick, Sue. Talk about Bill 124, because it's been a disaster. Talk about Bill 124. Go ahead.

Ms. Sue Hotte: Sorry, I didn't get the question.

Mr. Wayne Gates: Talk about Bill 124 and what it's done to staffing levels across the province of Ontario.

Ms. Sue Hotte: Well, definitely, there is a huge problem if we look at—

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

We'll now turn to the independent member for four and a half minutes. You may begin.

Mr. Adil Shamji: Ms. Hotte, you can finish your thoughts on Bill 124, if you like.

Ms. Sue Hotte: There are huge vacancies. If I look at just Niagara—and I did mention there were 659 only in our area. Throughout Ontario, what we're finding, because of Bill 124, is huge staff shortages, especially in nurses, RPNs, PSWs. It is creating and aggravating a real problem that we have. The health workers are overworked. They're leaving in droves because of the stress that they have. They already have long shifts; they're losing their days off. They're trying to do the best that they can to help in the situation of understaffing. They're forgoing holidays. And,

at the same time, they're going home and there's all this stress that's being brought. Plus, during COVID, there was a problem of, "My God, am I going to be bringing this to my family?" All right? And that is really huge.

People are leaving because they can get another job, and sometimes it's not in the health field. More often than not, it isn't. They can make the same salary and they haven't got all the headaches and the problems and the stress that they have right now. We need to address that. This government has not—in your budgets, you put in money since 2018 to cover health care, and you know what? When I hear the accountability officer saying, "Guess what? They didn't spend all that money. They didn't spend that billion dollars this year and they didn't spend that billion dollars next year," I'm looking and I'm thinking, "Holy moly, where are we? We're at $5 billion that hasn't been spent on health care." Why can't the government take that money and put it into making sure that our health care workers get the salary that they deserve, that they get the respect, that we're able to keep them?

You know what? These are highly trained people. Doctors and nurses, they don't grow on trees. It takes years to develop them. Although we have programs to bring in people from other provinces and countries and be able to give them the right to work, there's not enough. We already know, back in 2019, we were missing over 60,000 PSWs. That has aggravated. The government has had opportunities to really do things in terms of staffing. They had the money. And now they're saying, "Oh, in the last budget that we just announced, we've got all this money." Well, the proof is in the pudding. Are they actually going to put it in health care?

Mr. Adil Shamji: I hope you'll forgive me for interrupting. I just have one or two more minutes left.

The Chair (Ms. Goldie Ghamari): You have one minute left.

Mr. Adil Shamji: Dr. Smith, in your opinion—I think you're reassured by the fact that there will be a director. The parameters for what qualifications a director must have are not outlined in the legislation. What would you like to see as those parameters?

Dr. Kevin Smith: I haven't actually given that as much thought as I should to answer it robustly, but what I would say is that the director and the infrastructure of the ministry both have the health human resources to investigate concerns and monitor quality.

One other model that we have raised is the opportunity to use local hospital medical advisory committees, which I know you're very familiar with, as a consistent model of measuring quality. Especially if the surgeons and anaesthetists and other physicians involved work within that community, there is an opportunity for continuity of care. So I think the director actually having the relationship with the practising community and ensuring that he or she and their team actually have the skills of evaluation—

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

I'd like to thank both of our presenters for joining us here today and for your presentations. If you'd like to submit any written materials to the committee in addition to your presentation, the deadline for written submissions is tonight, Monday, March 27, 2023, at 7 p.m. Eastern Daylight Time.

The committee will now recess until 1 p.m. this afternoon, when we'll resume public hearings on Bill 60.

The committee recessed from 0957 to 1300.

The Chair (Ms. Goldie Ghamari): Good afternoon, everyone, and welcome back. The Standing Committee on Social Policy will now come to order. This afternoon we will resume 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 presentation. Following all three presentations, there will be 39 minutes of questioning for all three witnesses, 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.

To ensure that everyone who speaks is heard and understood, it is 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?

SCARBOROUGH HEALTH NETWORK

ONTARIO NURSES' ASSOCIATION

ONTARIO ASSOCIATION OF CLINIC ENDOSCOPISTS

The Chair (Ms. Goldie Ghamari): I will now call upon Scarborough Health Network to please come forward. Welcome. 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.

Please state your name for Hansard and then you may begin. You will have seven minutes. Thank you.

Mr. David Graham: Hello, my name is David Graham. Madam Chair, members of the committee, thank you for allowing me to participate in this important hearing regarding Bill 60. I am David Graham and I am the president and CEO of Scarborough Health Network. For those of you who may not know, SHN has three hospitals across Scarborough serving an identified catchment area of over 830,000 individuals. In a typical day, we treat 500 patients in our three emergency departments, 800 participants and patients in our in-patient units and 1,300 patients in our outpatient clinics. We perform over 900 diagnostic imaging tests and 140 surgeries.

We also have one of the largest orthopedic and eye programs in the region. SHN's eye program is designated as a regional centre of excellence and consists of 10 full-time ophthalmologists covering pediatric, retina, glaucoma, corneal and cataract procedures. In 2022, the eye program finished 5,700 quality-based procedures, plus an additional 1,000 cases on the provincial waiting list, totalling 6,600 cases in 2022. We are extremely proud of our surgical programs and the work they are doing to not only lower the wait times in Scarborough, but across the region.

However, we know that any wait is a long wait for someone who requires surgery. Every surgery is an urgent surgery when you or your loved one is the one waiting. I welcome the opportunity to work with our government, Ministry of Health and Ontario health partners to integrate community surgical centres and diagnostic centres into the broader publicly funded and publicly administered health system and to establish new partnerships between SHN and community-based surgical clinics to help ensure equitable and accessible publicly funded surgical care for patients.

I would like to echo the recommendations from the Ontario Hospital Association that active and coordinated planning for the implementation of CSCs will determine their success. This includes the need to use data to drive decision-making on where licences are approved and considerations are given on how hospitals with existing program infrastructure can be propelled to expand their surgical services. As CSCs expand into more complex areas of care, it will be critical that a transparent process requiring engagement from impacted community and system stakeholders is in place. Areas of coordination need to include the request for proposals and the applications of licences, health human resource implications and ensuring that the placement of CSCs matches local needs—all aspects contained within this legislation.

As the OHA has recommended, we must develop a privacy model that allows for the flow of personal health information between public hospitals and CSCs. The CSCs should participate in centralized provincial data imaging repositories that enable the flow of information, continuity of care and a better patient experience.

In terms of administration of the act, SHN and I believe that Ontario Health is best suited to take the lead, as they have the capacity to properly collect and analyze data to determine where moving procedures out of the hospital will have the greatest impact on communities' needs. Prior to expanding the scope of services of CSCs to hip and knee replacements in 2024 and beyond, there must be a transparent review and reporting on the success of the first phase of moving low-acuity eye care into the community. CSCs must also have similar oversight, accountability, quality-of-care and patient-safety requirements as public hospitals to ensure transparency and promote integrations between the two systems.

Quality and patient safety need to continue as priority one as the act is implemented. Independent oversight and inspections need to be backed by strong enforcement powers. To maintain public trust, the implementation of CSCs has to ensure the universality of access to services, while maintaining quality care and patient safety. This includes establishing a strong regulatory framework around the sale of enhanced services and medical goods. CSCs should have the same regulatory and reporting requirements as public hospitals. That includes accountability through the Excellent Care for All Act and public reporting of quality and patient safety indicators.

I also fully support the need for the use of existing hospital capacity, where possible, prior to licensing the new CSCs in a specific community.

Another aspect that will require broader system co-ordination is the impact on the health human resources. We will need to mitigate against significant migration of hospital workers to CSCs. This will be a crucial success factor once the act is implemented. To ensure that CSCs do not add to the strain on hospital health human resources, comprehensive capacity plans should be developed within each Ontario Health region to understand the local impact to HHR.

On the physician side, I support OHA's recommendation that physicians who work in CSCs must also have both privileges and on-call obligations at local hospitals. This prevents the loss of services in areas facing specialist shortages, especially in smaller and rural communities. To mitigate revenue loss for hospitals, the shift of less-complex patients away from hospitals should include substantive updates to QPB rates to reflect the resources required to provide the care remaining in hospitals.

I'd also like to echo the words of my colleague, Dr. Andy Smith, who testified before you last week. We support collaboration and action in several key areas, including expanding health care education and training spots, scope-of-practice expansion to optimize scope of nursing, expedited pathways for international practitioners, team-based models of care to support overlapping scope of practice, new-graduate support programs, the extern program and national licensure.

I'd also like to spend a few moments discussing other areas of the act that impact hospitals across Ontario. On the aspects of this legislation that deal with the credentialing of health care workers trained in other province, I welcome any measures that help us recruit qualified health care workers to Ontario hospitals. What nursing and front-line health care workers—

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

Mr. David Graham: —have endured during this pandemic is nothing short of heroic, and in my conversations with front-line staff, the number one piece of feedback I hear is the need to bring reinforcements to the front line of our hospitals. We need to ensure we maintain proper, safe staffing levels.

In closing, I would like to reiterate my personal commitment to work with our local health system partners to ensure the legislation is implemented in a way that supports patient safety, while maintaining the highest level of patient care and safety. The pandemic has placed a huge burden on Ontarians. We have a duty to create an environment where those in Ontario will have improved access to

care across the province. We are supportive of any arrangement which is focused on improving the health care experience for residents in Scarborough.

Thank you for the opportunity to be here today, and I welcome any questions.

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

We'll now turn to our next presenter, from the Ontario Nurses' Association. Please state your name for the record, and then you may begin. You will have seven minutes.

Ms. Angela Preocanin: Good afternoon. I'm Angela Preocanin, a registered nurse and first vice-president of the Ontario Nurses' Association. ONA is Canada's largest nursing union, representing 68,000 registered nurses and health care professionals in Ontario. We also have 18,000 nursing student affiliates. I'm here to deliver a clear message to this government on behalf of our members: Nurses are united in support of the public delivery of surgeries and hospital services.

ONA has significant foundational concerns regarding Bill 60. This bill is unnecessary and ill-advised. Bill 60 will deregulate what it means to be a nurse, will worsen patient care and will see more private corporations profiting off of your health care.

In our written submission, ONA lays out our concerns with regard to the private delivery of care, the deregulation of nursing and the dire impacts this bill will have on the health human resources crisis that already exists in our hospitals. We also offer real solutions to improving the public delivery of care.

Our health care system relies on nurses, but years of underfunding have created the retention and recruitment crisis that is now being used to justify privatization of our public health care under this bill. The real solution is to invest in properly funding and staffing our public health care system.

1310

We know Ontario has the worst RN-to-population ratio in Canada. According to the FAO's latest report, Ontario Health Sector: Spending Plan Review, Ontario needs to hire at least 34,817 nurses by 2027-28. Ontario has the lowest start wage for nurses in Canada, and the unconstitutional Bill 124 has certainly not helped.

Now with Bill 60, the government is planning to establish a parallel privately delivered surgical system which will undermine our public health care system even further. This bill should be scrapped.

ONA has significant concerns that there is no clear requirement in this legislation to ensure staff are not recruited from public hospitals. There are no parameters around pay, benefits, access to collective bargaining for staff in these new profit-motivated clinics. We've already seen privately owned surgical clinics and nursing agencies pay double the wages offered in public hospitals. This draws burnt-out staff out of our public system and exacerbates the staffing issues already faced in our public hospitals. This dynamic is further compounded by wage-suppression legislation like Bill 124, which applies only to publicly delivered health care settings and would exempt the privately owned facilities contemplated in this bill.

As nurses and health care professionals, we also have serious concerns about equitable access to care. Privately owned clinics will be able to refuse to treat patients with complex needs, only taking the easiest, highest-profit cases. For patients, this means you may be put to the back of the line, while those deemed healthy enough will be bumped to the front of the queue. For nurses working in public hospitals, this will mean an increase in patient acuity and a more unmanageable workload.

We also have serious concerns about fee-for-service and undue pressure on patients to purchase medically unnecessary so-called upgrades recommended in these private clinics. ONA recommends that facilities not be permitted to charge fees for uninsured services and instead offer the OHIP-insured services which have been deemed appropriate by the province. If these clinics are to operate, there must be proper oversight and accountability, which are both sorely lacking in this bill. The public must have confidence that the clinics are regulated by the Ministry of Health directly and that information gathered during the licensing be readily available for public scrutiny.

Now I'll shift gears to the deeply troubling schedule 2, which allows the government to amend the definitions of "nursing" to include individuals who are not licensed by the College of Nurses of Ontario. To grant the government the authority to circumvent this licensing and accountability structure is unprecedented and will have far-reaching consequences. There is nothing to prevent the government from imposing regulations passed behind closed doors to allow a PSW with a certain level of experience to work as an RPN or an RPN who has been accepted into the bridging program to work as an RN before receiving the proper education. The regulation of nurses and health care professionals by our professional colleges is a bulwark for patient safety and professional accountability in our health care system and should not be overridden. Again, this legislation is unnecessary and ill-advised.

This bill weakens the oversight of private, for-profit health care clinics and undermines the patients' safety by watering down the roles of licensed medical professionals, including registered nurses, registered practical nurses and nurse practitioners. ONA encourages the government to listen to the voices of the front line and listen to the health care professionals, not the corporate CEOs.

Ontario has the capacity in our existing public hospital system to expand access to surgical care. ORs are sitting empty for up to 15 hours each day because they do not have the staff to increase surgical capacity. The obvious solution is to provide hospitals with the resources to extend operating hours in their ORs.

We need to retain nurses and health care workers by improving their working conditions and showing them they are valued. There is no time to waste. Invest the resources that Ontarians desperately need and deserve in a publicly funded, publicly delivered and fully staffed health care system.

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

We'll now turn to our final presenter, from the Ontario Association of Clinic Endoscopists—did I pronounce that properly?

Interjections.

The Chair (Ms. Goldie Ghamari): Right. Endoscopists.

Please state your name for the record, and then you may begin. You will have seven minutes.

Dr. Ian Bookman: Dear members of the parliamentary committee, thank you for allowing me the opportunity to speak to the potential impacts of Bill 60 on behalf of my organization, OACE, the Ontario Association of Clinic Endoscopists. My name is Ian Bookman; I am a gastroenterologist, the head of division of gastroenterology at St. Joseph's Health Centre in Toronto and the medical director of the Kensington screening clinic in Toronto. I am the president of OACE, where we represent the approximately 70 out-of-hospital endoscopy clinics that currently operate in the province of Ontario. We currently provide one third of all endoscopic care, such as gastroscopies and colonoscopies, for patients in the province. We have been operating for the past two decades. Despite being private, in that we are not publicly subsidized by the government, we are all, every single one of us, 100% OHIP-operated, meaning not a single patient pays a physician to have a gastroscopy or a colonoscopy at any clinic in Ontario.

Bill 60 is being introduced as an opportunity to address backlogs in health care delivery in our province. The current unfunded state of our out-of-hospital endoscopy clinics means that many are on the fiscal brink of closing down. Rising costs with inflation and increased personal protective equipment that started with the pandemic and have become the new norm have made many of our spaces not sustainable. Public funds to support the delivery of endoscopic care are essential to continue to serve our population's needs.

With appropriate funding, many of our clinics can not only stay open but have the capacity to expand our services to higher volumes to address the backlog that was exacerbated by the pandemic. I want to make it clear: Our clinics are not interested, not wanting and not capable of replacing any hospital-based endoscopic procedures. We are most interested in ensuring that each patient receives health care in the most appropriate clinical setting.

For example, I provide endoscopic care in the hospital for my patients with heart failure, lung disease or on dialysis. I provide the same endoscopic care in the out-of-hospital clinic for my otherwise healthy patients who have a family history of colon cancer and require a screening colonoscopy according to Canadian guidelines. Just like a patient does not and should not go to a hospital to see their family physician to have a blood test or a chest X-ray, similarly, a patient should not be using up limited hospital resources to have a straightforward colonoscopy or gastroscopy. Similarly, hospital care is more appropriate and necessary for more complicated endoscopic care, such as dilatations of a narrowing in the bowel, laser treatment of cancer cells or injection treatments for internal bleeding. Because our clinics focus on a more narrow range of procedures, we can accomplish up to 30% more volumes over the same period than a hospital. Patients in ambulatory settings also recover faster and have lower infection rates. Bill 60 is therefore an important part of reducing procedure wait times, both in the hospital and out of the hospital.

Because our clinics have existed for the past two decades, we already have our own staff in place. Funding would not, therefore, create a sudden exodus of physicians or nurses from the hospital setting. In fact, funding would allow opportunities to collaborate. It would create an opportunity to end the isolated, non-connected, siloed structure of our clinics and hospitals that currently exists in our health care system. Funding would allow the opportunity for integration through regional coordination, centralized triage and uploading and sharing of documents and images.

Currently, a patient's experience in terms of wait time is entirely random based on their primary care provider's referral pattern. For example, if a patient is referred to clinic A with a wait time of eight months, then that is their destiny unless the primary care provider takes the initiative to call clinic B, physician C and hospital D to find out their respective wait times—time which the primary care provider is in short supply of and for which they are not reimbursed. An integrated system could offer a publicly funded regional coordinator to ensure all new patients have equal access to the shortest possible wait times for their needs. For those patients that are lost to follow-up, digital record sharing would allow a coordinated return to their original providers.

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A robust framework of quality assurance oversight for out-of-hospital endoscopy clinics has been in place for years through the College of Physicians and Surgeons of Ontario. It includes rigorous infection control, premise and patient safety, and procedure quality standards that are regularly assessed.

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

Dr. Ian Bookman: Tracking and sharing of clinically meaningful quality improvement end points, however, is lacking. Examples of these would include measuring wait times and cancer detection rates on a per clinic and per region basis instead of just on a per hospital basis, which is what we have now. A publicly funded system integrating out-of-hospital clinics can go towards uploading and sharing outcome data with Ontario Health, similar to the hospitals.

Bill 60 is forward-thinking and long overdue. The imperative is that it be implemented in a clinically appropriate, cost-effective way that benefits our health care system and our population. To that end, OACE requests that we continue to be engaged during implementation. We will look back one day and wonder why we waited so long to offer safe, high-quality, publicly funded health care in the community setting in addition to the hospital setting. Thank you.

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

I will now turn to the opposition for the first round of questions. MPP Gélinas, you may begin.

Mme France Gélinas: I would like to thank all three presenters. I will go in reverse order, so I'll start with you, Dr. Bookman. As far as I know, of the 70 clinics that exist right now in Ontario, all of them are physician-owned. Am I correct?

Dr. Ian Bookman: No, you are not correct. Many, if not most, are physician-owned. Some, like the Kensington Screening Clinic, are a not-for-profit organization—owned by Kensington Health—and others are owned by managers or business people. But the majority are physician-owned.

Mme France Gélinas: So there are some that are investor-owned corporations that provide the care through—

Dr. Ian Bookman: Yes. Similar to the owners of diagnostic imaging centres, some have invested in an endoscopy centre.

Mme France Gélinas: Okay. And of all of them, only Kensington is not for profit?

Dr. Ian Bookman: As far as I'm aware, only Kensington is not for profit.

Mme France Gélinas: Okay. Right now, you were talking about that the funding model is not sustainable. You were talking about the underfunded state of—do you know, under the IHF, how much you get for clinical fees?

Dr. Ian Bookman: I do. We get zero. Endoscopic care gets zero dollars right now. It's not qualified as an IHF.

Mme France Gélinas: Ah, okay. That explains a lot. Thank you.

Moving on to Mrs. Preocanin from ONA: It's nice to see you. You brought forward an interesting point that care in the community is not a bad thing. What is bad is when a for-profit, investor-owned corporation makes money off the backs of sick people. You mentioned not permitting add-on fees. Can you elaborate a bit as to what you had in mind when you shared that?

Ms. Angela Preocanin: That would be lenses for the eye clinics that provide option A or B. In some circumstances, I understand that joints are also options. That's what I have been told.

Mme France Gélinas: So the idea would be whatever the government pays for is what you are allowed to provide in the community-based clinic?

Ms. Angela Preocanin: Yes.

Mme France Gélinas: Okay. I agree.

You made an interesting point also with the PSWs doing the work of RPNs, and RPNs in bridging work as RNs. Is this what you said?

Ms. Angela Preocanin: The RPNs that are in a bridging program to accelerate their education to complete the registered nursing program are being utilized in a capacity, in some instances, where they are performing duties that are outside of their scope.

Mme France Gélinas: Are you saying that it is happening now, or that schedule 2 of the bill will allow this to happen?

Ms. Angela Preocanin: This will allow it to happen.

Mme France Gélinas: Okay. That's what I thought also.

And quickly to you, Mr. Graham: I like the idea not only that physicians would have to have privileges but that there should also be on-call obligations with their local hospital. Why would you make that suggestion?

Mr. David Graham: We would make that suggestion as part of the discussion in the bill specifically to make sure that there are the services that are part of hospital care and that they have access to it. So it prevents the physician from fully backing out of their requirements at the hospital to provide services.

Mme France Gélinas: You insisted a lot on universality. A lot of the pushback against the private investor-owned corporations is that they pick the easy—we call it the healthy and the wealthy—and the rest of us go to the hospital. Is this what you meant when you were talking about universality?

Mr. David Graham: What I'm talking about is the fact that there are long wait-lists. When we look within the province, there are over 200,000 cases sitting on surgical wait-lists, and of those 200,000, 40% are waiting for cataracts or for knee and joint replacements. When you are a sick person, what you want is the access to care—to provide care in an acuity setting that is appropriate for the level, as you'll have heard Dr. Bookman reference. These people who are going to be cared for in these facilities need the procedure, are waiting for the procedure and would be able to get the procedure faster by going through an IHF, where they don't have to have the acuity and the oversight provided in a hospital.

Mme France Gélinas: Okay, that makes sense. You did open up by giving us a whole bunch of stats as to how busy your three hospital sites are. An interesting stat was about the ophthalmologists doing 5,700, but you added 1,000 people off the wait-list which bumped it to 6,700—simply because you got more money? What happened that you were able to do that?

Mr. David Graham: I think part of the attraction of Bill 60 for me is that it actually takes a regional approach. So where we were able to ramp up our response based on COVID and the wait-list, we were able to do so. That variability across the province is there, and I think it's part of what Bill 60 needs to address, that they're calling for targeted investments where those wait-lists haven't been able to be reduced. The idea of actually leveraging the ability of hospitals to meet capacity and work to their full capacity I think is an important aspect of the bill.

Mme France Gélinas: Some of the hospitals were saying that because the money was limited—it ended at the end of March—that did not allow them to ramp up. Is this something that you've heard also, that if we were to make money available on a number of years, then many of them would be able to ramp up because they need a little bit of time to get there?

Mr. David Graham: I think capacity planning is something that's always going to be something that we need to undertake, and that would be part of what this exercise would do. So within the application for the licences, they would be looking at what the capacity already is in existence within existing health care providers, and we support that.

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

Mme France Gélinas: Am I hearing you right when you say that if we give you the opportunity, as in the hospital that you represent, you would be able to ramp up the number of cataract surgeries that you did just like you did this year if the resources were there?

Mr. David Graham: Again, I want to make sure I'm really clear here: There is a large provincial distribution issue. So SHN specifically I wouldn't want to discuss, but the fact is there is an interprovincial issue with being able to access the waiting list. We were successful at working through our waiting list and we did that in partnership with OH, but that doesn't change the fact that again, there continues to be 200,000 people on the wait-list, 46% of which are waiting for cataracts.

Mme France Gélinas: Agreed. Right now, are you in a position where you could continue to ramp up?

Mr. David Graham: SHN specifically is able to, and we would continue to do that work with the ministry.

Mme France Gélinas: Do you have resources past April 1 to do so?

Mr. David Graham: We are always working within our own—

The Chair (Ms. Goldie Ghamari): Sorry, you will have to save the answer for the next round.

We'll now turn to the independent member for four and a half minutes. You may begin.

Mr. Adil Shamji: Sir, would you like to finish your answer?

Mr. David Graham: Sure. We're always working with the ministry and OH to make sure that we're identifying the correct care and the way we're working through it.

Mr. Adil Shamji: Great. Perfect, thank you very much, and thank you to your hospital for all the amazing work that it has done for the people in Scarborough.

To the both of you—obviously, thank you to you and to you as well—both of you had spoken to the promise of the bill, and many of us see the potential. This morning, we heard from someone who spoke of potential unintended consequences, and I wondered if you could draw on your expertise in speaking to what any potential unintended consequences of Bill 60 might be and what we can do to avert those.

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Dr. Ian Bookman: Well, as I think it's always said, the devil's in the details. So while the grand picture is forward-thinking and the right approach, I think oversight in the integration, the regional planning and the implementation is essential. The last thing you want is funding to go to a clinic to go straight to line the pockets of the owners of the clinic to have no difference in the volumes that are being addressed and to have an efflux of nursing or staff resources out of the hospital. If done poorly, I think you could have all of the negative consequences. But, if done properly, I think you can maintain resources, you can expand the volumes, and you can have, finally, a long-overdue integrated health care system.

Mr. Adil Shamji: Thank you.

Mr. David Graham: I'd echo those comments, but I would also say that, when you read the bill and look at guardrails that are provided, I think the biggest concern for a lot of people is on the health human resources part of the bill. Requesting that detailed planning comes out that actually outlines what those resources are by procedure I think is an important safe guardrail for that.

Again, we always are trying to flip that and look at it from the perspective of those patients on our SHN waiting list. That's a community that was really hard-hit through a lot of things. There are still people who are uncomfortable coming back to the hospital. So we look at an ability to provide care in different settings that allow people to feel comfortable to get that care; it's something we are absolutely willing to support and trying work with through the system.

To your point, I think the implementation of it and making sure that it's seen as part of a continuum of the system and not a separate system is what's going to be important. What I mean by that is making sure you have access to one waiting list and that you're working through the same information and data requirements.

Mr. Adil Shamji: Thank you very much. So, Dr. Bookman, you've articulated, if executed poorly—and none of us would like to see that—the funds could go in the wrong directions. What would be helpful to see in this legislation to ensure that that doesn't happen?

Dr. Ian Bookman: Whether or not it's included in the legislation, I think it's important that the government work very closely with front-line workers and the stakeholders already involved on the front lines. We see every day and we know how we can improve the health care system, and we have ideas on how to best integrate and implement new funding.

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

Dr. Ian Bookman: I think that it would be a shame for them to roll it out forward without involving, for example, the organizations within the region along with the front-line workers. I don't know if it needs to be included in the legislation; I just think that it definitely needs to be implemented properly.

Mr. Adil Shamji: You may need to continue your answer during my next round of questions, but I did want to follow up on that. We've seen, for example, with temporary for-profit nursing agencies that the funds have gone to line the pockets of certain corporations, and we haven't been able to incorporate the protections in place in order to prevent that from happening. As we look at Bill 60, I consider it very important to see those protections in the legislation, not the regulation, so that we have an opportunity to do that.

And so perhaps—as we wait to come around—I would welcome any suggestions that I can bring forward in specifically the legislation to make sure that we don't have a recurrence of, unfortunately, the fiasco that is unfolding in temporary for-profit nursing agencies.

The Chair (Ms. Goldie Ghamari): Thank you very much. We'll now turn to the government. Who would like to begin? MPP Martin.

Mrs. Robin Martin: Thank you very much, Chair, and thank you to all of the witnesses for coming today and

taking your valuable time out to be here with us and give us some of your insights, which we greatly appreciate. And also thanks to all of you for all of the work you've done helping us get through some very difficult years and making sure patients get care, and also to all your workers, Ms. Preocanin—is that how you say it?

Ms. Angela Preocanin: Preocanin.

Mrs. Robin Martin: Preocanin, thank you.

I had a number of questions—very interesting insights offered, and it's hard to know where to start. But one of the things I wanted to ask about, Mr. Bookman, was that you talked about not needing necessarily new staff to do more surgeries because of the staff you already have in place in your clinic. I wondered if you could just explain that to people a little bit.

Dr. Ian Bookman: I'm only speaking of endoscopic care, so I can't speak to surgical centres or new infrastructure that's being built and staffed. But in terms of what we deliver—colonoscopies and gastroscopies—we are already existing with staff. We have our physicians; we have our nurses. The majority of our physicians are hybrid. Most of us work in a hospital and out of a hospital setting. Most of us do this to address the backlogs and de-stress our own practices. So this legislation, with respect to endoscopic care, is not going to result in a sudden mass efflux.

I'll just elaborate briefly on the last question, if that's okay. The government funds endoscopy right now in hospitals through what's called a QBP, a quality-based program, where they've costed out the direct costs for all the procedures. The government has already explored the costs of out-of-hospital procedures, so they know what these costs are without taking into account any profitability. I think there is opportunity to incorporate that type of modelling into legislation where you can, say, use the modelling that's been done by Ontario Health to cost out the per-procedure basis as a model for how funding should be implemented, so it does not go to line the pockets of the owners.

Mrs. Robin Martin: Okay. Thank you. Is it Mr. Graham or Dr. Graham?

Mr. David Graham: Mr. Graham. Either is fine.

Mrs. Robin Martin: Thank you. You and Dr. Bookman had both made a point of the regional assessment of need etc., and the government has committed to asking for targeted calls for proposals based on local needs. I'm just wondering—if either of you want to answer this—if that is in some way going to help address our need problem, based on particular areas, and also whether it's open to the government in this kind of a bill to issue as many or as few licences or payment for a number of cases as are needed in the specific area.

Mr. David Graham: So I highlight the wait-lists that are across the province, and it's clear in certain areas there is a demand, and the supply for hospital services cannot keep up with that. I think that by having targeted calls, by allowing it to be a geographic distribution, it makes a lot of sense, because there will be areas that will not need those. So for the government to rely on the ability to be able to issue where they see a need I think makes a lot of sense and allows us to have targeted pieces to the wait-lists.

Dr. Ian Bookman: I would echo that. I think regional implementation is essential. There's definitely not one-size-fits-all, and you have to caution that against the government getting into micromanagement. What we lack right now is data because there's been no integration. I think a key part of this is to develop some type of regional oversight to get a good sense of what's happening, not just in hospitals but in clinics currently and, then, from there could probably move forward and talk more intelligently about what volumes are necessary.

Mr. David Graham: To that point, that's where we look and say that the director position embedded within the Ontario Health group makes a lot of sense from our perspective because they'd be able to look at that demand planning from a holistic environment to make sure that the data available is actually run through a central repository.

Mrs. Robin Martin: All right. There's been some suggestion from the members opposite that it's somehow unfair and inequitable that the clinics will be taking the low-acuity cases and the hospitals will continue to do higher acuity cases. Do you see that as an equity challenge for this proposal?

Mr. David Graham: Certainly within SHN we do not. The way we see this is that the right care environment is something that we're always striving for. For instance, in the past when you came in to give birth, you were there for five days. We've now worked that acuity through the system to be able to reduce those lengths of stay. So what we're looking to do is work to make sure that people with the right acuity levels are being treated in the right acuity environment.

What we would say with the opposition is, we don't want to find ourselves in a position where people are able to bypass where they are on the waiting list because they're going to an independent facility. That's why, from our perspective, we see it as such a need that this is flown through one wait-list through Ontario Health to make sure that that wait-list is centrally managed and centrally known, so that you don't have queue jumpers.

Mrs. Robin Martin: Yes, and you may be aware that the government has committed to centralized wait-list management and made some investments into that. I know that Dr. Bookman emphasized integration, as well as you, Mr. Graham.

The other thing was the staff. I was going to ask Dr. Bookman, in your endoscopy clinics, what kind of staff do you use?

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Dr. Ian Bookman: We have reprocessing technicians and front-end clerks, and then we have RNs and RPNs. There are opportunities for collaboration in the sense that our clinic, the Kensington Screening Clinic, has formed partnerships with the University Health Network—

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

Dr. Ian Bookman: —and Unity Health Toronto. In part of that partnership, we did discuss sharing human resources when times were more difficult throughout the

pandemic—including RNs or RPNs—with the endoscopy sites at each location. I think in a regional care delivery model, there's great opportunity.

Mrs. Robin Martin: Thank you. Did you want to add anything there, Mr. Graham? Okay. Angela, did you have anything to say about that? I think you use mostly RPNs is what you said.

Dr. Ian Bookman: Mostly RPNs, but we do have RNs.

Ms. Angela Preocanin: My only comment to that is, we are then taking away from the public system. And to believe that that's not happening, when we have anecdotal evidence that endoscopy clinics and endoscopy suites in the hospital that are going to be leaving to go to private clinics have already asked their staff—

The Chair (Ms. Goldie Ghamari): My apologies. Sorry, I have to cut you off. We are done for this round.

We will turn to the official opposition. Who would like to begin? MPP Gretzky.

Mrs. Lisa Gretzky: Ms. Preocanin, if you would like to finish what you were saying, I would appreciate hearing it. It's unfortunate the government waited until the very end, where you wouldn't get a chance to actually speak, to ask you a question. But I'm interested in the full answer.

Ms. Angela Preocanin: Thank you. Endoscopy suites in the hospital that are asking nurses to leave and join them in their clinics, to leave the hospital to go to these clinics: That is a human health care crisis right there, when we're telling people we are leaving to go open our own clinic and take the nurses with us. We are removing that from the public system. That's very concerning.

Mrs. Lisa Gretzky: Thank you. One of the members from the government side said that we're implying inequity. Let me be clear: We're not implying it; we're stating it. We're stating it. It's a fact. There is an inequity if I am able to jump to the head of the line because I am low acuity and someone who has serious medical concerns has to wait for three, four, five years, in some cases. I can tell you, a gastroenterologist in Windsor years ago—they tried to refer me to one, and none of them would put me on a list because their list was five years long. The people with the greatest health concerns will sit and wait to be seen in the hospital because we already are struggling with health human resources thanks to Bill 124, but we'll have even fewer because many will be going to these private, for-profit clinics who can pay them better, who can give them better hours—no weekends. We're not implying inequity; the inequity will be there. It will be there. It already exists, in some cases.

Ms. Preocanin, during your remarks you had talked about the need for nurses, the shortage that we currently have. Could you just reiterate that number again so that I can be sure I have it written down correctly?

Ms. Angela Preocanin: It's 34,817 by 2027-28. That's the number that's been predicted. We are currently in a great shortage. We are in the worst crisis in health care for the health care workers. It is incredibly difficult to sit and hear "private health care" and "privatization" over and over and not consider the shortage that we already have in our public system.

Of course, health care workers will go where the hours are better, make no mistake. But the benefits, their ability to collectively bargain, their ability to have a decent wage—we don't know these things. We know someone is making that profit.

Mrs. Lisa Gretzky: So it's safe to say that Bill 124 is still a huge barrier to retaining health care workers, more specifically, nurses.

Ms. Angela Preocanin: Absolutely. And work-life balance. What's happening in the hospitals and the work environment has created a situation that is absolutely devastating to our nurses.

Mrs. Lisa Gretzky: Thank you. I just want to say—I know they're not here, but you can get the message back to them. ONA Local 8—if anybody's interested in watching it—put out a series of videos. I highly recommend seeing it to see what it's actually like to be a nurse in our hospital system and the health care sector these days.

I'm going to pass it to my colleague from Niagara Falls.

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

Mr. Wayne Gates: Thank you very much. Just a question to Angela. I've asked all the unions this question. How many members do you represent? Like, your union, how many do they represent in health care?

Ms. Angela Preocanin: Sixty-eight thousand.

Mr. Wayne Gates: Sixty-eight thousand. And I would think, with representing 68,000 members, that you had extensive consultation around Bill 60 because it's going to affect your members so heavily. So maybe you can tell me the number of meetings you've had and the dates.

Ms. Angela Preocanin: We are constantly in meetings with our members, and we are in constant media talking about these things. This is very concerning to us. The deregulating of our nursing staff, PSWs giving medications in long-term care—this is absurd. We need to ensure that the people of Ontario have the care they are so deserved of, and the right care provider giving the care to the patients that are here. We have no idea, really, how this is going to affect patient care, but we know patient care is going to suffer.

Mr. Wayne Gates: My question actually was, was your union consulted by the government on the bill?

Ms. Angela Preocanin: No.

Mr. Wayne Gates: So what we found out over the last two days—it's interesting for the other presenters as well to hear this—maybe not yourself at the end. I don't know; I apologize. But I know that David oversees unionized members. We've had the Ontario Federation of Labour here that represents 1.1 million workers, a lot in health care. We've had Unifor here, we've had CUPE here, and now we've had ONA here, and we have others coming later today. Not one union that represents health care workers in the province of Ontario has been consulted on Bill 60. Can somebody tell me that makes any sense? Anybody? It makes absolutely no sense not talking to the workers that, quite frankly, have saved so many lives over the last three years, that are exhausted and have been shown absolutely no respect by this government. Make no mistake about it. When somebody says, "How can you say that?"—how do

you not consult over a bill that may change how we look at health care for generations to come, including my grandkids and their grandkids? How can they not consult the workers? It makes absolutely no sense.

And that's why I get so upset when I see people that represent organizations, like yourself, David, that know how hard they're working every day. They're giving every ounce of energy. They're under—

The Chair (Ms. Goldie Ghamari): You have one minute left.

Mr. Wayne Gates: I've got one minute left? I don't want to ramble on and do a speech, but also, to your point: In long-term care, 5,400 have died. Most of them died in private, for-profit companies: 78%, which works out to 3,800 of our moms, our dads, our grandparents that have died.

Angela, I'd like you to take back a message. We've only got a minute left. Bill 124 created the crisis. They knew exactly what they were doing when they brought Bill 124 in, knowing that our nurses would leave because they're exhausted and they're disrespected. Their wages are held at 1%. I had a gentleman here today that was a CEO of a hospital making $855,000, and we can't give our nurses more than a 1% raise when inflation is running at 6% and 7%?

I'm sorry, guys; I didn't get to you. It wasn't deliberate. I would love to get to David. They won't give me more time. Give me 10 or 20 minutes. I'd love to ask you guys questions and have a real debate around this important bill. I apologize that I didn't get to you. It had nothing to do with not respecting the roles you play. It's because the way our committee is structured—

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

We'll now turn to the independent member for four and a half minutes. You may begin.

Mr. Adil Shamji: Thanks a lot. Dr. Bookman, continuing where we left off, I know you made one suggestion in your remarks to MPP Martin. Did you have any other suggestions?

Dr. Ian Bookman: Again, I'm happy to elaborate on the opposition. I don't know legislation-specific, but I do think that this is a very important landmark decision that would change the landscape forever going forward, and so definitely, all the stakeholders should be involved and consulted. It doesn't make sense not to. And I think, from that, perhaps there are other suggestions that might arise on how to prevent the concerns of further draining on health care resources or the linings of the pockets of private health care owners. But I think that stopping the improvement or the building of a better system is not the antithesis—is not the same as maintaining the status quo. We don't want to maintain the status quo just because we're afraid that it might get worse. I think that there are probably more ideas that would come out through consultations with my organization and others on the front line, but I can't give you more specifics right now.

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Mr. Adil Shamji: That's fine. Thank you very much, Dr. Bookman.

And just briefly responding to the comment from MPP Martin: From my perspective, the inequity isn't in having low-acuity cases happening outside of hospital. I actually think that there's merit in that. Where I worry about inequity is that it looks like low-acuity cases are going to be compensated at a higher rate than high-acuity cases, and that, to me, is deeply problematic and doesn't deliver the value to taxpayers that we demand and that my constituents ask me to fight for.

Mr. Graham, when we left off, you had been articulating that one of the potential unintended consequences could be around the HHR issues So I just wanted to briefly acknowledge that, and then turn to someone who probably knows more about HHR shortages than anyone, Ms. Preocanin. Can you tell us, is there anything that we can incorporate into this bill that would reassure you that we would be protecting our public health care, our public institutions?

Ms. Angela Preocanin: Ensuring that funding is going back into the public system, ensuring that we retain the nurses that we have, ensuring that there's equity amongst those who choose to go to a private system so that they are not advantaged to the point where nurses in the hospital will leave—that's very important. Stopping the appeal of Bill 124: It's not part of this bill, but it certainly is an underlying factor as to why we're losing nurses. Those are the things that we would recommend—the reinvestment in the nurses that we have.

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

Mr. Adil Shamji: Dr. Bookman, Mr. Graham, one of the concerns that we have heard from many people has been worry about upselling and upcharging that could happen in such facilities. Do you have any reflections on that or any guidance for us to protect our patients from that?

Dr. Ian Bookman: Well, with respect to endoscopic care, there's not much that you can upsell, so that doesn't apply too much to our clinics. But I would say that I think, again, it is an opportunity to incorporate into legislation, to say that OHIP-offered services are what should be offered, no matter where you receive them. We say, for colonoscopies, the patients should have the exact same experience no matter where it's done in the province, in hospital or out of hospital. The same should be for eyes or hips and knees. You shouldn't be offered upsells and perks just because it's a different location.

Mr. Adil Shamji: I have received some complaints that some patients have felt pressured to go for nutritional counselling and that kind of thing as part of their—

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

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

Mrs. Robin Martin: Thank you again to the witnesses. I think it's just unfortunate that the opposition spends all of its time making speeches and not asking questions, especially when we have such great witnesses here. But I'm certainly happy to ask questions myself.

One of the questions I wanted to ask is: I'm not a medical professional, but I understand triage works in the

way that high-acuity cases get treated first because they're high acuity. Is that correct?

Mr. David Graham: There's a stratification across priorities, yes.

Mrs. Robin Martin: And so high-acuity cases are always number one because there is some urgency.

Mr. David Graham: They're managed differently, correct.

Mrs. Robin Martin: All right. So currently, because we don't have much time to get to our low-acuity cases, that's why we have 200,000 people who are waiting. Maybe 100,000 of them are getting to high acuity because they should have been seen. Is that what I understand?

Mr. David Graham: What I would say is that when we look at what we're actually talking about, what would be moved out of the hospital, they're moving lower-acuity patients into an acuity framework that is more appropriate for the care that they need.

It is interesting to hear—we talk about the fact that we want the provider to be able to provide the right level of care. We fully agree, and we fully support that. What we would also say is that that also includes the physical location, that it's the right care, the right provision and the right environment. So it's the three.

Mrs. Robin Martin: Okay. Just with respect to the last few years, my understanding is, the government has given hospitals an extra almost $1 billion—I think $880 million—to help clear the surgical backlog, and that hospitals such as your Scarborough Health Network have been able to do more surgeries as a result and have brought the backlog of surgeries post-pandemic down from about 270,000 to about 200,000. Is that correct?

Mr. David Graham: That is correct. For SHN specifically, they were working to get through what they called long-waiters, to get those under 24%. We were able to work with OH to get those down to approximately 14% as of the end of March.

Mrs. Robin Martin: Well, thank you very much for getting all that done. I'm sure that that was really important to the patients who were waiting, as I know improving access to care is to all Ontario patients, and that's really what this bill is about.

Ms. Preocanin, you indicated that the ONA hadn't been consulted, but my understanding is that the ONA was at a briefing on February 23 on the legislation and that you issued a press release thereafter.

Ms. Angela Preocanin: Not in the consultation itself.

Mrs. Robin Martin: Well, I assume that you could have provided comments and did during your news release, if nothing else. So there was an opportunity to do so.

Interjections.

Ms. Angela Preocanin: A news release is just that, ma'am.

The Chair (Ms. Goldie Ghamari): Excuse me. If members have any comments to make, please make them through the Chair. I want to remind everyone that we have a few more hours left of committee hearings. Let's keep it civil. Let's not interrupt members when they're asking questions. Thank you.

MPP Martin?

Mrs. Robin Martin: Thank you, Chair. The other thing that I'm really interested in is how we can improve the delivery of access to surgeries for patients through this integration between clinics. I understand, first of all, that there is a step forward with this bill, because currently clinics are independent health facilities and not really integrated at all with our system, and that the bill is promoting integration and common direction with centralized wait-list management and the direction of Ontario Health. I just wanted you guys, if you could, Mr. Graham and Dr. Bookman, to comment on the importance of integrating as a way forward in helping manage.

Mr. David Graham: Yes. From our perspective, it's absolutely imperative that it gets integrated through Ontario Health and has a coordinating piece. We see it as a separate stream of care, not a separate system. So from our perspective, having centralized wait-lists, using central depositories for things such as diagnostic imaging—it becomes part of the path of care for the patient and gives them the opportunity to have something that's accelerated as opposed to waiting for in-hospital services.

Dr. Ian Bookman: I would echo that. I think centralized care and triage will improve access exponentially. There's a huge waste of resources both in and out of hospital right now, and centralizing the resources available is key to making sure it's rolled out properly.

Mrs. Robin Martin: You mentioned, Dr. Bookman, referral patterns, which I don't think people who aren't medical professionals maybe know that much about. Could you just elaborate on how this may help with making those referral patterns better?

Dr. Ian Bookman: Certainly. For example, right now, each primary care provider has their own referral patterns that they've gotten to know over the years—this specific orthopedic surgeon or this ophthalmologist—and that wait time might have grown. It's entirely in the hands of that primary care provider to research, to find if there's someone else with shorter wait times or not. Or the patient has to ask around and come up with a name to suggest to their primary care provider. It's quite archaic. Centralizing would allow oversight of the wait times for the care providers, the specialties within the region, and ensure that the patient got triage-directed towards the shortest wait time that's most appropriate for their care.

Mrs. Robin Martin: Thank you very much. I don't know if any of my colleagues have any questions. That's all I had.

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

Mr. John Jordan: Yes, I would just like to turn it back to the staffing, which has been probably the biggest concern in health care since about 2019, when COVID started. Maybe I'll direct it to Angela Preocanin.

This government has put a lot of emphasis on and finances in the health sector as far as staffing goes, from streamlining our internationally trained nurses—there have been 6,727 registered now in Ontario through that streamlining effect. The Learn and Stay program is another great program for rural and northern communities, to help get our young people in those environments and working in

those environments; $4.29 billion for long-term-care staff, for the health care workers in there—

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

Mr. John Jordan: My question is, when we're looking at the upskilling piece—you touched on that and the preceptor arrangement for that, and you indicated there was a risk of nurses working out of their scope as a result of that. Personally, I think, having worked in health care, it's a great program for training. I'm just wondering if you could expand on that.

Ms. Angela Preocanin: Ultimately, in the long-term-care sector, where PSWs would be asked to administer medications, that falls again on the registered staff that are there. They have to be able to be certain they're delegating that act to the care provider, and that is not helping their workload. That increases their responsibility and their workload because, ultimately, they are the professional who is responsible for that. So we are trying to upskill something that is not necessarily in the best interests of our patients, our residents and our clients.

Mr. John Jordan: So you're suggesting [*inaudible*] upskill them?

Ms. Angela Preocanin: We have to upskill where it is necessary but not where it is unsafe.

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

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, the deadline for written submissions is tonight, Monday, March 27, 2023, at 7 p.m. Eastern Daylight Time.

TORONTO CENTRE FOR MEDICAL IMAGING

KENSINGTON HEALTH

ONTARIO SOCIETY OF CARDIOLOGY TECHNOLOGISTS

The Chair (Ms. Goldie Ghamari): I'd now like to call upon our next set of presenters, starting with the Toronto Centre for Medical Imaging. Please state your name for the record, and then you may begin. You will have seven minutes.

Dr. Alnashir Ismail: My name is Dr. Ismail. I'm CEO of the Toronto Centre for Medical Imaging. Good afternoon, and thank you very much for the opportunity to present to you today. You are in the process of deliberating over an important piece of legislation and innovation of our health care system, and I thought it important that you have the chance to hear from an existing independent health facility, or IHF, licence holder in the medical imaging space. I'm a diagnostic radiologist and have operated at the Toronto Centre for Medical Imaging, TCFMI, since 1975 or almost 30 years. I've also served as an IFH assessor for the CPSO since 2000.

Imagine the following scenarios: A 40-year-old woman with two young children whose mother passed away from breast cancer at the age of 50. She feels a two-centimetre lump in her breast one day. Her doctor gives her a requisition to book an appointment for a mammogram. Or a 20-year-old student athlete who injures her finger playing varsity volleyball. An X-ray done at the hospital shows no fracture. Two weeks later, the finger is still swollen and painful. Her doctor gives her a requisition to book an appointment for an ultrasound. Hold that thought.

Let us take a quick journey into the history of medical imaging in Ontario. In the 1980s, when ultrasound and mammograms came of age, the government of the day decided that it would allow these services to be offered in IHFs. Today, 50% of all medical imaging, other than CT and MR, is done at IHFs. Despite that, the wait times for mammograms and ultrasound in some communities can be as long as six months.

TCFMI is a 7,000-square-foot IHF located in the financial district in the heart of downtown Toronto, offering a wide range of diagnostic imaging services, including X-rays, ultrasound, mammograms, echocardiograms and bone density scans. When we first opened, we were the smallest IHF in this catchment area and one of the smallest in the province, but thanks to our bold, innovative and creative patient-centric approach to diagnostic care, we have since grown to be the largest IHF in downtown Toronto and one of the largest in the province. The success of TCFMI has been based upon our core values of providing the highest-quality imaging, ensuring short wait times and being accessible to patients. At TCFMI, we aim to maintain wait times of 24 to 48 hours, ensuring patients are seen on time without delay. We've obtained voluntary and, of course, mandatory accreditations for the services we provide.

We have built a significant referral network with physicians across the city. While many of our patients either live or work in downtown Toronto, we see patients from across the GTA and some even travelling hours for their appointment. We see about 200 patients per day. These patients are taking the burden off an already overstretched hospital system. I can only speculate on what wait times for these types of medical imaging services would be if, like CT and MR, they were still done exclusively in a hospital—a one-year wait for a mammogram, maybe?

To be clear, these long wait times are not new. They've been around for decades. Most importantly, every patient who walks through our doors has their OHIP-funded imaging covered with their OHIP card, not a credit card. A chest X-ray is a chest X-ray. A spine MR is a spine MR—OHIP insured, nothing to upsell.

That 40-year-old mother of two young children lived almost a three-hour drive from TCFMI. She called our office for an appointment because she did not hear back from the imaging departments in her community and could not contact the appointment desk. These women are terrified of breast cancer, and rightly so. Every minute of waiting feels like an eternity. She had an appointment for a mammogram and breast ultrasound within 24 hours at TCFMI, and we offered to do a breast biopsy on the same day, if necessary.

As for the varsity volleyball player, she called the same hospital where she went for her X-rays and was told that she could have her ultrasound in two months. She found

TCFMI in a Google search, and we were able to scan her finger in 24 hours.

CT and MR have been around for almost 40 years. However, access to these has not been rolled out through the IHFs except for the 10 licences issued by the Harris government 20 years ago. Today, about 95% of CTs and MRs are done in hospitals, and of these, 80% are outpatients. So while wait times for services available in IHFs may be unacceptably long in some hospitals, the wait times can be as low as a few days, as is the case at TCFMI.

Meanwhile, the reason we are here today is because the wait times for the two imaging modalities, CT and MR, done almost exclusively in the hospitals in this province, can be as long as one year in some centres. It is for this reason that I fully support Bill 60 and the government's planned expansion of IHF licences for both CT and MR and believe that it is long overdue.

Based on our experience at TCFMI—with all the services we offer, with our almost 30 years of experience in this business in this most densely populated community in the province with the highest number of MRI machines and some of the longest wait times—we are confident that we would be the kind of partner the government would be looking at to address this serious issue.

For some arbitrary reason, you've been able to go to a clinic like TCFMI for an X-ray, ultrasound or mammogram, but to get a CT or MR, you've had to go to a hospital. Bill 60 will allow patients waiting for a CT or MR out of the hospital network—

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

Dr. Alnashir Ismail: —and move them to IHFs like ours with an exemplary track record of longevity, excellence and care.

Our hospitals should be for treating and caring for our sickest patients, not for mostly well people waiting for an imaging study. This initiative by this government will help take pressures off our already stretched hospital network. It will lead to a reduction in wait times, deliver care where patients live and work during regular waking hours for most people.

But for the government's plan to be successful, it needs to be rolled out strategically. We need to set the highest standards of quality and expertise in awarding these licences. Publicly funded, privately delivered health care has been a reality in Ontario's system for decades now. When done right, it works.

I would invite you to come and visit us at TCFMI to learn a little bit more about how IHFs should work. I thank you for indulging me here today by letting me share some of my thoughts on this subject.

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

We'll now turn to our next presenter, from Kensington Health. Please state your names for the record, and then you may begin. You will have seven minutes.

Mr. Adil Khalfan: My name is Adil Khalfan, and I have Terry Caputo on the line as well.

Good afternoon. My name is Adil Khalfan, and I am the president and CEO of Kensington Health. On behalf of the Kensington Health community, I would like to thank the members of this esteemed committee for giving me the opportunity to share our perspectives on Bill 60, the Your Health Act.

Before I make my comments about the bill, I would like to briefly tell you about Kensington Health. Kensington Health is a vibrant not-for-profit community health service provider located in downtown Toronto. Our services include ophthalmology, cancer screening, diagnostic imaging, caregiver support, long-term care and hospice care. Most of our services work with teaching and academic health partners, and pursue research and knowledge transfer for better care.

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Every day we come to work with the goal of giving new meaning to community care. We also believe that we cannot work alone. Kensington Health is proud to partner with health service providers across our region and the Mid-West Toronto Ontario Health Team. We have several unique partnerships with hospitals, and as a holder of IHF licences, we help to reduce the province's surgical backlog by moving routine procedures into community settings, thereby allowing hospitals to do what they do best: focus on the acute care needs of our community. We submit our data to the provincial wait time information system. While we have operated our IHF services, we haven't operated independently; we have actually been an integrated health system partner.

Kensington Health welcomes Bill 60. We welcome it because we have been living the models that it sets out since 2006, and, I want to add, we are doing it quite well. We're often noted by system leaders as the gold standard for not-for-profit IHFs.

Bill 60, if implemented thoughtfully, can improve access to equitable care in Ontario and has the potential to significantly move the dial in providing the right care, at the right time, in the right place. The changes proposed will help break down parallel systems into a better aligned and more integrated approach to augmenting system capacity.

At the heart of successful implementation must be a philosophy of system-wide integration. This means that IHFs—or integrated community health services centres, as they will soon be called—should not be funded and operated in isolation from the rest of the health care system.

There are four points I would like to make about the implementation. Firstly, it is critical to partner with hospitals, Ontario Health and our respective regions to collectively understand, plan and create capacity in response to system gaps to solve the real quality of life and health challenges for the people in our communities. Secondly, we must transparently report into a central repository to ensure that capacity and wait times are understood and responded to as a single system all focused on common goals. Thirdly, an independent third party should be established with the mandate to ensure that services and providers are providing safe, equitable care in complete alignment with the Canada Health Act. Lastly, we need to ensure that centres like Kensington, which have lived the model that is integrated, high-quality, safe and equitable, be incentivized to provide

such care and models to other communities across the province.

With these values as our north star, I'm confident that we can work even more seamlessly as a system to respond to the health care needs of our community. We know that this approach works. We live it every day. As an integrated health system partner, Kensington has demonstrated our capability to significantly reduce wait times on surgeries that can quite literally change lives.

I'd like to tell you a story about Mrs. M, a patient we saw at the Kensington Eye Institute. She's a 75-year-old widow on a fixed income who lives alone. Due to challenges with mobility, she has relied heavily on being able to drive to church and to other community activities to stay connected. Unfortunately, her vision deteriorated so much that she had to stop driving. Mrs. M needed cataract surgery. She was perfectly happy to continue using her glasses to see; she just needed her cataracts out.

Once in our care, her surgeon carefully explained her options and the implications for her vision. She was presented with an option of a fully OHIP-insured lens that would still require her to continue wearing glasses, or she could opt for lenses with an out-of-pocket fee that would eliminate the need for glasses. Together with the care team, Mrs. M decided on the insured option, as she did not mind wearing glasses. On surgery day, in just a little over an hour, Mrs. M's surgery was complete. A short while later, she was able to resume her daily activities and reconnect with her community. To those of us in the heath care system, cataracts could be just a routine surgery, but to Mrs. M, it changed her life.

The final consideration when we think about the implementation of Bill 60 is that there must be a commitment to transparency and patient choice. Kensington advocates strong transparency in cost of services: those covered by OHIP and any that come out of pocket at additional cost to the patient.

When implemented with appropriate oversight—

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

Mr. Adil Khalfan: —Bill 60 has the potential to make a real tangible difference in the lives of Ontarians. We are excited for the months and years ahead and look forward to working with our health care colleagues, near or far, in helping to fill the gaps in the system and meet the needs of our community. That's why we do the important work we do, giving new meaning to community health care.

The Chair (Ms. Goldie Ghamari): We'll now turn to our final presenter, the Ontario Society of Cardiology Technologists. Please state your name for the record, and then you may begin. You will have seven minutes.

Ms. Blair Arnold: Hi. My name is Blair Arnold. I am the president of the Ontario Society of Cardiology Technologists. I am a registered cardiology technologist with over 20 years of experience in the field. Thank you for the opportunity to present on behalf of the over 1,100 registered cardiology technologists, or RCTs, on Bill 60 to discuss proposed amendments to Ontario's Your Health Act.

I would like to ask the committee to consider the addition of an amendment to regulate vital organ health professions such as RCTs to better protect patient health and safety and reduce inefficiencies caused by the duplication of testing and assessment due to improper administration by non-RCTs as well as erroneous referrals for physician specialist consultation. This would create greater efficiency and cost savings, and strengthen recruitment and retention of vital-organ allied health professions.

Our members have received education and training in cardiac diagnostic testing, including ECG administration and interpretation, stress testing, ambulatory monitoring, implantable cardiac devices, cardiac catheterization and electrophysiology testing. They practise in teaching hospitals, community hospitals, outpatient labs and private physician practices. There are currently four accredited programs in Ontario that offer cardiology technology as a two-year diploma. RCTs are uniquely trained to detect cardiac anomalies and activate appropriate responses and referrals to other health care professionals and services.

COVID-19 highlighted the value that RCTs bring to patients and the health system, but also unveiled glaring issues with regard to patient safety, access and health spending. As RCTs are currently not a regulated profession but instead are delegated by physicians, this has left room for other professionals, namely nurses, respiratory therapists and lab technicians, to be tasked with performing the duties of an RCT. In a private clinical setting, even clerical staff have been trained on the job to perform some of this testing.

The safety issue arises when the test is performed incorrectly, which is all too common, and results in either misinterpreted or unnoticed anomalies. Our members have submitted many reports of patients suffering injury or, in extreme cases, death due to improperly performed tests and misinterpreted results.

Though RCTs perform under the delegation of a physician, the presence of a physician during and immediately after testing is not assured, and is, in fact, a rarity, as they attend to their practice demands. RCTs are entrusted to accurately perform and review the test results and notify the appropriate medical professional in the event immediate treatment or intervention is required, as they have received specialized and specific training in the interpretation of these results.

I recently received a report from one of our members detailing the outcome of poor testing performed by a non-RCT on a 10-year-old child. This patient was sent to a private outpatient clinic for an ECG, which was performed by a lab technician—a simple and inexpensive preliminary test which triggered an urgent consult one week later to a pediatric cardiologist due to suspected Brugada syndrome, a serious condition affecting the electrical signals that pass through the heart, which can result in severe injury and death. At the consult, a repeat ECG was performed by an RCT and showed a completely normal result. The RCT then, upon reviewing the previous ECG completed at the lab, moved two of the chest electrodes one rib spacing, which is approximately one centimetre on a child, and was able to replicate the same Brugada-style pattern.

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The cost to the patient and the health system was threefold: lost time from work and school and incredible stress for

the patient and their family; the expense of a pediatric consult, repeat ECG and an echocardiogram; and the loss of the consult appointment slot that could have served another patient with a legitimate cardiac complaint.

We recognize and appreciate our health care colleagues' role in providing care to Ontarians. However, they have not received adequate education and training in this space to deliver the right care at the right time to Ontarians, nor can Ontarians be sure they are receiving testing by a qualified professional.

Post-COVID patient volumes have swollen over the last 12 months, with many patients presenting to emergency departments and urgent care clinics with exacerbated illness due to lack of access to appropriate diagnostic testing during the height of the pandemic. Budgetary concerns have driven many health systems to elect to place the responsibility of cardiac diagnostic testing onto other professionals, including nurses, RTs and lab technicians, to avoid extra spending on human resources by utilizing RCTs.

The outcome is an increase in spending, namely for overtime due to increased workload, the need for repeat testing by an RCT due to improperly conducted tests, erroneous referrals to cardiologists and emergency departments, patient injury requiring hospitalization and, in extreme cases, death.

As the Ontario population ages, with cardiac disease incidence rates estimated to be between 4% and 25%, early and accurate detection and treatment of these diseases—

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

Ms. Blair Arnold: —would save the province approximately $20,000 to $80,000 per patient per day in hospitalization costs alone.

If we truly care about Ontarians, registered cardiology technologists need to be regulated to bring reinforcements to the front lines of our health care system, make Right Time, Right Care more accessible, to protect our health care budget and to align with the Plan to Stay Open: Health System Stability and Recovery.

Thank you for this opportunity to present.

The Chair (Ms. Goldie Ghamari): We'll now turn to our first round of questions with the independent member for four and a half minutes. You may begin.

Mr. Adil Shamji: Thank you very much to everyone who has presented. I know we have health care workers, or people who are enabling the work of health care workers, so thank you very much for all of your service, particularly during the pandemic.

I'll preface my remarks by saying I acknowledge the merit of moving diagnostic services and procedures outside of hospital, but it has to be done the right way. That, in my opinion, is actually a very, very difficult task.

For example, Dr. Ismail, I'm very happy to have you here because I want to make sure that we get our diagnostic services delivered to patients in the right way. We saw, for example, in Saskatchewan, that we went to for-profit, private MRI clinics. Between 2015 and 2019, there was actually a doubling in the wait time for MRIs which, to me, articulates the importance of getting this right.

From that perspective, Dr. Ismail, what do you think needs to be in this legislation in order to ensure that despite all of our best intentions, the wait-list doesn't increase, that we don't see unintended consequences such as upselling and upcharging? Do you have any recommendations for us?

Dr. Alnashir Ismail: I can only speak for my experience in downtown Toronto. Our experience in downtown Toronto has been of IHFs that have turned over a lot; some have gone bankrupt. I am not privy to what they did to do that, but I know what we have done over here.

What we have done at the Toronto Centre for Medical Imaging is, number one, focus on the highest quality of care possible. We're operating with five major teaching hospitals in our backyard. We have had to make sure, when the patients come to us, that they feel they are not being short-changed. So we have had to maintain the standards that the teaching hospitals are maintaining.

We have made accessibility extremely important. When we moved from a 700-square-foot facility to a 7,000-square-foot facility, we made sure that it would be accessible by the PATH, so that patients who are working—we've got hundreds of thousands of patients working in the downtown Toronto towers. We wanted to make sure that it would be easy for them to come to our office during their breaks.

And then the last thing is that we made the wait times extremely short. I just saw a woman who was in—literally an hour ago, before I came over here. She was in Florida and had a palpable lump. It was going to cost her $8,000 to get a biopsy in Florida. She came over here. I saw her right now. She's going to be booked for a breast biopsy in the next day or two. That is the kind of care that is possible to be delivered with the right operator. So the ministry has to make sure that they make the correct decision in picking the correct operator with the correct value system.

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

Mr. Adil Shamji: I appreciate you saying that, because that is one of my concerns. Currently, the decision of who becomes an operator is left to a director, but there are no criteria, absolutely, in the legislation that outline what makes a good director and how to protect against things like conflict of interest.

Mr. Khalfan, on the topic of high-quality care, I can't think of an institution that provides higher quality care than the Kensington institute. In your remarks over here, you mentioned that centres like Kensington need to be incentivized to provide such care to other communities across the province. Obviously, Kensington existed without Bill 60; it can, of course, exist within Bill 60, as can an entire spectrum of organizations with varying quality of care. How do we make sure in Bill 60 that we get a whole bunch of other institutions that are exactly like Kensington institute and not like some of the other institutions, perhaps, that Dr. Ismail referred to that have gone out of business?

Mr. Adil Khalfan: Well, in a quick statement, it would be a lot of collaboration with Ontario Health, providers in the government, academic—

The Chair (Ms. Goldie Ghamari): That concludes our time for this round.

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

Mrs. Robin Martin: Thank you to all the witnesses for being here.

If I could just invite you to continue on that answer, because I was going to ask the same question as MPP Shamji. Go ahead, please.

Mr. Adil Khalfan: I have to say, I love MPP Shamji's first name.

Mrs. Robin Martin: It is a good one.

Mr. Adil Khalfan: It is about collaboration. We do a lot of work with our academic partners to really understand the appropriate models of care. They help us determine where it's safe and how we put the right quality systems in place. Highlighting those aspects of this bill—I think the structures are in there in terms of safeguards to promote more work that way, and having the establishment of Ontario Health as a system operator. That tri-party partnership can go a long way in informing the process and the quality assurance going forward, but you still need a third party, a third party that has the clinical and quality-assurance aspects to it that can work within the academic constructs of what we need to be able to deliver. I think, again, more consultation that way, having operators inform the implementation plan—not-for-profit, credible operators that are there specifically for advancing the needs of the community and advancing the needs and outcomes of the patients we serve. So, more consultations and an integrated approach with our operators, the government and partners.

Mrs. Robin Martin: Thank you very much. I do appreciate the answer. We're certainly looking forward to collaboration around the regulations and making sure we get it right.

I had a question for Dr. Ismail as well. Perhaps, Dr. Ismail, you could tell me, as an operator of a downtown independent health facility currently—which, I imagine, is very convenient for people working down there. I used to work downtown and would have found that a very convenient place to get a scan or an X-ray. What are some of the ways that you think having an integrated clinic—like yourself, integrated with the health system—can help relieve some of the burdens currently facing and challenging our health care system?

Dr. Alnashir Ismail: It seems to me, at least from the imaging that we do over here, that there is a capacity issue, based on what I'm seeing with the hospitals.

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As an independent health facility, if I feel that our wait times are getting to a week and we don't think that a week is right, I just have to make a decision that I'm going to get another ultrasound machine. I'm going to tell my manager to hire me an ultrasound tech, and then we just do it. We have the space to accommodate that. I imagine that a decision like that would be very difficult in a big hospital-type environment. That is the single biggest reason why we have been able to keep our wait times low.

And we've done this with mammograms. We've got two full-time mammogram technologists right now because we felt we needed that. I don't see why there would be any difference for CT and MR. As long as the government works with us, we will add capacity to address the wait times. That's what we've done our entire life at TCFMI. That's what we will continue to do.

Mrs. Robin Martin: I take it—this is for either clinic operator—that every patient who comes through your door and pays with their OHIP card is a patient that you see. Do you ever reject patients for any reason?

Dr. Alnashir Ismail: If they have a valid OHIP card and we offer the service that they've come for, there's absolutely no reason. We don't know whether the patient has an OHIP card or not until they actually present for their appointment. So if it happens to be someone who is a non-Canadian, for instance, who doesn't have an OHIP card, they don't get to the front of the line, because we don't ask for that information when we book the appointment. It's only when they come over here that we know: "If you have an OHIP card, show it to me." If not, and if you're not an Ontario resident and you don't qualify, then, obviously, you don't get an OHIP-insured service.

Mrs. Robin Martin: All right. And Mr. Khalfan?

Mr. Adil Khalfan: The only time we would maybe reject is if it was an inappropriate referral to us. There are times when you may need cataract surgery, but you can wait another year because you're not at that safety mark. Those clinical guidelines are based on clinical forums that determine what's appropriate, what's not. But we continue to follow those patients. That's the only time we'd actually reject someone from getting the care they would need. It's all about clinical appropriateness.

We, at Kensington, always serve the needs of our marginalized population. It's part of our mission to have that equitable care. We're finding ways and times within the work week to actually accommodate some of the populations that are around our neighbourhood and in our community to provide that care that they don't always have access to in other centres. We actually have an equity, diversity and inclusion lead as part of the work we do at Kensington, because that's central to our mission.

Mrs. Robin Martin: Thank you very much for that. You also emphasized—is it Mr. Khalfan?

Mr. Adil Khalfan: Yes, "Mr. Khalfan."

Mrs. Robin Martin: You also emphasized patient choice and the importance of patient choice. I just wondered if you could elaborate on what you were referring to.

Mr. Adil Khalfan: As a nurse by profession, I think what resonated with me at Kensington is that it is a partnership. It's not just about us delivering care; it's about the community, the patient, the service provider, the entire organization working together. It is our responsibility to offer the choice—

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

Mr. Adil Khalfan: —and also our responsibility to elaborate and explain what each choice would mean for that particular person so that they're making an informed choice for what they need to do.

Our example that I mentioned totally outlined that she did not need to get that lens where she could do away with her glasses, but she made an informed choice with the care team as partners.

Mrs. Robin Martin: I see. So you left it up to her as to whether she wanted to continue with her glasses or not, or pay the extra cost so she could get rid of that.

Mr. Adil Khalfan: We did, but she made an informed choice.

Mrs. Robin Martin: Right. The most important thing is that she was fully informed—

Mr. Adil Khalfan: Absolutely.

Mrs. Robin Martin: —and could make the choice. Okay. Thank you very much.

My understanding about the Saskatchewan clinics that were referred to offhand was that they were started to try to clear pre-pandemic wait-lists. Anyway, that's for another province, I guess. Thank you very much.

The Chair (Ms. Goldie Ghamari): Thank you. I'll turn to the official opposition. MPP Gélinas.

Mme France Gélinas: I will jump a little bit, but I will start with you, Mr. Khalfan. I liked the stories that you shared with us. I have complaints from all over the province: She went to see her ophthalmologist, they needed to do a second eye measurement and it's $250, and then she comes to me and says, "Does the government reimburse me for that $250? Because I don't have the money to pay for that."

How do you do this informed consent? Who does it? How do you make sure that it is informed? Because I have thousands of people who had to pay and don't know why.

Mr. Adil Khalfan: Thank you for the question, an important one for ensuring that we are transparent in what's required and what's not. I can only speak from Kensington Health's perspective. Our role as a not-for-profit is to ensure that we have that partnership. We go through a transparent way of actually going and talking to the patient. I have the actual way in which we identify what the benefits and positives are for each choice the patient would make, and at the end, a transparent list of prices would be provided and the patient would have to sign off, as well as the health care provider who went through the conversation, to say, "This is what we discussed." That's our safeguard—

Mme France Gélinas: Is the health care provider the ophthalmologist or somebody else within Kensington?

Mr. Adil Khalfan: Sometimes it's the ophthalmologist; sometimes it's the nurse who is working with them or the tech. It's the care team at Kensington that would go with that patient and explain to them what they would require.

Mme France Gélinas: How much time does that take, and who pays for that time?

Mr. Adil Khalfan: That's covered by the services we already provide. Could you elaborate on your question about—who pays for the time of the consultation?

Mme France Gélinas: Correct. I saw your page. If somebody who needs cataract surgery doesn't read very well, I'm guessing somebody has to read that page for them. It takes time, effort, energy to go through this.

Mr. Adil Khalfan: I would argue that that time and effort is the responsibility of us as care providers, to provide that time to that patient. We can't categorize every single point of a therapeutic exchange. In this case, this would be the responsibility of the health care provider. We wouldn't charge extra for that consultation. It's part of the ethos of how we deliver publicly funded care.

Mme France Gélinas: You are one of the few who submit data to the province's wait time information system. How were you chosen? Or did you volunteer to do this? And how come nobody else does?

Mr. Adil Khalfan: Well, it starts with the inception of Kensington Health. As a centre that would provide out-of-hospital procedures, we work in collaboration with partners like Sunnybrook, UHN, Unity—at that time, St. Mike's—and Mount Sinai to create this opportunity to say, "Okay, if we are going to be that centre to receive the volume so that the hospitals can do what they need to do best, how are we going to track this happening?"

So that has been part of our existence. I think it's the right thing to do. As the government and Ontario Health start to implement a central wait-list management program, this information comes in so critical in terms of giving us a line of sight as to where we're doing well and where we're not doing well, and we hope to use this as a building block for future opportunities.

Mme France Gélinas: Do all of your ophthalmologists have privileges in hospital? And do they all take part in on-call?

Mr. Adil Khalfan: From what I understand, yes. We have cross-appointments in various hospitals. They also work as part of the Toronto school of medicine's ophthalmology department, so they have an academic part, but they also have appointments at the hospital for admission, should there be complications or not.

Mme France Gélinas: Do you figure this is an important part of the integrations that you talked about?

Mr. Adil Khalfan: I think it's critical. It's what we need for the safety of our patients, so that the systems work hand in hand and complement each other, so that we can actually all focus on one goal, rather than two parallel systems operating at the same time. These safeguards set up the building blocks to have that happen in a more formalized and structured way.

Mme France Gélinas: Would you be willing to share with us that piece of paper you showed me?

Mr. Adil Khalfan: Absolutely. We're all about transparency.

Mme France Gélinas: Much appreciated.

I still have lots, but I want to go to Dr. Ismail. Who owns the Toronto Centre for Medical Imaging?

1440

Dr. Alnashir Ismail: I do.

Mme France Gélinas: You do? Okay. Is it important for you that it be owned by somebody who is registered with the College of Physicians and Surgeons of Ontario?

Dr. Alnashir Ismail: I think it would certainly be advantageous for quality assurance purposes to have a stakeholder like a radiologist in that role, yes.

Mme France Gélinas: So if I hear you well, you're saying that you have been there for 30 years, you've done ultrasounds, mammograms, X-rays. You feel that you're ready to go on to do CTs and MRIs. Am I hearing you right?

Dr. Alnashir Ismail: Well, not me personally. But I know how to implement an organization that can do many kinds of imaging in downtown Toronto. I know how to do that. I know what is required. We have shown over the 30 years—take something like mammography. We did not have to be accredited for mammography until sometime in 2010, 2012. When I took over Toronto Centre for Medical Imaging in 1995, my first goal was to get accredited.

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

Dr. Alnashir Ismail: By 1997, we were accredited even though it was voluntary, and it was not made mandatory for another 15 years.

There was no accreditation program for ultrasound in the entire country, but for 20 continuous years, we sought accreditation from the American College of Radiology just to make sure that we were providing the kind of care that the experts at the American College of Radiology say we should be doing. We got the same amount of money for doing all the work. We didn't get any extra money. We didn't get any extra referrals, because no one really knew about it; no one really cared about it. But for our own peace of mind, we wanted to make sure that we were doing what was right, and that is what has allowed us to keep up with the hospitals in downtown Toronto.

We were the first clinic to be accredited for bone density when that program was rolled out by Osteoporosis Canada. So we would have absolutely no problem—

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

We'll now go to the independent member for four and a half minutes. You may begin.

Mr. Adil Shamji: Mr. Khalfan, I do like your first name as well.

I wanted to follow up on your earlier answer about how collaboration is one of the really important steps to ensure high-quality care. What exactly does that look like? We've heard during these public hearings that many stakeholders who would have wanted to have had a say in the formulation of Bill 60 felt as though they were left out. We see elements of the bill in which, for example, we have no idea what a director could be and therefore what the nature of that kind of collaboration could be. In your opinion, in concrete terms, what should collaboration look like?

Mr. Adil Khalfan: I think additional consultations, for sure, in terms of how to implement the bill, what the regulations look like; ensuring that membership of the consultations includes both administrators, clinicians and patients—because it's important to have the patient voice in some of those collaborations as well.

I would actually really like to make sure that Ontario Health as a system operator arranges those types of consultations with the government, because it is a partnership. Health care has to be a partnership both from a clinical perspective and administrative perspective as well as a strategic perspective.

The consultations need to also be informing what the wait times actually look like. Where do we have gaps? There are tables that are set up through Ontario Health regions that have their system partners together looking at performance data. That performance data actually helps to identify where we might need additional support, where we can actually leverage best practices—and using those platforms as a way to inform policy and regs but also understand the operations of what may be implemented. That tri-partnership type of approach is what we've been using even within the Kensington Eye Institute, where we work with the University of Toronto, we work with our clinicians, we work with our providers and our partner hospitals to say: How are we going to ensure that we're delivering safe care? How do we make sure that there are safety nets in place should we have some complications? How do we plan for better models of care? I mean, we share our anesthesiologist support from UHN, and through that, we've been able to come up with better models of care delivery using anaesthesia assistants, and really being able to augment the type of limited resources we have in a safe way. It's been working since 2006, so definitely time-tested and true approaches to delivering safe care.

Mr. Adil Shamji: Thank you. Earlier this afternoon, we heard from the Ontario Association of Clinic Endoscopists that one of the potential unintended consequences is that a model like this could lead to the diversion of funds to corporate pockets—a potential concern. I don't think that's what Dr. Bookman was saying is a guarantee, but he identified that as a concern. He shared with us some ideas about how we can protect against that—

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

Mr. Adil Shamji: —and I wondered if you have any ideas as well.

Mr. Adil Khalfan: I definitely do. I think as a not-for-profit, some of the elements that I identified in my opening remarks allude to transparency of prices, making sure that we're all submitting data to a central repository so we know which centres are doing well and which ones aren't, how we are selecting the cases, and being part of that central wait-list management system. I believe that those elements are critical as we start looking at what health care delivery means when you're augmenting capacity through integrated health service providers. Those would be just surface-level areas. I would have to drill down a bit further. But again, transparency, patient choice, submitting data to a central spot that can be reviewed collectively by system operators as well as clinicians is critical to understand—

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 seven and a half minutes. MPP Anand, you may begin.

Mr. Deepak Anand: My question is to Kensington Health as well. I was looking at your website. You offer a wide range, a diverse range of services, including long-term care, hospice, community care, cancer screening, diagnostic imaging, ophthalmology, eye tissue processing. With all that stuff, you have health care professionals, but do you have non-health care professionals as employees as well?

Mr. Adil Khalfan: Absolutely. We have RNs, RPNs, surgeons, care coordinators—

Mr. Deepak Anand: They're all health care—but non-health care professional employees as well?

Mr. Adil Khalfan: Yes, absolutely.

Mr. Deepak Anand: What do you see in their case in terms of the labour shortage? Do you see any labour shortage in their case as well?

Mr. Adil Khalfan: We rely heavily on the work of volunteers and others that provide a very holistic approach to health care. We have pastoral support. We have the Second Mile Club, who are community individuals that are trying to create a better quality of life when we're looking after the elderly. We have a seven-year wait-list to get into our long-term-care home because it's top quality. But what are we doing about those waiting on the wait-list to get in? And so services like the Second Mile Club, volunteer supports and virtual care strategies that the government is putting out are all elements to helping deliver that care quality required.

Mr. Deepak Anand: So just on that, I want to take an opportunity to ask you: Do you see Kensington coordinating with hospitals and other community-based service providers to support integration and care pathways? If so, what are those?

Mr. Adil Khalfan: Yes, I think the potential is large. We have a tried, tested, true model that can go to other regions, and I think we can definitely explore that further with the communities that need it. Every community across the province is different. In downtown Toronto, we have seven hospitals delivering care. In another community, there's only one hospital and it's the centre of that entire region. Understanding community choice, understanding the community service gaps is critical through the centralized data reporting, but then working with those partners to say, "Is there an opportunity? Would you like another not-for-profit partner to come in and utilize the same type of care processes we do with the great outcomes in your community?" That patient choice and that community choice is important to take into consideration.

Mr. Deepak Anand: Thank you so much, and again, thanks for coming.

Back to you, Chair.

The Chair (Ms. Goldie Ghamari): Further questions? MPP Martin.

Mrs. Robin Martin: I wanted to ask a question of Blair Arnold. I've just been looking at your written submission, because when you were speaking, Ms. Arnold, I took down that you were asking for RCTs, I think, to be regulated. Is that the only ask you're bringing to the committee, or was there something else you were also asking for? And maybe you can tell us how that relates to Bill 60.

1450

Ms. Blair Arnold: Well, the main ask is for consideration to regulate RCTs under Bill 60. How that relates is that we'd like to offer patients more of a reassurance that when they're getting one of these valuable tests, it's being done by someone who can detect that there's a problem before there is a catastrophic outcome, because currently we're not regulated and it has just become more and more obvious that this is something that needs to happen, especially with the changes that are going on in the health care system, especially since COVID. It has always been apparent, but since COVID, it has just become less of a "would be nice" and more of a "needs to happen." That is the biggest ask that I've brought today.

Mrs. Robin Martin: Okay. Thank you very much, Ms. Arnold.

My understanding, also, is that we heard that Kensington provides information to the provincial database for wait-lists, I believe. And my understanding is that endoscopy clinics in eastern Ontario do, as well as most hospitals. So we're improving the coordination in the system, and I think that's one of the objectives of this piece of legislation.

Dr. Ismail, I was wondering if you feel that integrating your clinic, which has operated as an independent health facility for a while, will be beneficial as a way of making sure that you are integrated with the system and part of the system, and if you are looking forward to that or if you are worried about that.

Dr. Alnashir Ismail: Oh, I'm not worried about it at all. If it makes it easier for patient navigation, then absolutely. Whatever is in the best interest of the patient is what our north star has always been, and it always will be as long as I'm in charge.

We are one of the only clinics in downtown Toronto that does breast biopsies, for instance, so we diagnose about 50 to 60 breast cancers every year. None of those tests are repeated at the hospital. We are able to integrate in our own way with the hospitals so that whatever imaging we do or pathology we do gets transferred to the hospital, and then they take over the patient's care from there.

So absolutely, if something can be formalized, I have absolutely no issue with that.

Mrs. Robin Martin: Thank you very much. I think that's great. It's nice, I'm sure, and reassuring for all Ontarians that we have such great clinic operators who are putting patient needs first and making sure that patients get the most appropriate, high-quality care—

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

Mrs. Robin Martin: I appreciate both of you coming and sharing that with us.

I guess the other thing I wanted to just canvass with both of you is if you are happy with the as-of-right provisions which are in the legislation, which is another step by the government to try to make sure that we have adequate health human resource personnel available to Ontarians, as it will be necessary, obviously, to operate clinics and hospitals. We want to make sure that we have all the health human resources we need. If you have any comments on the as-of-right provisions which we've put in the legislation to recognize licensing from across Canada?

Mr. Adil Khalfan: I think it's the right thing to do. We need to be able to both expedite the ability to work and transfer resources where required, to be honest—

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. I guess it's Mr. Khalfan—did I get that right? Not too bad. I'm impressed with that. Good. You're not-for-profit, right?

Mr. Adil Khalfan: Correct.

Mr. Wayne Gates: You said some interesting things in your comments when you were asked about staffing. You talked about RNs, RPNs, the labour shortage and volunteers, but you didn't really elaborate much on it. Maybe you can tell me two things: one, on the volunteers, which is very interesting to me; and the second part of it, has your staffing been affected by Bill 124?

Mr. Adil Khalfan: I'll comment: Most of our volunteer resources are for the elderly care that we provide at Kensington Gardens, volunteers who have found a connection to Kensington because they or their family members have gone through the great care that we've provided and have wanted to contribute back to the system that has looked after their loved ones. We take those volunteers and give them appropriate training, be it for hospice care, for end-of-life care, to be the appropriate volunteers, both for their own safety in the sense that it can be a very emotional connection but also to be able to give the right kind of service to the people who are going through really tragic times in their lives.

Volunteers also provide support through Second Mile Club. That is part of Kensington Health. This Second Mile Club has been providing community support and structure to the elderly in the community so that—our role is we want the elderly to continue to be independent in their homes where they can. Some of those volunteers actually provide mentorship to other elderly who have just been retired and now want mentorship in aging. How do we provide that? Volunteers provide support there.

We've had volunteers who provide support for screening at the door. We use them for wherever they want to contribute to the mission of Kensington Health. As a not-for-profit, I think we're able to provide that opportunity for people to give back to their community.

Has Bill 124 affected us? I think Bill 124 has affected everyone, to be honest, but I can't comment further on the impact of that at this point.

Mr. Wayne Gates: In fairness to you, I've been commenting on it quite regularly over the last three days, so I'm sure my colleagues understand Bill 124 a lot better than when they voted on it.

Dr. Ismail, I just want to say something to you before I ask a question to the entire panel. Your name jumped out at me because I'm a big Toronto Argonauts fan, and one of the best running backs ever in Toronto's history, when they were winning Grey Cups—and by the way, they won the Grey Cup again this year—his name was Ismail. I don't know if you knew that, but when I saw your name, I said that.

I got a question for all—

Dr. Alnashir Ismail: Rocket Ismail was a wide receiver in the 1990s, right?

Mr. Wayne Gates: Yes, there you go.

The College of Respiratory Therapists of Ontario have provided comment on Bill 60, and they noted a serious concern around the lack of regulatory authority within this legislation. Given how drastically it can change the model of health care delivery, is this a concern shared by technologists or medical imaging folks here with us today? All three of you could answer that, if that's possible.

Dr. Alnashir Ismail: I'm not worried about it, because we have always been at the leading edge of quality assurance. I was giving the example of ultrasound accreditation. For 20 years, we were the only facility in the entire country to have that accreditation. It was completely voluntary. No one else in the country had that accreditation. So I will apply the same criteria. Regardless of whether any standards formally exist or not, I would apply the same standards. They have accreditations for CT in the States. They have accreditations for MR available in the States. I will go and get those accreditations whether that is a requirement over here or not. It has never stopped me, and I will continue, because that is how I've maintained quality throughout my entire existence. That's what I'm going to do.

Mr. Wayne Gates: Thank you. Blair?

Ms. Blair Arnold: Within our group, we do hold our members to an extremely high standard. I've been told by some who are a part of a regulated health profession that we are a little too strict, but we do hold our members to an extremely high standard. That will not change, ever. We are actually revisiting increasing those standards so that we can maintain the high level of care given to our patients. With or without regulations, to be quite frank, we will continue.

1500

Mr. Wayne Gates: I can give you a quick example. I had open-heart surgery at St. Mike's, and the doctor there that performed the surgery—I have a mechanical valve, which I know you're quite familiar with. If you're lying on the couch at home, it goes "tick, tick, tick" all the time. Just to say, thank you for all the work that you do—because it was because of all the prep work that went into it. The reason why I told that story is that it didn't cost me a penny. It was publicly funded, publicly delivered by some of the best—probably the best—doctors, nurses and everybody in that system in the world. So I just wanted to say thank you for everything that you do there.

Interjection.

Mr. Wayne Gates: I've got a minute left. Is that what you're showing me?

The Chair (Ms. Goldie Ghamari): A minute and 10 seconds.

Mr. Wayne Gates: What have I got left?

The Chair (Ms. Goldie Ghamari): Well, a minute now.

Mr. Wayne Gates: Okay. Go ahead. I'll turn it over to my colleague.

Mme France Gélinas: Thank you. I just wanted a quick question to Ms. Arnold. Have you ever requested that HPRAC review your profession? Have they issued a recommendation as to whether or not you should become a regulated health profession?

Ms. Blair Arnold: We did approach HPRAC via a previous lobbyist that we had hired, back in 2007, I believe. Unfortunately, due to funding considerations, we were unable to complete that process. We did receive some recommendations, and to date, we have met and exceeded those recommendations as made by the HPRAC consultation—so, yes. This is our first attempt at this, once again, since 2007.

Mme France Gélinas: So in 2007, HPRAC reviewed your profession and put out a report?

Ms. Blair Arnold: They had a preliminary review, yes, and they put out a report. They had some suggestions, and we did fulfill those suggestions. We were going to continue on with having a formal submission. Unfortunately—

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

I'd like to thank our presenters for joining us today. If you'd like to submit any written material to the committee in addition to your presentation, the deadline for written submissions is tonight, Monday, March 27, 2023, at 7 p.m. Eastern Daylight Time.

MS. HELEN LEE

ONTARIO PUBLIC SERVICE EMPLOYEES UNION

NORTH BAY AND DISTRICT LABOUR COUNCIL

The Chair (Ms. Goldie Ghamari): We'll now call upon our next set of presenters. As a reminder, each of you will have seven minutes for your presentation, followed by questions from committee members. I will provide reminders of the time remaining during the presentations and questions. Please state your name for Hansard, and then you may begin.

Interjections.

The Chair (Ms. Goldie Ghamari): I'd just like to remind committee members to have conversations outside of the room. Thank you.

We'll now turn to our first presenter, Helen Lee. Please state your name, and then you may begin. You'll have seven minutes.

Ms. Helen Lee: My name is Helen Lee. I lost my grandmother, Foon Hay Lum, in a horrible COVID outbreak in a nursing home in long-term care in wave 1. She was 111 years old.

Professionally, I've worked in human resources, labour relations and change management in the Ontario public service for over 33 years before retiring.

The pandemic clearly showed that ownership in long-term care mattered as the private, for-profit homes had higher mortality rates. I see the impacts of privatization on long-term care and home care, and now I'm horrified to think that hospital services are the next to be parcelled out.

My experience informs me that this bill is directionally wrong. It's not bold and innovative, but brazen, irresponsible and, frankly, unnecessary. I don't use these words lightly. Moving in this direction is not evidence-based and only benefits private interests. Research shows that privatization does not reduce the wait times, nor provide better outcomes. We see this in other provinces and other countries. Let's learn from them.

The Canadian Centre for Policy Alternatives report in August for BC said, "Private surgeries and medical imaging are big business in BC," to the tune of $393 million in six years, and private clinics extra-bill—see Day's clinics.

In other countries, the Lancet journal noted that a study of Britain's National Health Service concluded that "private sector outsourcing corresponded with significantly increased rates of treatable mortality, potentially as a result of a decline in the quality of health care services."

"Our research raises doubts about whether the current extent of private sector use is optimal for the quality of care and suggest that further increases in for-profit provisions would be a mistake."

A provincial auditor report for a for-profit cancer care clinic in 2001 revealed that the for-profit clinics—cancer treatment clinics, previously—were more expensive, there was no measurable reduction in wait-lists, and they were scrapped in 2003—rightly so.

What alarms me about Bill 60 is that it entrenches and expands for-profit clinics in Ontario. The majority of these clinics will be for-profit. It diverts our finite human resources. It will poach the staff from our public health care system. There's no magic poof of human resources. Shortages in hospitals will be made worse, and hospitals will be left with all the complex cases as private clinics skim off the easiest patients. How does that make sense? Medical emergencies are going to be referred to emergency hospitals, and they're going to be less well-funded and staffed. Why would we do this to ourselves, to make this funnel to go to this low point where our hospitals are going to be funded even less? The current Ottawa pilot is a private entity that is operating out of a public hospital and it's using existing hospital staff, and they're paid twice as much. So we know that that's going to happen.

Even the office of financial accountability's last report said that independent health facilities will compete for the same health care workers. In Quebec, they're introducing—like Bill 60—a bill because they want to phase out the use of private health care agencies because of its impact on public health care.

This bill allows for the selling of non-insured services and products to people. There's no protections for patients against extra-billing. We have a growing group of seniors, and they rely on the government for oversight, yet there seems to be less and less of this oversight.

The bill funnels health care monies to private clinics rather than investing in our public hospitals. Ontario spends at the lowest rate, so if the government properly funded and improved the working conditions, we would stop the bleed out of workers and clear the backlog. I'm so troubled that health care monies were left on the table last year and, this year, were also underspent. It leads me to believe that the public system is purposely being choked—that's the status quo—and that people—patients and workers—are being pushed towards this for-profit care solution.

They will operate with less oversight, accountability and transparency. Oversight is left outside of the government to a third party or multiple parties, and they're given wide discretion, powers and responsibilities, including sole discretion on licensing and establishing new classes of service—wow. That is a big wow, and a total lack of transparency. No requirements to gazette any new clinics or anything. It opens up huge possible conflicts of interest

and possible corruption as they're not subject to any public disclosure or public reporting. And there are no quality standards. It's all left to regulation. This is a big change. Why would we leave everything to regulation? I don't know.

Complaint process: Public recourse is left to regulations again, and when I read the act, it says that the incident review process and reporting of incidents, if any, are left to regulation—interesting.

There's a watering down of qualifications in schedule 2—obvious concerns there.

Marginalized people will be the greatest impacted. Everybody's going to be impacted, but marginalized people are going to be greatly impacted. They always are. Seniors, racialized groups, women, the vulnerable, rural communities—they're all going to be hurt by this.

I urge you to focus on innovation within and not outside the public health care system. Our hospitals have quality and safety regiments that have been well practised. There are patient protections. These new clinics are just going to sprout up. They're not going to have anything. Scotland had—

The Chair (Ms. Goldie Ghamari): You have one minute left.

Ms. Helen Lee: —and they had the courage to invest in their public health care system, and they are doing well.

Focus on keeping existing staff, improving working conditions; recognize the moral injury and distress of the health care workers and drop your appeal of Bill 124.

Withdraw Bill 60. If the government isn't willing to do that, at least be reasonable enough to add amendments to this to include what stakeholders have raised as concerns and limit the fees to the same as the hospitals.

I've had the privilege of serving the public service for over half my life, and I would say governance, accountability, transparency, standards, measures—that's not red tape. It is not red tape. They are critical factors to the delivery of good care and health excellence, and I don't see that in Bill 60; I'm sorry. I don't see that in Bill 60 as it stands right now.

1510

Thank you very much for the opportunity. I may have spoken very, very quickly, but I'm quite distressed by this all.

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

We'll now turn to our next presenter, Ontario Public Service Employees Union. Please state your name for the record, and then you may begin. You will have seven minutes.

Ms. JP Hornick: Good afternoon. My name is JP Hornick. I'm president of the Ontario Public Service Employees Union. I'm joined today virtually by Jill McIllwraith, chair of OPSEU/SEFPO's health care divisional council and hospital support sector, and Sara Labelle, chair of OPSEU/SEFPO's hospital professionals division.

OPSEU/SEFPO proudly represents over 180,000 public sector workers, including more than 60,000 health care workers, who dedicate their working lives to caring for all Ontarians. This includes radiation technologists, cardiovascular perfusionists, laboratory technologists, occupational therapists, physiotherapists, respiratory therapists, nurses, PSWs, clerical staff, custodial staff, food service workers and so many more professionals who are essential to our public health care system and patient care, which all of us need.

These professionals chose to work in a public health care system that's rooted in equality and accessibility, that's based on patient need, not on one's ability to pay. It's what makes the public health care system better than all others and worth protecting at all costs. As someone who moved here from the United States, this is an incredibly, incredibly important topic for me. But our health care system here is in crisis because of understaffing and underfunding. Opening the door to an unlimited number of private, for-profit clinics will not solve either of these issues; it will unequivocally worsen the crisis. This is a fact.

Here's what's at stake for the people of Ontario because of Bill 60: more costs for patients and more uncertainty about what those out-of-pocket costs might be, private clinic surgeries that will cost taxpayers more than double what they would in the public system, less access for those who are least able to pay and can least afford the charges and those with pre-existing conditions, who are often turned away from private facilities. There are fewer checks and balances on these for-profit providers, whose predatory behaviour, like upselling on services to make a profit, will be allowed without limit or oversight, and longer wait times and more risk for patients if things don't go well during a procedure. Emergencies happen, even during so-called simple surgeries and procedures. If that happens, I'd much rather be in a public hospital, where I can be triaged and treated quickly.

Bill 60 won't just increase costs and wait times; it will spell the end of our public hospital system as we know it. It will pull even more staff away from the public system, where they have been disrespected and undervalued, and it will make the staffing crisis even worse.

We're here today to tell you that enough is enough. Health care workers are already fed up. They're overworked, they're underpaid, they're burnt out, they're leaving their jobs in droves. They're working to their limit every day to provide a high standard of care, and yet their wages have been cut, have been limited by Bill 124, and now this. This rubs salt in an existing wound.

If I hadn't made it clear yet, Bill 60 is not the answer to Ontario's health care crisis. Investing in our public health care system and staffing it properly is the answer.

Premier Ford and the Minister of Health have provided zero evidence that privatization would reduce wait times or support creative, innovative solutions like they claim. In fact, the research shows exactly the opposite. An OECD study has shown that in nations with both public and private health care systems, privately funded care produced longer wait times and drained resources out of the public system. Shortening wait times in the public system was achieved by increasing public investment, as has been spoken about by the previous speaker.

Right here in Canada, the data shows that provinces that have outsourced surgeries to for-profit clinics are waiting longer than they are even in Ontario. In BC, only 70% of patients received knee replacements within six months. In Alberta, it's only 53%.

But Bill 60 isn't really about finding solutions for people, is it? Ontario's health care crisis is a manufactured crisis that allows our public health care system to fail to clear a path for privatization. During a global health pandemic, with ER closures across Ontario and an ongoing staffing crisis, this government underspent by nearly $2 billion that was originally earmarked for health. With the unconstitutional Bill 124, this government systematically cut wages, making jobs in our public health care system uncompetitive and undesirable. And now, this government is treating the public health care system like it is beyond repair and the only solution is to open the door to private, for-profit clinics.

This is a game we've seen before. We fought it, and we've won. You need to withdraw Bill 60 now, because the real solution to reduce wait times and clear the surgical backlog is simple: more funding for public health care services and staff.

We have operating rooms in this province that sit empty because of underfunding and lack of staff. These are political choices. It doesn't have to be this way.

OPSEU/SEFPO members are deeply concerned that Bill 60 does nothing to protect staffing levels in our public hospitals or to ensure that private clinics are not recruiting from them. The retention and recruitment crisis is getting worse, yet we're seeing layoffs.

I was there when Minister Bethlenfalvy talked about his tour through Ontario and mentioned Alliston. But what he didn't mention was Stevenson Memorial Hospital, which is critically understaffed, and yet 12 health care professionals, including five RPNs in our own union, received layoff notices because the COVID surge unit is closing due to funding cuts. This is preposterous in the space that we're in right now.

Ontario's universal public health care system was built to serve the public interest—

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

Ms. JP Hornick: —with transparency and accountability measures in place. We have the opportunity to build public hospital capacity and to keep health care accessible to all Ontarians. This has to be the goal, not putting profits before people, which is exactly what this bill would do.

It's clear that arguments and facts are not enough to move this government to fix this crisis, but workers and communities coming together to demand better will. And we will do just that.

Our lives are not for profit. This is not our health care act; this is your health care act. It will only benefit a few. Our lives are worth more than that. Thank you very much for your time.

The Chair (Ms. Goldie Ghamari): Thank you very much. We'll now turn to our final presenter, North Bay and District Labour Council. Please state your name for the record, and then you may begin. You will have seven minutes.

Mr. Henri Giroux: Henri Giroux. I am the president of North Bay and District Labour Council and also the co-chair of the North Bay Health Coalition.

I begin my remarks today by saying that we have many concerns with the proposal of Bill 60, the Your Health Act, 2023, the proposal of the Integrated Community Health Services Centre Act. Two major concerns that I will highlight today are the costs of delivery of care and the increase of staffing prices.

It's already well-documented that a non-hospital-based for-profit medical clinic will divert resources from the public sector to private for-profit sectors. Private clinics will probably be more of a "day shift, higher pay" that will entice health care workers to leave the public system. I was already approached by a lot of health care workers saying that they probably would do that because of money.

There is no real protection against staff poaching from our local public hospitals. Bill 60 lacks safeguards against this problem and will give private clinics a potential recruitment advantage, diminishing the pool of health care workers.

Canada has no surplus of health care workers. Ontario has the worst staffing crisis we have ever seen recently. This is of concern as it's a result of staffing shortages that were brought on by and have persisted since the pandemic.

The government persists in capping wages to nurses, the health professionals, the support staff, and angers the staff to the point that they quit their jobs or they move on. Now, the government continues to pursue Bill 124.

In northern Ontario, we see it every day in the public hospitals right now and in long-term care, that employers are poaching to get staff in their own facilities with rewards and higher pay. We also see this as an erosion of the bargaining rights and the bargaining unit that may flow from hospitals into private clinics, as there's no protection because the recent amendments to the Public Sector Labour Relations Transition Act have made it difficult for successor rights through transfer of health care services and employees.

1520

For-profit privatization of our public services takes away funding and will be devastating to smaller communities, particularly northern communities. Studies have revealed that there's more death rates in for-profit hospitals because they have less trained staff to maximize their profits. There's no real public accountability and there is poor enforcement in the existing private clinics. We know that public hospitals have strict safety and quality standards. It's overseen by an independent hospital board of directors, and qualified standards require it to act in the public interest.

Hospitals have occupational health and safety committees. They have disease surveillance programs. They include nurses, managers and administrators in decision-making. None of these safeguards are required under the ICHSCA. That's a big problem, especially if it's under an inspection body determined by a regulation of cabinet. The inspection would mean less transparency and would have less employee

union involvement. There's less information; therefore, it would be kept from the public.

I find that this enforcement would be like that of our long-term care, which has been found entirely inadequate in ensuring quality of care. The long-term-care sector is a prime example of where for-profits have lobbied against regulations, even the annual surprise inspection enforcement and accountability, and have been successful. We've had more deaths in for-profit than in not-for-profit and municipal homes in the past few years of COVID.

When it comes to accessibility, the new regulations show that there's no specific provision that would give clients that can't pay extra or upgrade over a patient that can pay—we already see it today: that if you can't pay, you get to wait. Also, there is no provision in place that can stop private hospitals taking people from other provinces, or even states, that could jump the wait-list if they have the cash.

In Bill 60, the model will be costly. It has been proven in Britain that private clinics cost 11% more than public. In North Bay, for example, we've seen the cost of the public-private partnership hospitals—triple the cost to build, instead of building it publicly. In fact, there's no real public accountability in existing private clinics. Research is showing poor quality, safety concerns, higher user fees and choosing fewer ill patients at the expense of the local hospitals.

To finish, this government is choosing to dismantle 100 years of effort—

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

Mr. Henri Giroux: —among Ontario's public local hospitals to improve their service. Instead, the government is choosing purposely to bring in private clinics. Lack of funding—the lowest rate to our hospitals in Canada; less beds per person; the majority of public hospital operation rooms are only open 9 to 4 and closed on the weekends; and the report of the Financial Accountability Officer of Ontario shows that this government has underspent on health care by $2 billion.

In our opinion, there's no need to bring in private clinics. It's a choice—a choice by this government. A better health care alternative does exist.

Finally, we are worried about the future of our grandkids and our great-grandkids that will have to pay with their credit card, not OHIP card, as we have it presently.

Enough is enough. Please stop this madness and withdraw Bill 60.

The Chair (Ms. Goldie Ghamari): Thank you very much. That concludes the time that we have.

It's my understanding that the voting bell is going to ring. I believe it's going to be ringing shortly. Do we know how long the bell is?

The Clerk of the Committee (Ms. Lesley Flores): Ten minutes.

The Chair (Ms. Goldie Ghamari): It's a 10-minute bell, so I suggest at this point that we take a recess so that we can go vote, and then, as soon as it's done, we will resume immediately. So just come back really quickly, and that will give anyone—if someone needs to take a health break, they can do it before the vote.

Thank you very much. We'll recess and come back as soon as the vote is done.

The committee recessed from 1525 to 1545.

The Chair (Ms. Goldie Ghamari): We're now going to resume public hearings on Bill 60, An Act to amend and enact various Acts with respect to the health system.

At this point, we're going to turn to the government for questions for seven and a half minutes. Who would like to begin? MPP Martin.

Mrs. Robin Martin: Thank you to all the presenters for being here. My understanding is that OPSEU was consulted about the legislation and our plans around the Your Health Act on February 2. Is that correct, Ms. Hornick?

Ms. JP Hornick: I'll have to double-check—

Mrs. Robin Martin: But you were consulted?

Ms. JP Hornick: Well, we've been consulted on many different bills. What is the question you have about this particular consultation—

Mrs. Robin Martin: I just wanted to know if you were consulted. I was just trying to ask that question. Thank you, but I will get to more.

The next question I had was: Bill 60 allows as-of-right. Where health care providers are from other Canadian jurisdictions, they can work in Ontario sooner while they wait to be licensed. This is really a first step that the government is taking toward national labour mobility for health care workers. My question is, would OPSEU members benefit from national labour mobility?

Ms. JP Hornick: I'm going to actually turn this over to Sara Labelle, who is a front-line health care worker.

Ms. Sara Labelle: Thanks for the question. We already have national mobility in many of the professions that we represent. We have respiratory therapists that have a national certification body, the Canadian Board for Respiratory Care; the CAMRT, which is the Canadian Association of Medical Radiation Technologists; the CSMLS, the Canadian Society for Medical Laboratory Science; and for physiotherapists, pharmacists, occupational therapists, there are already national certification bodies to enable mobility across the country. That is already happening. I mentioned that when I presented on the 20th, that this happened 30 years ago.

Mrs. Robin Martin: Thank you very much, Ms. Labelle, for those comments.

For Monsieur Giroux: I had a question. I think you were talking about staffing plans and how important it is to make sure there are staffing plans. Certainly this is something we would look at for how we can make sure that the system is integrated. Part of what Bill 60 does is to take what have previously been independent health facilities and make them integrated with our system.

I think you were talking about hospital staffing plans and you were concerned about that. My understanding is that local hospitals would have to approve a staffing plan and the hospital would have a say if any new licences become available locally. And so, my question to you is, if that were to happen, does that address your concerns, or

some of the concerns that you were expressing, Monsieur Giroux?

Mr. Henri Giroux: I think the concern that we have is that there's not enough staff to go around all over. We do see now where we have staff going to other facilities, and some facilities are short of staff. If we see integration with clinics, we strongly believe that there won't be enough staff to do that.

The part that I read of Bill 60 is very weak the way it is, and we believe that this is not going to happen. Hospitals are not really going to be able to make the determination of who's going to leave and who's not going to leave. It's going to be up to the staff. When I talk to staff in North Bay here, in the hospital, they're saying, "If it's higher money, we're going to leave and we're going to go work for private clinics." So they're not going to listen to the hospital and decide what the hospital is going to do. That's our concern, for sure.

Mrs. Robin Martin: Nothing in Bill 60 requires the clinics that are going to be established, if it passes, to be private clinics, and I know there was some concern about that. There were different models that would be appropriate that could be put forward under Bill 60, and Bill 60 ensures that people will pay with their OHIP card and not their credit card for OHIP-insured services. No centre can refuse an insured service to a patient who chooses not to purchase an uninsured service or upgrade. No patient can pay to receive insured services faster than anyone else. It protects insured patients from being charged for insured services or a component of an insured service. To pay or receive a fee or benefit from an insured person for providing preferred access to an insured service and/or to make the provision of an insured service conditional upon an insured person paying a block fee for uninsured services—all of these are things that the legislation addresses and that regulations will address even more fully.

1550

So my question is—I think it was Ms. Lee who mentioned the cancer clinic that was opened in 2001, or something, at Sunnybrook to provide cancer patient treatments, breast and prostate cancer radiation. I already mentioned at this committee earlier that I was in the Ministry of Health at that time as a policy adviser to the then Minister of Health. What the CROS clinic, as it was called, was able to do was provide breast and prostate cancer radiation therapy to patients who, before that, had to travel to Buffalo and Rochester to get breast and prostate cancer radiation treatments.

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

Mrs. Robin Martin: They were able to do that.

To travel to the US, it was $11,500, I believe, per case, but we paid them the same amount that they were paid in the public system, in the public hospital. What we did was offer an extra $500, I think, for the last 500 cases as an incentive to clear the backlog, and then we closed them after the backlog was cleared. The benefit of what happened there was that every cancer centre in the province—there were eight at that time—after that provided after-hours use of their radiation bunkers and other equipment. So it ended up increasing patient access to care, which is what this bill is also about. I just wanted to relay that information.

The Chair (Ms. Goldie Ghamari): We will now turn to the official opposition. Who would like to begin? MPP Gélinas.

Mme France Gélinas: My first question will be to Mr. Giroux. You may not know this, but you are the only presenter from northern Ontario. I will bring you back: The request for people to appear went out on a Thursday, people had the Friday or the Monday to register, then the registration deadline had passed, and we sat there and never really started to work till the following Monday. This really narrow period of time for people to appear really does not work if you want to hear the voices of people from northern Ontario.

Mr. Giroux, I'm really happy that you're here, so my first questions will be to you. If those investor-owned corporations set up surgical suites in northern Ontario, what do you figure are the chances that they will go into the rural northern Ontario communities that you serve?

Mr. Henri Giroux: Well, my thought on that is that those agencies are there to make money. We believe that they will be situated in big areas where there's more flow and that northern Ontario people will probably have to travel to go to where the clinics are that will provide a service that they want.

Right now, the way it is, hip surgery—we have people from Timmins, from Cochrane who come to North Bay because there's no place close by. So I believe that it will be in bigger cities and not necessarily in small cities. In northern Ontario, we have a lot of small cities, and we have a lot of small and medium hospitals that we believe will also be affected by all this change.

I hope that answers some of your question.

Mme France Gélinas: Yes, it does. Whether you look at Madsen, Iroquois Falls, Cochrane, Smooth Rock, Espanola, Sturgeon Falls, all of the little hospitals do provide surgery. They provide a way lower number of surgeries than the big centres, but they provide care to people in northern Ontario where we live. Those investor-owned corporations, those for-profit clinics that will open in big cities down south just means that, for the people of northern Ontario—I'm one of them, and so is Mr. Giroux—we will have longer to travel. Although, if you look at the wait times, we are often off the charts for how long we have to wait for care. But those private, for-profit, investor-owned corporations are not going to come to Sturgeon Falls. They're not going to come to Matheson, Iroquois Falls, Cochrane, Espanola or any other city in northern Ontario. They're going to go down south.

I don't have much time, so my next question will be for Ms. Hornick. You made it clear that you believe in a publicly delivered health care system. You may know that Sunnybrook has a very successful hip and knee surgical suite. It is in the community. It is not in the hospital; it's across the street from the hospital. They do hip and knee surgery 50% cheaper and 30% faster than they do in the hospital through their outpatient clinic, and they do same-day surgeries. You

probably know that in Ottawa, the private sector has offered twice the wages of the health care workers to come and work in those clinics. Do your members in Sunnybrook get twice their wages when they go work in the outpatient centre for hip and knee?

Ms. JP Hornick: No. We have 400 members, give or take, in Sunnybrook and, no, my understanding is that that's not the case. We also have a similar situation, I believe, in London Health Sciences, where we have 1,300 members. This is absolutely cheaper, more effective and safer to keep in public clinics rather than for-profit.

Mme France Gélinas: So what I hear is that you are open to having surgical suites in the community. It is really the oversight and accountability that you want to maintain in the public system, to make sure that the medicare that we know, where care is based on need, not on ability to pay, continues. What do you see as some of the dangers if those clinics are owned by for-profit, investor-owned corporations?

Ms. JP Hornick: Absolutely. I think that what we see in that case is the potential for a two-tiering of the health care system that cannot be taken back. Because when you put health into a profit model, you are not looking at accessibility for all Ontarians; you're looking at health care that's delivered on the ability to pay.

Jill, do you want to address this as well, as somebody who has been working in the system?

Ms. Jill McIllwraith: Yes. There's definitely going to be a pull away from hospital staffing if there are private clinics. I don't believe that the private clinics are going to be run under the same strict health codes that we are in hospitals. The hospital staff are definitely dedicated; they have to be, because of the wages. I don't think you're going to find that same situation when they make it into private clinics. It's not going to work.

Mme France Gélinas: You are right that in the bill, there is very little as to what oversight will look like, as to what quality control would look like, as to what accountability will look like. There's a little wee bit about patient complaints, which is very little—

The Chair (Ms. Goldie Ghamari): You have one minute left.

Mme France Gélinas: —and that's about it.

I wanted a quick question to Ms. Lee. First, sorry about the loss of your mother. Same question to you: What are your fears if the private, for-profit, investor-owned operations operate those surgical suites?

Ms. Helen Lee: There isn't going to be the rigour. There's not going to be the standards. We're already clear in legislation, this proposed Bill 60, that the oversight is going to be a third party, right? So I think that there are not enough controls.

And coming from the long-term-care experience—I mean, it was horrible. In Ontario, long-term care is 58% for-profit. We should have learned from it, but we haven't. I am quite upset about that. I don't think we should be steamrolling into this other area—

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

1600

We'll now turn to the independent member for four and a half minutes. You may begin.

Mr. Adil Shamji: Ms. Lee, I'm very sorry to hear about the experience of your family and your family member. I'm curious to know, in the wake of all of that, do you feel as though your family has received justice or transparency around ensuring something like this never happens to anyone again?

Ms. Helen Lee: No, actually, I don't, because I feel that the legislation—the government has been very busy writing legislation to protect itself and its private interests. Bill 218 shielded the for-profit companies from liability and it increased the bar for negligence in terms of gross negligence. I don't think we've learned. What will it take for us to learn again?

We didn't learn from SARS. Then we had the pandemic—totally unprepared for that. Ontario didn't even have a pandemic plan. You could have copied BC's, man.

I am very concerned about the direction that we're going in. I hope that we would take a pause and think about it, because we lost lives. There are going to be more lives lost. We know that for-profit clinics have worse outcomes. It's less investment of highly skilled people.

This is not good. This is directionally not correct at all. This is not good governance or good public administration at all.

Mr. Adil Shamji: Thank you, Ms. Lee.

Mr. Giroux, as we heard, you are our only northern stakeholder in these public hearings. I wonder if you could tell us just a little bit about the state of health care and health care accessibility in North Bay and then whether you think Bill 60 has the components to address any challenges that you and your community are facing.

Mr. Henri Giroux: First of all, it's really a disgrace to see there's only one person from northern Ontario. Again, the time limit was very, very short. I just so happened to see on Saturday, "You better post now or it will be too late." So I posted then, and it was only two days before that. Again, northern Ontario gets shafted.

In the health care field, right now, especially in North Bay, we have hospitals, we have long-term care that are suffering from not having staff. We have long-term care where we know—I worked in the long-term-care field for 39 years, and we see the complexity of the seniors right now. We see that staff are needed badly. We've been short of staff even before COVID, and it's getting worse now. We're seeing hospitals taking away our PSWs and bringing them to hospital. Long-term care is very short. We have one on sometimes 14 or 15 patients per eight-hour shift. People go home tired. They go home crying because the work is not done properly, and they really want to do better work.

We see Bill 60 as a problem in northern Ontario. As I said earlier, we know a lot of those clinics are going to be down in bigger cities.

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

Mr. Henri Giroux: We also see that shortage of staff is going to get worse. Even though the lady before said

something about bringing staff from other provinces, the other provinces are doing the same thing. I saw a big sign in Sudbury the other day: "Come and work in Alberta. We have work for you." Everybody, all of Canada, is fighting for staff. We're going to see that all through health care if this bill passes through. It's going to be bad.

I have 12 grandkids. I feel bad for them coming in the future where, if they want service, they're going to have pay through their credit card. Even though they're saying they're not, we've seen many, many areas where you have to pay.

I think northern Ontario is going to be neglected again, like they were neglected for this event here. We're going to have to have money in our pocket to travel to those places. I know that in Sudbury—

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

We'll now turn to the government for seven and a half minutes. Who would like to begin? No more questions from the government? Okay.

In that case, we'll turn to the official opposition for seven and a half minutes. Who would like to begin? MPP Gates.

Mr. Wayne Gates: It's a pretty sad day, because the community members are here and you don't have questions—a pretty sad day for this committee.

Really quick: How many members do you represent?

Ms. JP Hornick: Over 180,000 across the province.

Mr. Wayne Gates: Over 180,000. And do you realize—because I heard them ask a question to you and it's pretty tough to know exactly—that CUPE, Unifor, ONA, SEIU and the OFL were not consulted on Bill 60? It works out to about 1.8 million workers—absolutely a bad joke on behalf of this government. If that's working for workers, I'm missing something in the province of Ontario. But I will ask questions, so I'll start that off.

This will go to JP. As a critic for long-term care, I have witnessed some of the worst health care outcomes in our private homes: direct neglect to save money at the expense of residents, the seniors of our province. Do you think the experience we've had as a province with our failed private, for-profit long-term-care model will happen with private surgery clinics? And I want to make sure I say it, because I've said it all day: 5,000 seniors have died; 78% of those deaths happened in private homes. JP or anybody else that wants to—and I have one more question I want to get out as well before I turn it over to Ms. Gretzky.

Ms. JP Hornick: On the question of consultation: With respect, in my experience with this government, consultation does not mean that feedback is incorporated or even listened to. Our experiences with consultation have often come in the form of being told what's going to happen, less so about what we'd like to see happen. So I appreciate the time taken today.

In terms of whether I believe that we will see similar outcomes, yes, because what we look at in this bill is a lack of safeguards to prevent a crisis like that from occurring. We don't see anything that provides preference for the provision of out-of-hospital surgical or diagnostic services on a public or not-for-profit basis and nothing to restrain private integrated community health service centres from operating on a for-profit basis. So we have to assume that will be on a profit model.

We have to assume, then, that with the profit model comes cream skimming; that these private clinics will look for the simple, easy procedures, leaving public hospitals to deal with the more complex and expensive procedures. This does not allow balance in budgeting; it does not allow balance in staffing.

What we've seen already is an attempt to lure people, staff, from public centres into private agencies and into private clinics. That results in understaffing. That results in worsening labour conditions and that results in worsening care for patients, and we should all be petrified of this as a model.

Mr. Wayne Gates: Yes, I'll just add to that: I certainly believe that, if we move into private model like we did with long-term care, residents of the province of Ontario are going to die, there's no doubt about it, just because of health and safety.

My second question before I turn it over to my colleague: With empty operating rooms across Ontario, what do you think is the primary motivation of this government? Are they simply trying to funnel public health care dollars into the hands of private corporations, the same folks that like to donate to the Premier and this party? All three of you can answer that, but please keep in mind that I've got somebody else who wants to ask questions too.

Ms. JP Hornick: Sara, I'm going to turn that one over to you, because I'm certain—

Mrs. Robin Martin: Point of order, Chair?

The Chair (Ms. Goldie Ghamari): Sorry. Is there a point of order?

Mrs. Robin Martin: Yes, on a point of order: I believe that MPP Gates just imputed motive of the Premier, and I don't think that that's appropriate, according to the rules.

The Chair (Ms. Goldie Ghamari): I would like to remind members to keep their questions to the witnesses and to not impute motive on other members. We try to follow the same rules that are in the House, so let's keep it that way. Thank you.

Ms. JP Hornick: Sara, if you would like to speak to this item of history repeating itself, potentially?

The Chair (Ms. Goldie Ghamari): She's muted.

Ms. JP Hornick: Sorry, she's muted. I have a sneaking suspicion that we would share—

Interjection.

Ms. JP Hornick: Oh, there we go.

Ms. Sara Labelle: Thanks for that question. We don't have to look any further than the pandemic. There were tons of examples that have been provided where governments have paid more for services in the private industry. But if we look just throughout the pandemic for COVID testing, this government sent testing to California at $250 per test when you could pay for them in Ontario for $30 to $40 per test. We had people who tried to get access to COVID testing in order to visit their loved ones in long-term care, and they had to pay. The only way they could get

access was to pay in private clinics. We already are seeing that, and we saw it throughout the pandemic.

1610

When asked, "What is the motive?" there is no other conclusion to be drawn here, based on all of the evidence in front of us, of who benefits from moving services out of hospitals and who is going to pay the price. There is no other conclusion to be drawn from the evidence that is before us and years and years of experience across the country and across the world of who benefits from health care. It is a multi-billion dollar industry. And it is an ideology that this government, according to Bethlenfalvy, who told me at a lobby day when you were first sitting as a brand new government five years ago that if they could privatize it, they would privatize it—that is your own government. That is your ideology. There is no other conclusion to be drawn.

Mr. Wayne Gates: I'll turn it over to my colleague.

Mrs. Lisa Gretzky: How much time do I have?

The Chair (Ms. Goldie Ghamari): A minute 50.

Mrs. Lisa Gretzky: I don't really have time to ask a question, then. What I do want to say is that MPP Martin just made a comment about my colleague from Niagara Falls, but that is the exact same thing. She impugned motive on Ms. Labelle when she was here presenting the other day. I think that that's rather unfortunate, trying to diminish and discredit her knowledge and experience of the health care system by saying because she ran for the NDP, somehow she's not qualified to speak about her experience and her qualifications—

The Chair (Ms. Goldie Ghamari): I'd like to remind all members, please, let's just focus on asking questions of our panellists. It's why they are here. When we spend time pointing fingers at each other, I think it's a little disrespectful to the time that the presenters have put in to be here. Let's just focus on asking questions while we still have them.

You have one minute left.

Mrs. Lisa Gretzky: Thank you, Chair. I would also say that MPPs going after presenters is not appropriate either.

The Chair (Ms. Goldie Ghamari): It's your time—

Mrs. Lisa Gretzky: No, the other day, she was actually attacking Ms. Labelle.

The Chair (Ms. Goldie Ghamari): I'm talking about right now. It's your time to ask a question.

Mrs. Lisa Gretzky: We heard the government talk about equity of access. We've heard some of the presidents and CEOs of some of the hospitals and other facilities talk about equity of access. When you're taking lower-acuity patients and putting them into these clinics, but those with higher acuity are in public hospitals where they're understaffed and having to sit on wait-lists in order to have their medical treatment, their procedures, do you think that that's an equitable system?

Ms. JP Hornick: Absolutely not. I think that's a system that is predicated on one's ability to pay, and it is reprehensible within a public system like ours.

Interjections.

The Chair (Ms. Goldie Ghamari): Sorry, I'm just pausing your time here for a moment.

If you'd like to have a conversation, please have it outside. If I can hear you, you're speaking too loud. Thank you.

Continue.

Mrs. Lisa Gretzky: Can I just ask again? Because we had the ONA in here earlier, and they said that Bill 124 obviously is a big barrier. We had a president and a CEO actually from Kensington Eye Institute who very plainly said Bill 124 affected everyone.

Can you just quickly give off a list of who your members are again, what fields they work in, just for the record?

Ms. JP Hornick: Yes. Jill, do you want to answer this?

Ms. Jill McIllwraith: I mean it's very—

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

We'll now turn to the independent member for four and a half minutes. You may begin.

Mr. Adil Shamji: I seem to recall that the OPSEU Hospital Professionals Division represents over 250 health care professionals at point of care and behind the scenes, all of whom do exceptional work in service of the patients and people of Ontario. Am I right?

Ms. JP Hornick: You are correct.

Mr. Adil Shamji: Let's reflect on that for a moment. You are our eyes and ears on the front lines and behind the front lines of health care. What are you seeing in terms of the opportunities to improve and find efficiencies in our health care system, without giving way to for-profit profiteering and corporate interests?

Ms. JP Hornick: Absolutely, thank you. Jill, I will turn this one over to you.

You're correct; we represent hundreds of classifications within both the hospital professionals division and our health care division.

Ms. Jill McIllwraith: We need to have money put into the health care system to start fixing it. Bill 124 was the icing on the cake for hurting the health care workers in Ontario. Until the government does that—we've told them for years that we need greater education for the people to bring them into health care. Classes have gotten smaller, longer times before graduation. Everybody knew that there was a shortage coming, but Bill 124 really decimated the staffing in hospitals.

Mr. Adil Shamji: Great, thank you. I don't have any additional questions, unless—

Mr. Henri Giroux: I want to say also, in the long-term-care area, when they took away the regulation for long-term care—we fought a long time for 3.5 hours of care. Now we're fighting for four hours care, and now it should probably be 4.25 hours of care, because we're seeing that the staff are just run off their feet and they're not able to do the work that they really want to do. By putting more money towards that instead of putting money towards private, again, it would bring better care for our seniors and better care for a lot of people that are on this call. Because it doesn't matter—one day, we're all probably going to end up there, and we should be able to fight for that. Instead of spending money on private, we should be spending money

and bringing it to long-term care and to hospitals and keep it public. There's no need. There's an alternative there, but the government doesn't want to do the alternative, and that's to spend more money.

Mr. Adil Shamji: Thank you. Ms. Lee?

Ms. Helen Lee: If you really want measures—I mean, the government's thing is across the industry, right? It's not by institution, not by facility. So it's not even true measures, man—just a comment in terms of the hours of care.

Mr. Adil Shamji: Thank you very much.

I don't have any further questions, Chair.

The Chair (Ms. Goldie Ghamari): Thank you very much. At this point, I'd like to thank the presenters for their participation.

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

COMMUNIST PARTY OF CANADA (ONTARIO)

REGISTERED NURSES' ASSOCIATION OF ONTARIO

The Chair (Ms. Goldie Ghamari): We'll now turn to our next presenters, the Communist Party of Canada (Ontario). Please state your name for the record and then you may begin. You will have seven minutes.

Mr. Andrew Garvie: Okay, thank you. My name is Andrew Garvie. I'm here on behalf of the Communist Party of Canada (Ontario).

I just wanted to quickly introduce the party. The Communist Party of Canada is 102 years old this year, and the Communist Party in Ontario is 83 years old. We are proud to have been among the first advocates for public health care in Canada.

It took several decades to achieve medicare in Canada, and even then, medicare was far from universal and fully public. Important aspects of essential medical care, including dentistry, eye care, home care, long-term care, mental health care and prescriptions, continue to be excluded from insured services. Outpatient care also remained in the private sector's control. However, the core of essential medical services were provided by government-funded hospitals. It is this core of the public medicare system that is now under attack, and this attack is being facilitated by Bill 60.

As has been widely stated, the expansion of private clinics and the private delivery of surgeries will mean extra charges for care, aggressive upselling of procedures which patients do not require and a deeper drain on already insufficient government funding as for-profit facilities siphon it off. Essentially, Bill 60 greases the skids to allow this to take place. It expands the power of a director to issue licences to private clinics while reducing opportunities for public oversight, enabling quick privatization and offering no standards and regulations. Meanwhile, schedule 2 of Bill 60 allows for the creation of new categories of potentially lesser-skilled, lower-wage health care workers, which will facilitate further deterioration of wages and working conditions in the sector and ultimately lower the quality of public health care.

There is a backlog of 200,000 surgeries which, we are told, makes expanding private clinics a necessity. We can expect mass privatization of previous hospital services. The Premier himself has said that 50% of surgeries could be done out of hospital, meaning they are a target for mass privatization.

However, there is plenty of government money and existing public health care infrastructure that is being unused. In 2022, 158 emergency rooms in Ontario were closed because of a lack of staff, while operating rooms remained idle for the same reason.

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The province has underspent on health care by $1.25 billion during the first nine months of the 2022-23 fiscal year, according to the Financial Accountability Office. During the same three quarters of this fiscal year, the province spent 104% of the budget attributed to private clinics. This government is starving public health care in order to expand private clinics.

The supposed cure facilitated by Bill 60 is a fatal threat to the public system. The disease our public health care system is facing is caused by 50 years of cuts, neoliberal restructuring, other incursions of privatization and attacks on public sector wages and working conditions. The real cure is to reverse all this and to expand public health care to include dental, pharmacare, vision, mental health care and long-term care. That's the truly universal public health care system we need.

So why is this government—and, it should be said, other provincial governments as well, not all of them Conservative—moving in the opposite direction? Corporate interests are keen to capitalize on the crisis in health care. If they are allowed to do so, we can see our near future south of the border. Once big business entrenches itself in this area, it will be hard to roll back. The US has an all-powerful corporate health care sector that has successfully held back public health care in that country. Corporatization is responsible for countless medical bill bankruptcies and some of the worst health outcomes per dollar spent on health care in the world.

It is worth mentioning that corporate Canada has its eyes on the health sector too. One example is Loblaw, which owns Shoppers Drug Mart, of course. They launched the PC Health app in 2020, and in 2021, they purchased a large chain of physiotherapy clinics. Loblaw has said that the health sector is one of its four priority areas for growth. This is one of Canada's largest corporate monopolies, infamous for the bread price-fixing scandal, and they're in hot water again these days because of price gouging on grocery items, which continues to be a major driver of inflation.

This government is not for the people and it is not working for workers, but instead serves the interests of Loblaw and other monopolies. Fortunately, we know that Ontarians will fight for public health care. The current

crisis can be reversed, starting with decent wage increases for nurses and health care workers that have had their labour rights stripped from them under Bill 124.

Most working-class Ontarians do understand that the idea of profiteering on people's ill health and deaths is reprehensible and inhuman. We urge the members of the standing committee to reject Bill 60 in its entirety.

The Chair (Ms. Goldie Ghamari): We'll now turn to our next presenter, the Registered Nurses' Association of Ontario. Please state your name for the record, and then you may begin. You will have seven minutes.

Interjection.

The Chair (Ms. Goldie Ghamari): Yes.

Dr. Doris Grinspun: Okay. Thank you. Sorry about that. I thought that he was getting questions first.

Thank you so much. I am Dr. Doris Grinspun, the CEO of the Registered Nurses' Association of Ontario—with chocolate in my mouth, I must say. I'm joined virtually by my colleague Kim Jarvi, RNAO senior economist. We have to thank the standing committee for the opportunity to respond to Bill 60.

People across Ontario should be alarmed by this legislation. It represents an attack on our universal health care system through an open-ended push towards for-profit provision of health care. Evidence from other jurisdictions shows that Bill 60 will not solve the current health crisis in Ontario and is not the solution to reduce backlogs for surgeries and diagnostic services. Bill 60 will divert funds away from our publicly funded health care system and create new, more costly health care structures; disrupt the health care workforce; dismantle the current health professions regulatory framework, which protects the public; and impact transparency and public accountability in the health system. I'll expand briefly on each area.

First, Bill 60 will result in a massive transfer of health care services and resources to the for-profit sector, with no limitation on which services can be profitized. There is no requirement in the bill to demonstrate cost savings or quality improvement. An expanded parallel for-profit health care system—with a costly parallel bureaucracy—will compete for resources and funding and cherry-pick profitable procedures, leaving the most complex patients to public hospitals. And I have seen it; I just came back from Chile, so let me tell you about that.

None of this is necessary. Our publicly funded system already has infrastructure to address the surgical needs of Ontarians, and they must be addressed. A more cost-effective approach is to make full use of existing capacity, for example, by opening our ORs 24/7 rather than creating a parallel system at great cost. Many have said this to you.

Second, Ontario is experiencing a full-blown nursing crisis based on historically low RN-to-population ratios, compounded by the impact of the pandemic and government policies like Bill 124. By establishing a parallel, for-profit health system, Bill 60 will lead to the poaching of nurses and other health professionals into the for-profit sector. It will further damage our understaffed public sector health care workforce, a workforce already stressed to the point of burnout.

Third, Bill 60 effectively dismantles the current health professionals regulatory framework which protects the public. RNAO is especially concerned with proposed amendments to the current definitions of all categories of nurse, physician and other health professionals to include—

The Chair (Ms. Goldie Ghamari): Sorry to interrupt.

I'd just like to remind visitors and guests to please stay on that side, not where the MPPs have their notes and documents. Thank you. That goes for both sides of this.

All right, continue.

Dr. Doris Grinspun: —a member of the respective college or another person prescribed by the regulations. This conflicts with Ontario's system of title protection for health professionals' related scope of practice and role expectations by allowing new categories of health professionals under the current protected titles. This threatens patient safety and erodes public trust in Ontario's health system.

While these changes may be made in the name of fast-tracking availability of nurses from across Canada to practise in Ontario, this is not the solution. There are approximately 18,000 Ontario nurse registrants currently outside the province employed in non-nursing positions or not employed at all. Let's bring them into the Ontario workforce and offer better pay and working conditions.

Finally, RNAO is gravely concerned about Bill 60's scope and its impact on transparency and public accountability. It would grant heightened powers on the minister, cabinet and as yet unspecified or undefined directors to prescribe by regulation the key details related to the future provision of health services in Ontario. The bill itself contains no obvious limits on the outsourcing of publicly funded health services to the private sector. We don't see levels of accountability and oversight in the bill equivalent to those that exist in our hospitals.

In conclusion, RNAO recommends:

—withdrawing Bill 60 completely;

—opening up operating rooms, step-down units and diagnostics 24/7, seven days a week as is done in many other places;

—mandating any and all existing new independent health facilities to provide professional liability insurance protection to the entire staff—that's not in the bill either;

—arming the public hospital system with staff and resources to provide safe, extended services; and

—developing a comprehensive HR strategy for this province.

Evidence shows Bill 60 will not solve Ontario's health care and nursing crisis. Instead, it will undermine our system. And dare I say, it's done on purpose. Some of you already asked that. I say it's on purpose.

RNAO submitted a detailed analysis of the bill, and I invite members of the committee to review it, and look forward to answering your questions.

The Chair (Ms. Goldie Ghamari): Thank you very much. We'll now turn to our questions, starting with the official opposition for seven and a half minutes. You may begin, MPP Gélinas.

Mme France Gélinas: My first question will be to you, Dr. Grinspun. You made a very clear case that the transfer of health human resources, mainly nurses, will have a devastating impact.

I will say to you, if you had a choice to work Monday to Friday, 9 to 5, caring only for healthy and wealthy patients that recuperate really fast, or working night shifts, weekends, statutory holidays, evening shifts, what would you pick?

Dr. Doris Grinspun: Madame Gélinas, let me tell you, because I came back from Chile, here is Bill 60 and what happened in Chile. Here is Bill 60 and what happened here—that people have, really, not a very good memory—years ago.

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The ones that have the means actually also will not win anything. They will get more surgeries and more procedures than what they need, and they will end up like my sister in Chile that hardly can walk—out of too many surgeries, because she can pay for the best insurance money can buy. And those that don't have it end up getting less. This is the situation everywhere in the world where there is a parallel system. I feel that even people sitting here do not understand that everybody loses out—everybody loses out.

Yes, it will create more instability in the system and more hardship and more ill health, and let me extend it also to less safe streets. People do not realize that we will create with that less safe streets. When you increase the gap between the haves and have-nots, what you end up having is less safe streets. We just saw it, in fact, this weekend, with the tragedy of a son of one of my colleague nurses that works at Mount Sinai, the son that was stabbed.

What we need is to put resources in the public sector to enhance the services, from primary care to hospital care to palliative care to mental health, through one single-tier system. That's what brought me and my family to this country. I feel like I'm back to the first time I sat here. Why I joined RNAO from Mount Sinai Hospital, where I was the director, was to fight an omnibus bill of then-Premier Harris. We are back at the same "let's get it done." That's not what we need to get done. We need to get done a strong publicly funded health system for everybody that's universal.

I'm sorry. It's so upsetting. It's so upsetting to those of us that chose this country for a good reason. It's the dismantling of what we have. It's not constructing anything.

Mme France Gélinas: I feel your pain. I mean, the medicare is something that we're all proud of. This is what gives us the assurance that care is based on our needs, not on our ability to pay. I would say it defines us as Canadian. It attracts people from all over the world to join us in Canada, in Ontario, because of what we have, and I agree with you that once Bill 60 goes by, we will have destroyed that, and it just hurts me to no end. I will do whatever I can to stop it. I fully agree with the comments that you've shared with us.

Mister—I don't know how to pronounce your last name—Jarvie?

Mr. Andrew Garvie: Garvie.

Mme France Gélinas: Garvie. Thank you. You made a strong point that what we should be looking at is expanding medicare to make sure that our eyes and our mouth are included, that our mental state is included, that pharmacy is included, that long-term care—I would add to this that home care is also a part. What would you say would be the effect of bringing all of those other parts into medicare? Medicare right now is hospital services and physician services. Everything else that you've named is not part of this. What difference would it make if we were to bring them in?

Mr. Andrew Garvie: Yes, definitely home care should have been on the list. At the very least, the immediate steps forward in privatization that this government has done over the last couple years in home care would be important to reverse immediately. But the overall effect of expanding health care to include pharmacare, mental health care, dental care would be to actually provide decent health care to everyone, and obviously the social indicators would improve across the board.

Fundamentally, it's under a principle that I think most Canadians do agree with, that nobody should profit off of people's health. Anybody that's been to the dentist will understand that when you go there, you wonder—the dentist often looks at what your insurance will cover and says, "Okay, we're going to do this; we're going to tweak that a little bit; we're going to play with your insurance company"—I don't know, maybe it's because I have bad insurance, but that's what they do to me. And that kind of level of negotiation with the doctor could easily happen at these private clinics, if that's moved into this sector. Essentially, it's going back to the days of snake oil salesmen, really. You don't know if you actually need what the clinic is telling you. I don't want to be thinking that when I'm lining up for a surgery. I don't want to be second-guessing whether or not they're trying to upsell me.

Mme France Gélinas: I fully agree. Health care happens between two people, a care provider and a person who needs care, and the relationship of trust needs to be there or quality care cannot be delivered.

Back to you, Dr. Grinspun: You saw in the bill that we are changing where an RPN can do the work of an RN. What do you figure are the dangers of that? Right now, when you call a nurse a nurse, we know exactly what we're getting. After schedule 2 has come into law, we won't. What are the dangers of that?

Dr. Doris Grinspun: Well, the danger of really dismantling or softening a regulatory framework is safety for the public. That's what it is at the end of the day. And safety for the public means health outcomes, simple as that.

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

Mme France Gélinas: So do you see this as—

Dr. Doris Grinspun: Yes, it's one of the points that we are raising.

Mme France Gélinas: You've seen that in long-term care, PSWs will be allowed to give out medication, which is an act that is usually restricted to nurses. Do you see danger in that?

Dr. Doris Grinspun: Yes, it is. People compare it to someone helping someone at home; no, it's not—when PSWs are already worked to the limit. It's not just to give a pill, right? It's to see that the person can swallow, to see that the person—it will be impossible, and PSWs are saying that themselves.

Mme France Gélinas: But the idea is that the for-profit long-term care home can pay a PSW less than they pay a nurse, and therefore make more money.

Interjection.

Mme France Gélinas: Yes, fully agree. Thank you.

The Chair (Ms. Goldie Ghamari): There are 10 seconds left—okay, so we'll go to the independent member, then, for four and a half minutes.

Mr. Adil Shamji: Thank you very much. It's always wonderful to see Dr. Grinspun. Thanks to you and, obviously, your members, my sister being one of them, for all the incredible work that you do for our health care system.

Your contributions are already immense. One of the concerns that has been expressed about schedule 2 and the redefinition of nurses is, of course, it undermines what nurses do as opposed to empowering them. What could we be doing to empower nurses more to support our health care system to the maximum of their ability?

Dr. Doris Grinspun: So what we have suggested to government many times is that what we need is to ensure, first of all, Bill 124 to be gone, and to have nurses represented as they should. What we should be doing is enabling nurses through appropriate staffing to provide the care that our colleagues want to provide, need to provide, so they feel satisfied and remain in the profession rather than going to other jurisdictions, which is happening.

What we need is to provide them with tools to continue to improve evidence-based practice, which we are discussing with government—all the areas of evidence-based practice and embedding them, for example, in long-term care and in other sectors. That is the program Ontario made. It was started with Elizabeth Witmer back then. It's a program that is successful in Ontario. It's reaching every other country in the world, and it's a pride of Ontario as a province and Ontario's nurses. Those are the types of initiatives we need to expand, not initiatives that threaten, really, the capacity of nurses to provide excellent care.

Mr. Adil Shamji: One of the things that the RNAO is very well known for is that it publishes best practices and standards for clinical care. I've reviewed them myself. I'm always very impressed with them. Do you think that Bill 60, as written, would be in compliance with something that you would submit as best practices or clinical standards?

Dr. Doris Grinspun: So I came back from Chile, I told you—about exactly our program. By the way, it's not paid through taxpayer dollars or our members; it's paid by the government of Chile. With the government of Chile, we work in all their public hospitals with the guidelines, as we do here, very successfully. We also work with the private sector. That's why I know the private sector. Here is the private sector: This is a clinic we just kicked out of our program in Chile, because they treated this clinic as if it was Shoppers, or as if it was a mall—

The Chair (Ms. Goldie Ghamari): Excuse me, I thought I asked you to not approach the committee members. You can take pictures from back there, where the audience is sitting.

Dr. Doris Grinspun: If you read this, it's investor-driven, this clinic. We took it out of our program, and it aches my heart because they were outstanding. They switched hands. They sold from one group of investors to another. Anyone that speaks Spanish, google it, because it's just sad.

But this doesn't happen only here. You don't remember because you're too young, but the Koval couple, which had the King's medical centre right here on University Avenue, was given seven years in jail. I can give you a copy after—seven years in jail. They stayed one year and then they were out.

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

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Dr. Doris Grinspun: When the wrong incentives get into the wrong place and you don't have good ways of monitoring that—and I don't see anything in the bill that will monitor, or that is monitoring as we speak, even, these places. Hospitals have monitoring. They have accreditation. They have all kinds of standards. Let's open them. Let's use the evenings, let's use the nights, let's use the weekends and let's get rid of the wait times, because we do need to get rid of them. But we have the infrastructure and the safety net right there.

Mr. Adil Shamji: Great. Thank you very much.

The Chair (Ms. Goldie Ghamari): Thank you. We'll now turn to the government for seven and a half minutes. MPP Quinn, you may begin.

Mr. Nolan Quinn: Thank you to both presenters, Mr. Garvie and Dr. Grinspun. A question for—I apologize; I think I said your name wrong—Dr. Grinspun.

Dr. Doris Grinspun: Don't worry.

Mr. Nolan Quinn: Bill 60 allows as-of-right, where health care providers from other Canadian jurisdictions can work in Ontario sooner while they wait to be licensed. This is a first step towards national labour mobility—and it looks like our federal government is trying to copy what we're doing in Ontario by allowing everyone to move freely throughout the country—for health care workers. Would RNAO members benefit from national labour mobility?

Dr. Doris Grinspun: You know, it's something I have spoken with my colleagues across the country about a lot. It's a dicey proposition. We have already a large, large number of RNs waiting years for registration here: some because the college took too long; others because they don't get their papers from the feds. I know all of this because I work with the feds on fastening that. Let's first use the ones we have here. Let's give them the chance to practise to full scope—

Interjections.

Dr. Doris Grinspun: I am trying to answer your question. Let's do our best to have them practise here, because that's why they came. That's why they made Ontario their home. Let's give them the chance to practise, rather than trying to bring them from other jurisdictions that perhaps are worse than us—

Mr. Nolan Quinn: Okay, but with the as-of-right, would your members benefit from it? If we're bringing more people—

Dr. Doris Grinspun: They are not asking for it. We asked our members; our members don't need that. Our members want to include the RNs that are waiting already—thousands of RNs waiting here in Ontario; IENs, internationally educated nurses, waiting for registration. That's what our members will benefit from.

Our members will benefit from doing away with Bill 124, not challenging that bill, so that they can be compensated appropriately and they will stay here rather than going to Nova Scotia, Alberta or BC. You know that they're going there, right? Or to the US, which is even worse; we lose them completely from the country.

That's what our members will benefit from. That's what RNs want. We have the second-lowest RNs per population in Canada right now—second-lowest RNs per population. We can solve that.

Mr. Nolan Quinn: Thank you. I've heard a lot from different RNs and RPNs about the staffing shortage, so the as-of-right will help bring some new members to Ontario to be able to help.

I'll jump to my second question. This morning, we heard from Kevin Smith from UHN, who said that some UHN nurses also spend time working in partner settings to help expand their skill sets, like community care settings. Would RNAO members benefit from opportunities like those once integrated health facilities are partners with the hospitals?

Dr. Doris Grinspun: Not at all. In those clinics, what they will have is the less complex patients, not the most complex. Dr. Kevin Smith probably already told you, and maybe he should have, if not, that any patient in a private, stand-alone facility—especially investor-driven, but all of them, quite frankly. As soon as the patient will get complicated, they will be sent in an ambulance back to the hospital. This is why the minister reinforced—and it's in the bill—that doctors who work in the stand-alone clinics need to have admitting privileges in the hospitals. Dr. Kevin Smith knows that, from the past and from current.

The Chair (Ms. Goldie Ghamari): MPP Martin?

Mrs. Robin Martin: Thank you to the witnesses for presenting. I think everybody agrees that we need a strong, publicly funded system for everyone, and that is why we are working very hard to strengthen our public health care system. Bill 60 is part of that strengthening.

We're very concerned that patients do not have access to care, and unfortunately—you were talking, Dr. Grinspun, about the gap between the haves and the have-nots if we establish these clinics, but actually, these clinics are available to anyone. We heard from some clinic providers earlier; they don't say no to anyone, and the services are paid for with their OHIP card.

But the current situation right now, as you know, is that we had a 270,000-surgery backlog post-pandemic. The government gave almost a billion dollars—$880 million, I think—to hospitals to clear that surgical backlog. They did manage to reduce the number of cases down to, I think, 206,000 surgeries that were waiting.

Unfortunately, right now, if people can't wait or prefer not to wait, people who are haves, people who have money, can choose to take their health care dollars and leave the jurisdiction—leave Canada, and take their health care dollars and go outside of Canada to buy services. But unfortunately, people who don't have resources are stuck on a wait-list.

What this government is trying to do is to make sure there are more publicly funded, accessible surgeries here for patients, so they don't have to wait. That is what Bill 60 is trying to achieve.

Of course, we're all very proud of our health care system, but we also all realize that it has faced challenges, especially since the pandemic and over the last little while, and we want to make sure that these clinics are based on need and not ability to pay. That's why we're taking these steps.

I was also interested—and I've looked at some of your best-practice guidelines, which I think are very helpful. One of the questions I had as a result of that was, if you could advise us whether best practices—I know you said you were going to Chile to help them. Are those best-practice guidelines available and consistent across Canada?

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

Dr. Doris Grinspun: Yes, and we use them—that's why I know so much—the health sector. We use them whether it's for-profit entities or whether it's not-for-profit, because patients require best practices.

However, as you will realize if you go to long-term care, in long-term care, a lot of the places implementing them are not-for-profit, even here in Ontario. Organizations choose what they take, right? Ideally, they should be embedded in electronic health records; I have spoken with Minister Calandra. They should be included across the board, and that will improve long-term care in a huge way.

Those are two separate issues. The issue that the government is trying to do, to have these clinics, to solve the issue of wait times—let me tell you, we all want to solve wait times. Let's open operating rooms—

Mrs. Robin Martin: Thank you, Dr. Grinspun, and—

Dr. Doris Grinspun: —let's open ICUs, and let's have them 24/7 every day of the week, and we will for sure fix the problem—

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

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

Mrs. Lisa Gretzky: I'm going to start with Mr. Garvie. As a past dental assistant, I will agree with you wholeheartedly that dental care is health care. In fact, many people in this room may not know, but if you have oral

health issues like an abscess, an infection in your mouth, that can actually kill you. It can kill you. So we should absolutely have dental care as part of our universal health care system.

I'm going to have a question for Dr. Grinspun, but I want to start with a quote first, because the question comes from this quote. This was actually in the presentation from OPSEU. The quote says, "The average stroke unit has one staff member assigned to 40 beds. On a day when that position's not covered, the rest of us are running from our positions trying to help. No one gets proper care on those days.

"Who is the government talking to? They're not talking to the people working at the front lines. Nobody asks us, even at our hospital. They just do what they think works, and then it fails."

My question to you is, based on that and your knowledge, obviously, from your members: Is there anything in Bill 60 that is really going to address the staffing crisis that we already have within the hospital system? Opening up these private clinics: Is that going to help the staffing crisis that we're seeing in hospitals?

Dr. Doris Grinspun: The quote that you read, first of all, warms my heart in a bad way, because I'm a rehab nurse by background. But let's leave that aside for a minute.

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Not only is there nothing in the bill that will solve that situation, the bill, without a doubt, will make it worse. It will make it worse not only for the have-nots, it will make it worse for many of you. It's sad, because I see my sister—she can hardly walk; seven back surgeries. Likely, she needed two.

The bill will make things worse. It will drive staff from one sector to another, it will create instability and it will not solve wait times. It's very well known: It will not solve wait times. It will make it worse.

Mrs. Lisa Gretzky: You're right.

Dr. Doris Grinspun: And it certainly will not solve the staffing.

Mrs. Lisa Gretzky: The evidence shows—I mean, you just have to look at BC and how they're starting to buy back these clinics—that it clearly fails. It doesn't work.

Earlier today, the president and CEO from Scarborough Health Network actually talked about equity of access and addressed something the government keeps raising: that these private clinics, these for-profit clinics, take the low-acuity patients. Anybody who has more complex medical needs, then, has to go to hospital for procedures, and then will have to wait longer, because we do not have the health care workers there.

I think you and I can both agree that repealing Bill 124 would start to change that. As someone who lives in a border town and sees nurses cross the border every day to go to work where they're respected, I fully agree with you there.

Would you agree that Bill 60, as the government is saying, actually levels the playing field, so to speak, for everyone in the province, so everyone has equitable access to health care, or is this going to—as you had said earlier; I guess you answered the question already—have the haves and the have-nots?

Dr. Doris Grinspun: Number one, Bill 60 will not solve the problem in the short term. In the long term, it will bankrupt the health system, because you pay more to for-profit, investor-driven corporations. They need to make their money somewhere.

I am much less naive, because this is my fourth country. Bill 60 is—first of all, the system was starved for resources, so you create the forum for people to complain. Then you create this bill. This bill will continue to deteriorate the system. More people will ask for private services, and then there is no way back from it. It will destroy the fabric. But let me tell you: It will end in unsafe streets. I lived in those streets in other countries. I came to this country to live differently. I also was in the US for six years. This is not new to me. I saw my patients sent home when they were not ready to go home.

Bill 60 will not level the playing field. It will create more instability, more haves and have-nots. The haves will get more care than what they need—more care is not always good, especially if it's surgeries—and the have-nots will get less. And yes, the wait times will increase for most of the people in this province, and the others will get more care than what they need. It will result in deteriorated health outcomes for Ontarians.

Mrs. Lisa Gretzky: Thank you. I'm going to hand it to my colleague from Niagara Falls.

Mr. Wayne Gates: Doris, I don't know if you remember: I actually met you, going back years ago, under the Mike Harris government, when we were fighting together for health care. During that fight, the reason why—I just happen to have the stats: Mike Harris laid off 6,000 nurses. He closed 43 hospitals and closed 1,140 beds. We were out with our flags fighting for health care back then, and we were able to stop Mike Harris. Here we are, 20 years later, doing the same thing together.

Billions of dollars in profit is what the private sector is after—billions. There's billions of dollars in health care, and that's what they're after. That's what the bill is about. That's what this government is going to do.

But I'll ask you a question. Obviously, we have asked this government to invest in our public system, to use those open operating rooms to clear backlogs. The government said no. They said no. How much do you think Bill 124 has contributed to the backlog in our health care system?

Dr. Doris Grinspun: Hugely, but I first want to answer your first comment, without names. I don't want to compare the previous Premier with the current Premier. Let me be on the record on that. I do not.

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

Dr. Doris Grinspun: Second, there are good people in all governments. Minister Elliott was the person who started the program on evidence-based guidelines. Christine Elliott supported it, and I expect that every single government would support it.

Bill 124 was a big aspect of the situation with nursing, why nurses are going to Nova Scotia, the US, BC etc. I

have begged our current Premier to do away with and certainly not to challenge the bill when the court said that it's unconstitutional.

I never thought I will be sitting here talking about the same that I was speaking back then. I left Sinai and I came to RNAO to fight that fight, and I'm back here to fight that fight again, because this universal health care is important to Ontario, to Canada and to people like my family.

That's where I draw the line. I told the Premier back then, this Premier: That's where we draw the line. Nurses draw the line on universal access to health care.

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

We'll now turn to the independent member for four and a half minutes. You may begin.

Mr. Adil Shamji: Dr. Grinspun, I've heard many stories from my sister, who is a nurse in emergency medicine, but I'm curious to hear from you what nurses are seeing on the front lines and what lessons that has for our health care system and where it needs to improve.

Dr. Doris Grinspun: Our health care system needs to fix the wait times. There is no way around that. We can say it was before the pandemic, partially. The pandemic certainly aggravated it also.

But as our colleague, the parliamentary assistant, just mentioned—Kevin Smith said that they had fixed, more or less, the wait times when they were given resources. Let's give more resources to the hospital. Let's open all operating rooms.

In fact, a senior person in government said to me, "Doris, we don't even need to open all the operating rooms. Open some one day a week, and we can fix the problem." Senior people inside government are saying this. They might not say this to you, but they're saying this to me.

Let's open the operating rooms, let's put the staffing there, and let's get done with these wait times. But let's not get into this business of investor-driven—Kensington Clinic, yes; not-for-profit clinics adjacent to hospitals, yes. Investor-driven, for-profit corporations? The answer is no. It will create worse—not just for nurses. Nurses will have work, always. This is not about nurses. This is about the people of this province.

Mr. Adil Shamji: I recall reading somewhere that some senior bureaucrats had also expressed reservations about Bill 124 and its impact on the health human resource crisis.

Dr. Doris Grinspun: That's correct.

Mr. Adil Shamji: One thing that I'm hearing anecdotally from a lot of people—from a lot of nurses, specifically—is that they're being driven out of the profession. How significant of a problem is that?

Dr. Doris Grinspun: Few are driven out of the profession; they're driven out of this province. It's Bill 124.

It's two things. It's Bill 124 in terms of compensation. We're one of the lowest. In fact, for the first three levels of nursing out of school, we are the second lowest in the country. So that's number one. Those are the people that have the luggage here. They can walk and go and create new lives somewhere else, and they go.

The second is the workloads. They are one and the same, because if you don't have enough nurses, then the workloads go up. That results not only in nurses continuously leaving the province, but also results in unsafe care. It results in frustration. It results in outcomes that are not what we want for Ontario.

What is there, though, is hope. There are, more than ever before, people applying into nursing. Let's keep them here. Let's create the conditions for them to stay here. Those that came out of the country and are living in Ontario, let's bring them, fast-track their registration.

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

Dr. Doris Grinspun: Let's bring them to work, and let's create the conditions for them to stay here.

Mr. Adil Shamji: Thank you very much.

I have no further questions, Chair.

The Chair (Ms. Goldie Ghamari): Thank you. We'll turn to the government for seven and a half minutes. MPP Martin, you may begin.

Mrs. Robin Martin: Thank you again to the presenters. Dr. Grinspun, just a couple of things: I know my colleague MPP Quinn was asking you some questions. Minister Jones did issue a letter to the College of Nurses of Ontario in August, requesting them to pull out all the stops to register as many nurses as possible who are here. We certainly hope that we get as many of our nurses registered as possible, and we're certainly trying to do everything we can. That's one of many things that we are doing to try to address our health human resource backlog demand. We certainly need to have more nurses working there.

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You also talked about investing in hospitals, but I think you know that we invested almost a billion dollars—$880 million—in hospitals to try to help us clear our backlog. They managed to get them down from 270,000 to about 206,000. So we have made that kind of an investment.

Because I've heard you speak at other things, I know that you're a fan of moving services out of hospitals and into community and primary care. This is again an attempt to move services out of hospitals and into community. I guess I'm just a little bit perplexed as to why this isn't something that is appropriate as a way to move care out. I guess what I'm asking is—certain care, of course, has to be done in hospitals. I think we'd agree on that. Is that correct? You would agree that there are certain things that have to be done in hospitals: the high-acuity cases, surgeries etc. Is that right?

Dr. Doris Grinspun: Is that the question?

Mrs. Robin Martin: Yes.

Dr. Doris Grinspun: Okay. Surgeries need to be done either in hospitals or in not-for-profit entities. The issue is investor-driven for-profit, and I think you know that. You know the difference of what we have made.

When we say "community services," we are talking home care, which was a good investment now in the budget, and we are very appreciative. It's in primary care where there was no investment. Peterborough, Orillia: You know that

nurse practitioners are ready to go with not-for-profit, salaried compensation, primary care clinics. They were not approved. Like that, there are many others. That will now start to drive nurse practitioners, yet again, away from this province to other jurisdictions that are allowing them to work for the public in a not-for-profit base.

The issue is investor-driven, for-profit care. It will never deliver quality care. It provides the wrong incentives and the wrong outcomes. It provides more to people than what they need, and to the others, it provides less.

Mrs. Robin Martin: Thank you. So let's just explore that a little bit. There's nothing in Bill 60 that says that a clinic has to be a private clinic, so potentially, we could have more Kensington-style clinics which come out of Bill 60. My question is, first of all, are you okay with that? And then, what exactly is it that makes it investor-driven? For example, we've had a few medical professionals who have clinics, who run clinics, and they hold them through a corporation. They're shareholders in the corporation, but they run the clinic and they're subject to professional standards. Is that kind of outpatient clinic or a surgery clinic okay with you?

Dr. Doris Grinspun: So, Kensington clinic—in fact, we were there during the opening of that clinic—is not investor-driven. It's not-for-profit.

This, which I will leave with you, was investor-driven, and they run away with the money. The clinic that is being opened—and there are several, as you know. They have approached government already. I just happen to be aware. Many of them are for-profit, investor-driven. Those are the ones that we oppose, for obvious reasons.

Mrs. Robin Martin: Okay. I was just trying to understand what the difference is in your mind and what is appropriate to have out of hospital and what is not appropriate to have out of hospital.

Dr. Doris Grinspun: Very good. Not-for-profit clinics are okay; not investor-driven is okay—because the Kensington clinic is not-for-profit, it's not investor-driven; it's simple procedures. The others are different, so that's what we're talking about, the investor-driven. By law, I'm sure you know, they first need to respond to the shareholders. The first group that they need to provide care to, so to speak, by law is the investors. Then comes patients and if patients go bad, they put them back into the hospital system.

Mrs. Robin Martin: Right. But you're aware that you can grant a licence with restrictions that require you to put patient care as the thing that you have to look after, whatever profits you can manage to get out of—

Dr. Doris Grinspun: Not by law with investor-driven, as you know.

Mrs. Robin Martin: But we're making a law right now, Dr. Grinspun, so we can put in what we like.

Dr. Doris Grinspun: Well, I haven't seen it. That's what's missing, right? That's why we shouldn't run into it. That's exactly what's missing. There is nothing in the bill that sets any protections of any kind or anything. In fact, directors are not going to even be—you know.

So there is a lot—I suggest that we slow down, we do the homework together, we consult a lot more, we look at the implications so then we're not running after the implications and running after people that run with the baggage and the luggage.

Mrs. Robin Martin: Thank you very much, Dr. Grinspun. I don't have any other questions. I just believe that what we can't wait for is more access to patient care—

Dr. Doris Grinspun: Let's open the ORs.

Mrs. Robin Martin: —and 100,000 patients, in my understanding, have been waiting longer than they should be waiting for care, and that is unacceptable to this government.

Dr. Doris Grinspun: We agree with you and we say: Open the ORs in the evenings and in the nights and on the weekends—and we will not even need to open all of them.

The Chair (Ms. Goldie Ghamari): This concludes our time. I'd like to thank the presenters for their participation. If you would like to submit any written materials to the committee in addition to your presentation, the deadline for written submissions is tonight, Monday, March 27, 2023, at 7 p.m. Eastern Daylight Time.

This concludes public hearings on Bill 60 and our business for today. Thank you again to all the presenters.

As a reminder to committee members, the deadline for filing amendments to the bill is 5 p.m. Eastern Daylight Time on Wednesday, March 29, 2023.

The committee is now adjourned until 9 a.m. on Tuesday, April 4, 2023, when we will meet for clause-by-clause consideration of Bill 60.

The committee adjourned at 1707.

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