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Official Report of Debates (Hansard)

Thursday 20 May 2010

Journal des débats (Hansard)

Jeudi 20 mai 2010

Standing Committee on Justice Policy

Comité permanent de la justice

Excellent Care for All Act, 2010

Loi de 2010 sur l'excellence des soins pour tous

Chair: Lorenzo Berardinetti
Clerk: Susan Sourial

Président : Lorenzo Berardinetti
Greffière : Susan Sourial

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON JUSTICE POLICY

Thursday 20 May 2010

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DE LA JUSTICE

Jeudi 20 mai 2010

The committee met at 0903 in committee room 1.

SUBCOMMITTEE REPORT

The Vice-Chair (Ms. Leeanna Pendergast): Good morning. We'll come to order, please. Welcome to public hearings on Bill 46, An Act respecting the care provided by health care organizations. Good morning, everyone, and thank you for being with us here this morning.

Our first item on the agenda is the report of the subcommittee on committee business. I need a mover for the report, please. Mr. Balkissoon.

Mr. Bas Balkissoon: Your subcommittee on committee business met on Thursday, May 13, 2010, to consider the method of proceeding on Bill 46, An Act respecting the care provided by health care organizations, and recommends the following:

(1) That the committee hold one day of public hearings at Queen's Park on Thursday, May 20, 2010.

(2) That the committee clerk, with the authorization of the Chair, post information regarding the committee's business one day in the following publications: the Globe and Mail, the Toronto Star, and L'Express.

(3) That the committee clerk post a notice regarding the committee's business on the Ontario parliamentary channel and the committee's website.

(4) That interested people who wish to be considered to make an oral presentation on Bill 46 should contact the committee clerk by 12 noon, Tuesday, May 18, 2010.

(5) That, on Tuesday, May 18, 2010, the committee clerk provide the subcommittee members with an electronic list of all requests to appear.

(6) That groups/individuals be offered 15 minutes in which to make a presentation.

(7) That, if all groups/individuals can be scheduled, the committee clerk, in consultation with the Chair, be authorized to schedule all interested parties.

(8) That, if all groups/individuals cannot be scheduled, the committee clerk, in consultation with the Chair, reduce the presentation times to 10 minutes.

(9) That, if all groups/individuals cannot be scheduled with 10-minute presentations, each of the subcommittee members provide the committee clerk with a prioritized list of names of groups/individuals they would like to hear from, by 4 p.m., Tuesday, May 18, 2010, and that these names must be selected from the original list distributed by the committee clerk to the subcommittee members.

(10) That the deadline for written submissions be 5 p.m., Tuesday, May 25, 2010.

(11) That the deadline (for administrative purposes) for filing amendments be 12 noon, Thursday, May 27, 2010.

(12) That the committee begin clause-by-clause consideration of Bill 46 on Monday, May 31, 2010 (subject to authorization by the House).

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

The Vice-Chair (Ms. Leeanna Pendergast): Thank you. I would like to draw the attention of the committee to number 12, please: "That the committee begin clause-by-clause consideration of Bill 46 on Monday, May 31, 2010 (subject to authorization by the House)." I'm just drawing the committee's attention to the fact that we do not, at this point, have authorization by the House, and if we do not receive that authorization, then we'll meet on Thursday, June 3, as scheduled.

Any discussion?

Mr. Bas Balkissoon: I move adoption.

The Vice-Chair (Ms. Leeanna Pendergast): All in favour of accepting the subcommittee report? Opposed? Carried.

The second item is a housekeeping item. The College of Chiropractors of Ontario has made a late request to present this afternoon. In keeping with what we've just heard in item 4, that they would have to apply by Tuesday, May 18, we need unanimous consent of the committee to allow the College of Chiropractors to present this afternoon to the committee. Is that acceptable? Unanimous? Thank you very much.

EXCELLENT CARE FOR ALL ACT, 2010

LOI DE 2010 SUR L'EXCELLENCE DES SOINS POUR TOUS

Consideration of Bill 46, An Act respecting the care provided by health care organizations / Projet de loi 46, Loi relative aux soins fournis par les organismes de soins de santé.

LIFELABS MEDICAL LABORATORY SERVICES

The Vice-Chair (Ms. Leeanna Pendergast): Item number 2 on our agenda is to begin public hearings. At this point, we would ask LifeLabs Medical Laboratory Services and Jeff MacDonald, if you're present, to please come forward. Good morning, sir. You have 15 minutes for your presentation. If you don't use up the entire 15 minutes, that time will be shared equally amongst all three parties for questions. When you begin, we would ask that you state your name for Hansard, please.

Mr. Jeff MacDonald: I'm Jeff MacDonald, and I'm general manager for LifeLabs Medical Laboratory Services.

Madam Chair, I'd like to thank you and the committee for inviting me here today to present on Bill 46, the Excellent Care for All, Act, 2010. I represent LifeLabs Medical Laboratory Services. We are the largest community laboratory provider in Canada and a vital member of a patient's extended health care team.

By way of background, LifeLabs Medical Laboratory Services provides medical testing to patients under the Ontario health insurance plan to help in the prevention, diagnosis, monitoring and treatment of disease and illness. With a provincial infrastructure of 2,000 health professionals, testing centres and collection centres, we provide access to essential laboratory testing across the province.

We are an important member of the colon cancer check program and a founding partner in the Ontario Laboratory Information System, which is the precursor to a full patient e-health record. Already, we play an important part in assisting those with diabetes better manage their disease and have a current proposal in front of government on how we can provide further infrastructure and service to proactively manage patient compliance in their care plan as well as driving improved health outcomes and, downstream, cost avoidance for the health care system.

We provide all of these services through a capped funding agreement which delivers greater value to the public health care system every year, since annual increases in demand for our services far outweigh any increase in our annual rate of funding.

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With regard to Bill 46, the Excellent Care for All Act, 2010, we recognize that the bill is officially and initially focused on the Ontario public hospital sector with which LifeLabs works every day, providing core and reference testing services along with management and administrative services.

While our hospital partnerships provide us a unique perspective, I am here today to provide support for the government's ultimate goal, which is the application of the bill's guiding principles to all aspects of the health care system. As the minister said last Wednesday, "Quality must cut across the entire continuum of care." LifeLabs supports all of the principles that underpin Bill 46, and we offer the following specific comments relating to the section of the bill dealing with the expansion of the Ontario Health Quality Council's mandate.

The first area: Supporting the use of clinical practice guidelines and protocols is crucial to ensuring that quality care is provided and funded appropriately. I'm proud to say that LifeLabs and our industry association, the Ontario Association of Medical Laboratories, are leaders in the development and deployment of laboratory clinical practice guidelines, with over 30 that are in practice in the province today. LifeLabs currently tracks many important quality, service and access indicators, which are reviewed by our quality committees and are routinely utilized to improve our service, as outlined in our quality improvement plan documents. We would support and lead industry-wide performance improvements through standardized key indicators based on best practice. We support the concept of building an integrated health care system that taps into the expertise of community partners and health care professionals, and we have much to offer the Ministry of Health and Long-Term Care in this regard.

We are pleased that Minister Matthews is asking questions related to the appropriate utilization of our medical services and the value received under the insured health care services. LifeLabs brought forward a similar issue in its 2010 pre-budget submission to the Standing Committee on Finance and Economic Affairs. In this submission, we raised the example of inappropriate Vitamin D testing.

LifeLabs' volume of Vitamin D testing has grown by more than 450% over the past two years and increased another 150% by March 31 of this year—all under a capped funding situation. A recent report of the Ontario Health Technology Advisory Committee concluded that vitamin D testing is not warranted for the healthy population. We agree with the findings of this report and support publicly insuring vitamin D testing only in medically necessary situations but not as a screening test for otherwise healthy individuals. We ask that the government work with us to bring conclusion to this issue quickly.

We share the government's objective of ensuring that future investments in health care achieve results and improve patient health. Funding services based on appropriate clinical practice guidelines is key to achieving this goal.

LifeLabs is also advocating solutions and tools which will better ensure that public health insurance dollars are being applied only to clinically appropriate situations that improve health outcomes. As an example of this, we are promoting items such as rules-based electronic ordering with embedded decision support for laboratory testing, test panels and results-based algorithms designed to provide the best clinical information while minimizing unnecessary testing. LifeLabs has the expertise and experience to bring these solutions across the entire laboratory system.

Secondly, funding must reflect quality and value. LifeLabs is a leader in quality improvement in the labora-

tory sector and is committed to continuous quality improvement as a critical goal. Our company meets or exceeds the gold standard of laboratory accreditation, the Ontario Laboratory Accreditation under the Quality Management Program—Laboratory Services. Our reference laboratory was the first to be accredited in Ontario, and every lab in our system has scored higher than the provincial average in this accreditation process. We believe that the government should take these types of items into consideration when funding laboratory services.

Thirdly, funding must flow with the patient. Over the last two years, more than 30 Ontario public hospitals have transferred outpatient laboratory testing into Ontario's community laboratory sector. This is the equivalent of approximately $17 million in gross OHIP billings. LifeLabs has absorbed hospital outpatient closures in communities throughout Ontario, with some examples being being Thunder Bay, Sault Ste. Marie, Hamilton, Niagara, Sarnia, Halton, Stratford, Toronto and many more.

While we agree that the community is the proper place for these patients to receive their medical laboratory testing services, funding for these services has not followed the patients from the hospital sector into the community sector. LifeLabs, along with the other community laboratory service providers, has had to accommodate these higher patient volumes within our capped funding budget.

In summary, Bill 46 is an important and laudable piece of legislation that focuses on patients, on quality and on best practices while delivering value for every health care dollar that the government spends. As an important part of the patient's extended health care team, LifeLabs is supporting the guiding principles behind Bill 46, ensuring that clinical practice guidelines are developed and implemented across the system to ensure that quality care is provided and funded appropriately. Moreover, providing funding based on continuous quality improvement and a patient-centred approach will ensure the patients receive the best care when and where they need it most.

LifeLabs looks forward to working with the government in the coming years and providing the leadership needed to extend and apply these principles more broadly across the system, including in the delivery of medical laboratory services.

I appreciate your time this morning. Thank you.

The Vice-Chair (Ms. Leeanna Pendergast): Thank you, Mr. MacDonald. We have just under three minutes for each party for questioning. We'll begin with the official opposition. Ms. Elliott.

Mrs. Christine Elliott: Good morning, Mr. MacDonald. Thank you very much for your presentation. I did have a question regarding your capped funding budget. How often does that get reviewed, and is it coming up for review again soon?

Mr. Jeff MacDonald: Our capped funding arrangement is an arrangement between the Ministry of Health and Long-Term Care and the Ontario Association of Medical Laboratories. There is an overall industry cap and then there is a corporate cap for each corporation that provides these services. That agreement is negotiated on, most usually, a three-year basis. We are in the third year of our three-year agreement at this point, which also has an opener in the third year of the agreement, where we would sit down with government to understand whether the forecasted volumes ended up being the true volumes and look at other regulatory changes.

At this point, our volumes have actually more than doubled what we had forecast at the beginning. We're running at a greater than 12%, year over year, volume increase, and this year we'll be receiving a 1.4%, year over year, funding increase. That's on top of an HST issue, which affects our industry by about $13 million. We cannot, obviously, charge the government the HST. and we have nowhere to pass it on. We also do not receive similar funding credits as hospitals do, where there would be an 87% tax credit on the HST.

Mrs. Christine Elliott: So you're already struggling with volumes and now you've got the HST on top of that.

Mr. Jeff MacDonald: Correct.

Mrs. Christine Elliott: I gather the ministry is aware of your concerns in that respect?

Mr. Jeff MacDonald: Absolutely.

Mrs. Christine Elliott: Okay. Thank you.

The Vice-Chair (Ms. Leeanna Pendergast): Ms. Gélinas.

M^me^ France Gélinas: Good morning, Mr. MacDonald. Thank you for coming. I understand some of the examples you've given regarding bone mineral density testing and vitamin D. What you're telling us is, from where you stand, you have a viewpoint as to the utilization of lab services. Sometimes you see anomalies develop that are maybe not the best use of taxpayers' money and not the best use of your capped budget either. How can you effect change? You don't control the tests that come in; you just do them—I'm assuming; I don't want to put words in your mouth. How would you see a system where you are an integral partner and you see anomalies developing? What would be a good chain so that we learn from your experience and influence change?

Mr. Jeff MacDonald: Thank you for the question. It's a key question within our industry. You are right about our current situation in that we perform the testing that is requisitioned by physicians and asked of us to do. We do already have a number of mechanisms to influence appropriate ordering behaviour. In saying "appropriate," some testing is over-utilized; some testing is underutilized. At this point in time, diabetes testing of those with diabetes is underutilized.

We have clinical practice guidelines, as I mentioned. There are over 30 in existence. They are recognized worldwide as world-class guidelines. We place comments on our reports when we feel that the physician might need additional information about when to order a test appropriately.

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We also are looking forward to working with the Ministry of Health and the Ontario Medical Association in a proposed tripartite committee that was brought up by our industry, where we can work together as a triangle of important stakeholders to influence ordering behaviour.

At the end of the day, you need to engineer solutions into this arena to ensure compliance, and that's where electronic laboratory ordering that is rules-based would come in, where if it makes no medical sense to order two tests together, you wouldn't be allowed to. Also, decision support: If a physician is suspecting a certain area of investigation into a patient, an electronic tool would be able to provide guidelines and pathways for that physician to perform that ordering. We believe that all of these will bring us towards better utilization.

On the diabetes front, which is underutilized, we also have a proposal in front of the government as to how we can actually ensure that patients better manage their care plan and are receiving their laboratory testing according to Canadian Diabetes Association guidelines.

M^me^ France Gélinas: How confident are you that this tripartite committee will see the light of day?

Mr. Jeff MacDonald: We have not met yet. I know that our assistant deputy minister is making the connections happen. We are hopeful to begin meeting in the fall. I don't have any further viewpoint other than that.

M^me^ France Gélinas: Thank you.

The Vice-Chair (Ms. Leeanna Pendergast): Thank you very much. Questions from the government? Mr. Balkissoon.

Mr. Bas Balkissoon: Good morning, and thank you for being here.

Based on your input, I get the impression that you're very supportive of the bill and that it's going in the right direction. Can you comment in terms of how you see it being used? I know it's strictly focused on the hospital area. If we were to roll it out to the other sectors as time goes on, how do you see it improving the whole health care outcomes for patients?

Mr. Jeff MacDonald: Maybe I can comment on how I can see it applying to the laboratory sector.

I believe that the capped funding environment that we are in today would be improved by having some measure of ensuring that those who do a better job in service and quality are rewarded to a larger degree, which will help them reinvest those dollars into continually improving their service to the patients. I believe that LifeLabs is the highest-quality player and highest-service player within our industry. I'm biased, of course, but these would be mechanisms for us to truly continue that improvement pattern, which will end up in improved patient outcomes and improved cost savings, cost avoidance and value for the money that is paid to laboratory services.

I also see our ability to provide these services across greater than the community sector, and I am very encouraged by the language that the public sector will be reaching out more to the community sector providers to help assist in the improvement of the overall system. This bill, I believe, paves the pathway for that.

Mr. Bas Balkissoon: Thank you very much.

The Vice-Chair (Ms. Leeanna Pendergast): Thank you, Mr. MacDonald, for your presentation.

Mr. Jeff MacDonald: Thank you.

INFORMATION AND PRIVACY COMMISSIONER OF ONTARIO

The Vice-Chair (Ms. Leeanna Pendergast): We'd now like to call on the Office of the Information and Privacy Commissioner of Ontario. Dr. Cavoukian, please come forward. Good morning. Thank you for being here this morning. You have 15 minutes for your presentation. As you know, any time that you don't use will be shared equally amongst all three parties. If you would introduce your team to us this morning, please.

Dr. Ann Cavoukian: Good morning, ladies and gentlemen. My name is Ann Cavoukian. I'm the Information and Privacy Commissioner of Ontario. I'm joined here today by my assistant commissioners Ken Anderson and Brian Beamish. I thank you very much for allowing me to speak to you today.

Madam Chair, members of the standing committee, I thank you for the opportunity to comment on Bill 46, the Excellent Care for All Act, intended to ensure that health care organizations are responsible and accountable to the public. Accountability is key.

As you are aware, my office is responsible for overseeing both the public sector access and privacy laws and, most notably, health-information-sector privacy legislation in the province of Ontario. It is further to this mandate that I'm here to speak to you today. In particular, I'm here to request that Bill 46 be amended to include hospitals as institutions under the Freedom of Information and Protection of Privacy Act—a simple amendment.

One of the primary purposes of Bill 46 is to improve the transparency and accountability of the health care system. In my view, the most effective and efficient way to achieve this objective is by bringing hospitals into public sector access and privacy legislation. Access to such information would enable citizens to obtain information necessary to scrutinize important public policy choices such as how their tax dollars are being spent and to participate fully in the democratic process. This is particularly important given the current economic environment and given the recent attention to and scrutiny of the expenditures of the health sector.

The precise language for the proposed amendment is set out in our written submission, which has been provided to the clerk of the committee. However, let me take the time available to provide you today with a brief rationale for the proposed amendment. Also, the amendment and the submission are very short and straightforward.

Hospitals are currently required to protect personal health information, medical information, and to provide

individuals with access to their health-related records. Designating hospitals as institutions under the Freedom of Information and Protection of Privacy Act would complete these responsibilities by providing transparency, which is presently lacking, and access to general records, such as those related to the procurement of goods and services, as well as matters of governance such as budgets and costs of facilities, programs and services offered by hospitals.

For many years now, my office has been repeatedly calling upon the government to extend public sector access laws to all publicly funded institutions, including hospitals and universities. We were successful in bringing universities in under the act. They were made subject to the Freedom of Information and Protection of Privacy Act in 2006. We're very grateful, and it's been working very well. Hospitals, however, have yet to be covered. In my most recent annual report, I again urge the government to bring Ontario hospitals under freedom of information.

Our hospitals are subject to public sector legislation in the area of health information, PHIPA. But I want to make it very clear: Our hospitals are not subject to public sector legislation in terms of freedom of information, unlike every single other province in this country. Ontario is the only one that does not have this kind of scrutiny for its hospitals. To me, that is appalling and, quite frankly, an embarrassment when I meet with my fellow commissioners from across the country, because we have outstanding health information privacy legislation.

PHIPA, the Personal Health Information Protection Act, which we introduced in 2004 and came into effect in 2005, is outstanding. Everyone raves about this legislation all around the world. The United States is reviewing its HIPAA legislation, the privacy rule associated with its legislation, and it reviewed all health information privacy laws around the world. The only one law they picked to form the framework as the basis for the revisions to the privacy role in HIPAA is Ontario's PHIPA. So we can be very proud of PHIPA. The only thing we can't be proud of is the fact that there's no public sector coverage in terms of transparency of hospitals under freedom of information.

Bill 46 imposes transparency and accountability requirements, including the establishment of quality committees, the creation and posting of annual quality improvement plans, carrying out surveys of employees and persons who receive services, and the development and posting of patient relations processes. These will all require additional resources, which is already considered under Bill 46. So any additional resources to implement the freedom of information requirements that I'm asking for would be negligible to non-existent. It's going to cost hardly anything to add hospitals under Bill 46.

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Bringing hospitals as institutions under FIPPA would not interfere with the effective and efficient delivery of health care services in any way—that's the other point that's very important—because the collection, use and disclosure of health-related information will continue to be governed under PHIPA, which as I said, is working beautifully. It's a perfect statute. It's really to be commended. That's already under way, so there's no issue.

It would also not interfere with the following areas: existing protections limiting the disclosure of quality-of-care information as defined under the Quality of Care Information Protection Act, 2004. Quality of care would remain outside of the purview of what I'm proposing. There's just no issue. It's not going to be a problem. Labour relations or employment-related matters in subsection 65(6) of our act, FIPPA, aren't going to be covered either because they've been out for many years. If you may recall, Bill 7 took out labour relations from FIPPA, so labour relations is not going to present a problem.

To minimize the impact of the Freedom of Information and Protection of Privacy Act, the proposed amendment also need not come into full force and effect upon royal assent. If you needed a year to delay it, for example, to permit the necessary time, so be it. To allow sufficient time for hospitals to prepare for their new responsibilities, the proposed amendment could come into force at a later date, either proclaimed by the Lieutenant Governor in Council or as specified in Bill 46.

My office will be pleased to work with the Ministry of Health the Ontario Hospital Association—which I have been speaking to regularly—and hospitals to ensure a smooth transition. As I said, I've already spoken to the OHA, to the president and chief executive officer of the OHA. I've spoken to the Minister of Health and Long-Term Care very recently and will continue to do so to convey these views.

Let me conclude by saying that I'm here to seek your support in providing the citizens of Ontario with the rights of access enjoyed by citizens in every other province in Canada. Ontarians deserve no less.

Thank you very much for considering my views in relation to Bill 46. I urge you to make this a reality. I would, of course, be pleased to respond to any questions you may have.

The Vice-Chair (Ms. Leeanna Pendergast): Thank you very much, Dr. Cavoukian. We have about three minutes for each party for questioning, and we'll begin with the third party. Ms. Gélinas?

M^me^ France Gélinas: Thank you. It's a pleasure to see you. I must say that you're preaching to the converted right now. I support you 100%. It doesn't cost anything. The major stakeholders are on board. The Ontario Hospital Association is on record. It is the right thing to do. I agree with you. PHIPA is way up there. It really put Ontario on the map.

You have been bringing this issue forward for a while. What are the arguments against?

Dr. Ann Cavoukian: I'm the wrong person to answer that, but I'm going to take a shot at it. What surprises me and what delighted me was that in October of last year, the OHA, on their own, came forward to the government and said, "Bring hospitals under freedom of information.

We want to have that kind of transparency." I was thrilled. I immediately contacted the OHA, Mr. Closson, the CEO; I contacted the Minister of Health. I've been doing a letter-writing campaign—poor government—to the Minister of Health and to the Premier. The Premier has publicly said that he'll seriously consider it; he's very interested in doing this.

I don't think philosophically there's a problem. I think why it's snagging, if you will, is resources. Everyone is concerned with not increasing tax dollars; I understand that. As I've outlined, I truly think this would not cost additional dollars because you have to have a framework in place for Bill 46, with all the transparency requirements that it introduces. The resources you introduce for that, I think, will cover what may be required under FIPPA. Also, PHIPA already has a system in place where you have people: You have staff who respond to requests for personal health information, which is permitted to be given to patients. You can also use those resources, so I don't think it's a resource issue.

I know there was an issue with quality of care. You don't want to mess with quality of care, and it's not a problem with that at all because quality of care already is quite separate and would continue to be. I'm happy to put that in writing.

If it's not money and it's not quality of care, I am at a loss. I really am. Truly, for not only the transparency and accountability, but why should Ontario citizens—it's like we're second-class citizens because we don't get this. Every other province in the country has this. I'm embarrassed. I'm rarely embarrassed, because we do such an outstanding job in Ontario. We lead. Truly, with PHIPA, we're at the head of the world.

Let's make this single correction and equal them.

M^me^ France Gélinas: You said that you wrote to the Premier and the minister. Would you be at liberty to share their answer with the group when you get an answer?

Dr. Ann Cavoukian: I've already gotten answers. They've both been very responsive. They're certainly interested in promoting transparency. The Premier said that he would seriously consider it. I recently met with the Minister of Health; she was very interested as well. I think her concerns, understandably, relate to resource implications. No one wants this to cost more; I understand that. We would work very hard to work with the government and the OHA to craft a solution to keep the resource expenditures minimal.

M^me^ France Gélinas: Thank you.

The Vice-Chair (Ms. Leeanna Pendergast): Thank you very much. Mr. Balkissoon?

Mr. Bas Balkissoon: Good morning, and thank you for being here.

You said that you have been in constant contact with the OHA and the ministry with regard to your request. Other than saying that the OHA is supportive, have they expressed any issues with you that they would require to get up to speed to meet legislation, and what would those be?

Dr. Ann Cavoukian: As I said, I have spoken to them. I did a round of consultations with them in October when this came out because, really, we were delighted. I applauded them, and everybody was spoken to—letter writing. Recently, when we noticed that there was an opportunity through Bill 46 to introduce an amendment—which we have drafted, so there's no work on the part of the government—that's when the conversations arose again.

I only just heard a few days ago—I'll be very clear—that there was any kind of problem, so I contacted the OHA again. I spoke to Mr. Closson and his team. The discussion centred around there needing to be a thoughtful consideration of the process and what factors could be affected. I was perplexed, and I spoke to them as I'm speaking to you. I said, "I'm baffled." We've been looking at this for 20 years; this is not a new issue. Quality of care is not on the table. Resources: We can work on that. There are already resources required under Bill 46.

Help me. Is there—

Mr. Ken Anderson: Labour relations are not there.

Dr. Ann Cavoukian: Labour relations are not there. It's out; it has always been out.

I don't get it. Consider a discussion of what issues? I'm sorry; I sound like I'm being cavalier. I'm a little frustrated. I honestly don't know what the issues are beyond that. Quality of care: Absolutely right for them be concerned with, but it's off the table. It will not be an issue, believe me, and I want quality of care as much as anyone.

The resources: We can work with them, as I said. There are already resource implications built into Bill 46. We will work very carefully to just find a system to add to that that will ensure that that also extends to PHIPA.

Mr. Ken Anderson: Start-up time of a year—a delay.

Dr. Ann Cavoukian: That's right, and we're happy to offer that. Understandably, it would take time for hospitals to prepare and get ready for this. All of this takes time. I fully accept that. That's why we conceded that it could take—start-up time, a transition period of a year or a period yet to be determined; that could certainly be discussed. I think those were the issues.

Mr. Bas Balkissoon: Thank you very much.

The Vice-Chair (Ms. Leeanna Pendergast): Thank you. Mr. Chudleigh?

Mr. Ted Chudleigh: Under the bill, the hospitals have to set up quality assurance committees. Each hospital has to do this. Since these quality committees would be operating under the CEO, or at least the CEO would have some influence over the striking of these committees, do you see that as an inherent conflict of interest? I'd appreciate your comments on whether or not you think the standards that the CEO has to meet should be provincially mandated as opposed to mandated by each of the hospitals.

Dr. Ann Cavoukian: Those are very good questions, and I want to be very clear: I have not turned my mind to those issues. We have been focusing on the transparency and accountability issues of Bill 46. I don't know if I'm qualified to give you a solid answer on that, so I don't

even want to attempt to speculate. It's not my area of expertise, and I just don't want to be speculating. I apologize.

Mr. Ted Chudleigh: Within your organization, if you were to set up quality standards, would you see yourself as having influence over the committee that would be set up to do that? Do you think that would be a fair and practical way to do things?

Dr. Ann Cavoukian: I'm going to ask my assistant commissioner to help me with that question.

Mr. Ken Anderson: With respect, as our commissioner has said, it's not an area that we've currently been discussing. But in terms of governance and management more generally, there's a broad literature on quality assurance, quality care and so on, and how to do that. So if we were setting that up, we'd go back to the literature, study that and come to our conclusions. We haven't done that backgrounding, and so for us, I'm sorry; it would just be speculation and not properly informed.

0940

The Vice-Chair (Ms. Leeanna Pendergast): Ms. Elliott?

Mrs. Christine Elliott: Thank you very much for joining us today, Dr. Cavoukian. I think that the suggestions that you're making make sense if you are going to go to the extent of having a quality assurance committee. The suggestion that you have made makes perfect sense and can be implemented without any increase in cost to increase transparency and accountability, and the Ontario Hospital Association is on side with it. I think your amendment makes very good sense. Thank you.

Dr. Ann Cavoukian: Thank you for your support. Thank you very much.

The Vice-Chair (Ms. Leeanna Pendergast): Thank you very much for your presentation and for being here with us today.

Dr. Ann Cavoukian: Thank you.

ONTARIO CHIROPRACTIC ASSOCIATION

The Vice-Chair (Ms. Leeanna Pendergast): Our next group has had to cancel, so we will move to the Ontario Chiropractic Association. Fortunately, Dr. Robert Haig is here with us already, so we thank you for being here and for beginning early with us. Thank you very much. As you know, you have 15 minutes. Any time you don't use will be used up for questioning. You can begin. State your name for Hansard, please.

Dr. Bob Haig: Thank you very much, and good morning. My name is Bob Haig and I'm the executive director of the Ontario Chiropractic Association. First of all, let me thank you for this opportunity to provide some input into your deliberations.

The Ontario Chiropractic Association, established in 1929, is the professional association representing the chiropractic profession and the chiropractors in Ontario. It's a voluntary association whose mission is to serve its members and the public by advancing the understanding and use of chiropractic care. Over 3,000 chiropractors, or 82% of the practising chiropractors in Ontario, are members of this voluntary organization.

Although chiropractic services are not publicly funded in Ontario, they remain an important part of the health care system. Chiropractors work independently in private clinics, but they also work with other health care practitioners in collaborative settings: within family health teams, in community health centres, in long-term-care facilities and in some hospital settings.

In Ontario, chiropractors play an important role providing health care to more than a million patients annually. Musculoskeletal disorders—the chiropractor's area of expertise—rank second only to cardiovascular disease as a major cause of chronic health problems and long-term disability. Musculoskeletal disease is a major cause of long-term health problems and disability, and a large proportion of Ontarians with these problems rely on chiropractors and regard them as an important resource within the Ontario health care system.

In Ontario and across Canada we are all justifiably proud of our universal, publicly funded health care system. The health care system consumes 46 cents of every program dollar, and I think we all understand that that's predicted to go much higher in the years ahead unless we start to do things differently. So there is understandable pressure on health care funding, and as that pressure increases, there will be tough decisions to make, not unlike the decisions made in 2004 to de-list chiropractic services, most physiotherapy services and most optometry services. I am not questioning those decisions at all, but I'm using this to draw a parallel between them and the tough decisions that are ahead. It's important to point out that the changes in funding status that were made a number of years ago did not diminish the role of these services in our health care system or render them any less valuable to the millions of patients who rely on them, nor have they reduced the need for a system that integrates health care providers in a way that puts patients in the centre.

Today, the existence and utilization of optometry, physiotherapy and chiropractic services by Ontarians, and the collaboration between those practitioners and practitioners in the public system, continue to support the government's quality and patient-centred agenda. These practitioners facilitate the sustainability of the public health care system, and this actually does lead into the comments I wanted to make on Bill 46, which are brief and are restricted to those parts of the bill that deal with the Ontario Health Quality Council.

Let me first express our support for the government's focus on organizing health care around the patient, as was emphasized in the speech from the throne. We support the government's intent to ensure the best quality of care for Ontarians by continuously improving quality across the system and promoting evidence-based care that is collaborative and patient-focused. We have three main points.

The first one relates to the overall focus of the council. The functions of the council as set out in section 12 are

most welcome. Monitoring and reporting on access, health human resources, health system outcomes and population health is clearly an important role. The existence of a dedicated body that reports not just to the minister but to the public on these issues is laudable. Ontarians cherish our health care system, but they do not always fully understand the difficulties that the government faces in sustaining it. The mandate of the health quality council will help in this regard.

In section 12(1)(a), points (i) and (ii) refer to monitoring and reporting on access and health human resources, but they restrict those examinations to publicly funded services. On the other hand, points (iii) and (iv) require the council to report on overall health and population health status as well as outcomes for the health system overall, generally speaking.

In the face of the significant economic challenges, we need to make a concerted effort to make sure that all parts of the health care system are functioning well and, just as importantly, that they're functioning in a coordinated and supportive manner.

The considerations of patient access and availability of health human resources within the public system should take into account the impact of and should determine how best to utilize those health human resources which work in the not-funded system but work in concert with the publicly funded system. Patients who receive these unfunded services realize that the public system does not operate in isolation. So we're recommending that section 12 be amended so that the references to monitoring and reporting on access and health human resources apply to the system as a whole rather than to just the publicly funded part of the system.

With respect to clinical practice guidelines, I know we echo others in the health community by applauding the government's focus on evidence-based care and CPGs. The chiropractic profession has considerable experience with the development and application of CPGs and looks forward to contributing to the work of the council.

Chiropractors utilize a wide range of evidence-based interventions. Many of you will be aware that spinal manipulation, as a treatment, as an intervention, is used primarily by chiropractors. It's used by others, but 90% of the spinal manipulation that's delivered to patients is delivered by chiropractors.

What you may not know and may not realize is that there's more evidence related to the effectiveness of spinal manipulation in the management of acute and chronic back pain than there is for any other back pain intervention. That's why a recent analysis of 17 international practice guidelines published in the journal Spine found that spinal manipulation was consistently considered a first-line intervention in the management of back pain. Studies have demonstrated not just the effectiveness of the treatment but also the impact it has on reducing medication use and other costs in the system. And yet today, in our publicly funded system, there's limited capacity to deliver this effective, evidence-based treatment to Ontarians who are living with one of society's most debilitating and costly conditions.

I'm not suggesting that chiropractic should be re-listed under OHIP, but we're recommending that the clinical practice guidelines that are developed or considered by the health quality council take into consideration the full scope of the evidence and that it be used to inform and shape the delivery of quality care, regardless of whether or not the services are publicly funded.

The chiropractic profession in Canada has been developing clinical practice guidelines since 1993. For example, the guideline on adult neck pain not due to whiplash was published in 2005, and the document includes not just the technical guideline but also a short version for ease of use by practitioners, a patient handout, a clinical decision-making algorithm and a cervical spine manipulation decision-making algorithm. A similar group of documents was produced for the most recent guideline on whiplash-associated disorder in adults, which was published in the journal Work in 2010.

It's important to understand that the development and dissemination of clinical practice guidelines is only the first step and is not sufficient to ensure quality care. We understand the disparity that exists throughout the health care system between clinical practice guidelines and actual practice. Knowledge transfer, the process by which guidelines become understood and adopted by clinicians, is key to their dissemination but is also very difficult to implement. That's why we have partnered with the Institute for Work and Health, along with the College of Chiropractors of Ontario and the educational institution, which is the Canadian Memorial Chiropractic College, on a program to facilitate the uptake and use of not just CPGs, but also best-evidence practice by chiropractors in Ontario.

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Guidelines are taught in the educational institutions, where behaviour and future practice patterns can be most influenced. A recent X-ray utilization study based on OHIP data reported a 21% decrease in the use of radiographs by chiropractors between 1994 and 2000. That, of course, is consistent with what the emerging guidelines were saying should happen at the time, and the authors attributed that to the education that chiropractors were receiving as the vehicle for translation.

Given the chiropractic profession's experience in the development of comprehensive clinical practice guidelines and the importance of these guidelines to the health system as a whole, we recommend ensuring that the Ontario Health Quality Council's role with respect to CPGs is not limited to publicly funded organizations or services.

Finally, with respect to the quality council's ability to make recommendations on funding, the chiropractic profession understands the depth of the dilemma facing the government. A move to clearly and decisively base funding on evidence is an extremely positive thing. We applaud the call in section 12(4) for public consultation and public tabling of the reports on this. These provisions describe a new level of commitment to transparency and patient-centred care.

The very concept of patient-centred care requires sensitivity to patients' needs and choice regardless of the sources of funding. We appreciate that this bill focuses on publicly funded health care organizations, yet changes to these organizations will impact the health care system in general, including those practitioners not publicly funded, but who also contribute to the provision of quality evidence-based, patient-centred care. Further, the not-publicly-funded sector of the health care system care has expertise that is of value and can be tapped into. We recommend that these practitioners or their organizations be participants in the development of advice to the minister and others on these matters.

That completes the presentation, and I would be happy to answer any questions.

The Vice-Chair (Ms. Leeanna Pendergast): Thank you very much, Dr. Haig. We have about two minutes for each party to ask questions. We'll begin with the government. Mr. Balkissoon.

Mr. Bas Balkissoon: Mr. Haig, thank you very much for being here today. I just want to thank you for your presentation.

The Vice-Chair (Ms. Leeanna Pendergast): Mr. Colle.

Mr. Mike Colle: I just had a question, Dr. Haig. The intriguing thing is, you mentioned the reduction by 23% in the use of radiology in the treatment of skeletal issues. Can you explain that briefly?

Dr. Bob Haig: During the 1990s, when the scientific evidence started to demonstrate that the use of X-rays should be more limited because the value in many patients simply wasn't there and that it should be reserved for those patients where there was suspicion of something serious, the guidelines that came out of various sources started saying exactly that: The use of plain film radiography for the vast majority of simple low back pain is not warranted. What I'm saying is, as a result of that during that period of time—and it was largely the education that took place in the educational institutions that triggered that reduction. I'm speaking to the value of those kinds of guidelines, but also to the difficulty it takes sometimes in order to translate evidence into actual practice.

The Vice-Chair (Ms. Leeanna Pendergast): Thank you. Ms. Elliott?

Mrs. Christine Elliott: Thank you very much, Dr. Haig, for your presentation. It was very helpful, and I gather that what you're trying to do is to make sure that we don't continue to operate within the same box in the delivery of health care services, that we be innovative and we use all health care professionals to the fullest scope of their practice, and if you don't have everyone at the table, you won't get to understand the full perspective.

Dr. Bob Haig: That's a much better synopsis than I made. Yes, that's right. Ontario needs a health care system that is actually broader than the publicly funded one. I know that's maybe a bit of heresy, but in reality it exists now. We need to make it work as well as we can.

Mrs. Christine Elliott: I agree, and I thank you very much for bringing that perspective to us today.

The Vice-Chair (Ms. Leeanna Pendergast): Thank you. Ms. Gélinas?

M^me^ France Gélinas: Good morning, Bob. Nice to see you again.

You brought a focus on one little part of the bill, which has to do with the health quality council, and I think you made a very good, clear explanation as to: If the mandate of the health quality council is limited to what's publicly funded, we're going to miss the boat. Because I expect that there will be reluctance on this side of the room to accept this, what do you figure will happen if we continue? If we don't make an amendment to the bill and the bill stays the way it is, where they only look at publicly funded, what will happen?

Dr. Bob Haig: The bill will still be very effective if that happens. The concepts of basing funding and basing care on evidence and guidelines, the principle of that and putting that in legislation and applying that to just the publicly funded system will have very significant impacts. From the perspective that I sit at, it could be greater than that if that mandate was expanded, but there's no question that it will be a very significant piece of legislation that will have significant positive impacts.

M^me^ France Gélinas: So if we look at the example that you bring forward on spinal manipulation, Ontario could develop best practices for a spinal disorder that completely exclude spinal manipulation, because right now, it is not performed by the insured part. How could that be best practice, when all of the evidence in the world will show us, but we will completely ignore that evidence because it's not evidence that comes from the publicly funded—how could that be good?

Dr. Bob Haig: Practice guidelines tend to not talk about professions; they talk about interventions. So it's inconceivable to me that a guideline could be developed in Ontario that did not reference spinal manipulation, and that does present a challenge.

M^me^ France Gélinas: It's inconceivable? It's not inconceivable to me, the way the mandate is written right now. They will be looking at what our publicly funded health care professionals are doing. That's why you want changes.

Dr. Bob Haig: That's why we want changes.

M^me^ France Gélinas: Very good. Thank you.

The Vice-Chair (Ms. Leeanna Pendergast): Thank you very much, Dr. Haig, for your presentation.

Seeing no further business for this committee, we are recessed until 2 p.m.

Mr. Mike Colle: Excuse me, can I have some clarification of who was here and who wasn't supposed to be here? I see the chiropractors are here.

Interjection.

The Vice-Chair (Ms. Leeanna Pendergast): No. CUPE cancelled; they were unable to be here. Then there was the college of chiropractors, who called in late and asked us if they could present. So we're looking to put

them in this afternoon, because we got unanimous consent.

Mr. Mike Colle: Okay, that's good.

The Vice-Chair (Ms. Leeanna Pendergast): This committee is recessed until 2 p.m. Thank you.

The committee recessed from 0958 to 1403.

The Chair (Mr. Lorenzo Berardinetti): Let's call the meeting to order. Welcome to the Standing Committee on Justice Policy afternoon session. I want to thank Leeanna Pendergast for chairing this morning.

Ms. Leeanna Pendergast: My pleasure, Chair.

We're here on Bill 46, An Act respecting the care provided by health care organizations.

REGISTERED NURSES' ASSOCIATION OF ONTARIO

The Chair (Mr. Lorenzo Berardinetti): The next deputation, scheduled for 2 o'clock, is the Registered Nurses' Association of Ontario. If you'd like to come forward, you can sit over here. Also, there's water available. I understand that you may want to take a photograph; there's a photographer present. As long as committee members don't mind—there's a request to take a photograph. You have 15 minutes to make your presentation. Any time that you don't use for your presentation will be used for questions from committee members.

Ms. Irmajean Bajnok: Thank you very much. It's a real pleasure to be here. I really want to thank you for giving us this opportunity to share our views and recommendations related to this most important act.

My name is Irmajean Bajnok and I'm the director of the best practice guidelines program at the Registered Nurses' Association of Ontario. With me today is Valerie Rzepka. She is nursing policy analyst at RNAO.

RNAO, as many of you know, is the professional association for registered nurses who practise in all sectors and roles in this province. We represent 30,000 nurses but speak, really, on behalf of all registered nurses in the province. Our mandate is to advocate for healthy public policy and for the role of registered nurses in enhancing the health of all Ontarians. We appreciate the opportunity, as I've said, to present this submission on Bill 46 to you, the Standing Committee on Justice Policy.

The RNAO welcomes this legislation because it seeks to promote evidence-based practices and make health care organizations and executives accountable for providing the highest-quality patient-centred care. However—and there's always a caveat—in order to make Bill 46 stronger and more effective, we do believe, based on our experience as registered nurses and as an association of registered nurses, that a number of amendments must be made if the government wants to achieve its goal of continuous quality improvement while, at the same time, being accountable to the public and to patients.

Bill 46, as it now stands, applies to every health care organization, defined in section 1 as a hospital according to the Public Hospitals Act and "any other organization that is provided for in the regulations." Initially, as we read it, the legislative changes will only apply to the hospital sector, with other sectors coming on stream at a later date.

At first glance, it seems understandable why this legislation will be phased in over time, but we believe there is a risk that the bill's best intentions may lead to its undoing. If the Ministry of Health and Long-Term Care wants to improve value and quality, success will rest on the rate of readmissions to hospital. Last year, according to ministry figures, a full 140,000 patients were readmitted to hospital within 30 days of their original discharge. If high-quality, age-appropriate care is not available in the community for those leaving hospital, many—as this statistic shows—will inevitably find themselves back in hospital, often occupying alternate-level-of-care beds.

For that reason, we believe it's crucial that the legislation include a robust home care sector, allowing people to live independently at home with dignity. The same assurances of quality and accountability that we expect of hospitals with Bill 46 should also be expected of the community sector.

Reducing hospital readmissions and increasing value depend on improved efficiency at every stage. For example—and I've just personally experienced this over the weekend—it's not unusual for some hospital patients to wait several hours or even until the next day for physicians to be available to sign their discharge orders or transfer them from one unit to another. This has a negative effect on patient satisfaction, it blocks patient flow through the hospital, it increases the risk for hospital-acquired infections and it unnecessarily wastes resources. Sometimes these delays can extend over an entire weekend, preventing a patient who is sufficiently recovered from being discharged.

Nurse practitioners have the knowledge and skills to admit, treat, transfer and discharge patients in in-patient settings. With the necessary regulatory authority, nurse practitioners can and will play a key role in improving the smooth movement of patients through the health care system.

A section of the bill is also devoted to the establishment of quality committees. Such a committee would monitor and report to the health care organization's board of directors. It would also have the power to make recommendations regarding quality improvement initiatives and policies, ensure that scientific evidence of best practices is circulated to employees, and monitor the use of these best practice guidelines.

One thing that is not spelled out in this bill is the membership and composition of these quality committees; this is to be determined later in regulation. We believe the principles of interprofessional collaboration should be established in the act itself and not wait for regulations and that the makeup of quality committees includes representation from each regulated health profession practising in the organization.

RNAO has a wealth of experience in the development and implementation of evidence-based best practice

guidelines. I, myself, have the privilege of leading a wonderful team that oversees and carries out the development and implementation of these guidelines in a variety of settings in this province, in the country and around the world.

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In the area of clinical care, excellence in practice is a dynamic process in which the best theoretical and practical knowledge is considered and adopted in each encounter with a patient or a client. Such excellence, we believe, is fundamental to achieving the best health outcomes for the patients, for clients, for the caregiver and for the system as a whole.

RNAO's international affairs and best practice guidelines program, as I've mentioned, is a signature program. It has set the bar for evidence-based practice, not only in nursing but in a number of other health care professional groups. This program was launched 11 years ago in 1999 with multi-year funding from the Ministry of Health and Long-Term Care. To date, it has developed 35 clinical best practice guidelines in key areas of patient need, and it has developed seven healthy work environment best practice guidelines.

In its 11-year history, RNAO's best practice guidelines program has resulted in significant improvements to health care. I'll share two examples with you.

Long-term-care homes that implemented the falls best-practice guideline, in a national initiative we were asked to lead, saw a 40% reduction in falls and in injury from falls. With each serious fall costing the system about $35,000, you can appreciate that outcomes such as this are positive for the residents and clients we serve and also positive for the bottom line.

Another example shows that in Montreal, where we do have an organization that is implementing our guidelines, the McGill University Health Centre reported a 50% reduction in the rate of pressure ulcers as a result of using the best practice guidelines in this area. Again, what we have found is that using those guidelines, then, not only increases the quality of care but reduces cost.

Our leadership in promoting the use of best practice guidelines has been recognized locally, nationally and internationally. We have received numerous awards—three that I'll mention. One is an excellence award from the Minister of Health for our work in long-term care improving the quality using best practice guidelines. Another is international, again, through linking our best practice guidelines with bringing the best evidence to the point of care.

Evidence-based practice is critical to the provision of quality, client-centred care, but just as important is ensuring a healthy work environment in which to work. We have developed guidelines, then, that also focus on key work environment areas, such as respect, developing effective leadership, creating positive health teams and promoting a culture of safety. Medical evidence is critical but not the sole source of high-quality research. We believe that health care professions such as nursing contribute significantly to the body of health care research that focuses both on clients as well as on healthy work environments. We would hope that the investment that the Ministry of Health has made in our program related to best practice guidelines would be cemented with the integration of these best practices across all sectors of the health care system and reflected in this act.

Under the government's proposed legislation, every health care organization must develop and make public a quality improvement plan for the upcoming fiscal year. Upon request, as you know, the health care organization must provide a draft of the plan to its LHIN for review before it is made public. This plan would include the results of patient and caregiver surveys, data about critical incidents, annual performance improvement targets, and information on how executive compensation is linked to achievement of those outcomes or those targets.

Public disclosure of an organization's quality improvement plan is desired and certainly desirable. What's not clear in the legislation is whether a LHIN could withhold or delay certain pieces of information if it was deemed in their interest. RNAO believes transparency must be the rule of the day for that reason and believes the legislation should be amended to prevent the ability of a LHIN to receive a draft of the annual quality improvement plan before it is released to the public.

In order to further improve accountability and ensure transparency in the system, RNAO believes the public must have access to information on the expenditure of public money. This includes making hospitals subject to public scrutiny under the Freedom of Information and Protection of Privacy Act, ensuring public oversight of hospital consultancy contracts and granting the Ombudsman the right to investigate public complaints against hospitals and other health organizations. Currently, Ontario is the only province where the Ombudsman does not have jurisdiction over hospitals and long-term-care homes, despite receiving many serious complaints from these facilities.

In the preamble to Bill 46, the language pointedly states that the quality of a health care system is synonymous with accessibility, equity and integration. We would add to that a recommendation that hospital boards reflect the diversity of their communities and that the appointment process be—

The Chair (Mr. Lorenzo Berardinetti): Ms. Bajnok, I don't mean to interrupt, but you have about a minute left.

Ms. Irmajean Bajnok: —be democratic, transparent and representative of the community's demographic profile.

I wanted to also mention information about the medical advisory committee. The medical advisory committee proviso in the Public Hospitals Act really provides one caregiver—physicians—with inequitable access, we believe, to decision-making structures and to key administrative personnel. We believe that medical advisory committees should be replaced with interprofessional advisory committees, allowing all professions to have a

say in the provision of care. In addition, we do believe that the presence, then, of the head of the MAC on the board again gives unequal power to one particular group.

We wanted to end by stressing that we truly believe it is important that we focus on quality of care through continuity of care and continuity of caregiver, and we want to strongly reinforce that the provision of 70% full-time in our health care organizations is really a critical component of continuity of caregiver.

We want to also stress that, in hospitals, there be great attention paid to the assignment of one patient or the full care of a patient to an RN or an RPN, as the situation warrants, with RNs caring for complex patients and RPNs caring for those who are stable. We feel that changes in the care delivery model that move away from this have had detrimental effects on the system.

We wanted to end by focusing on the fact that there has been an announcement at the same time that indicated that government—

The Chair (Mr. Lorenzo Berardinetti): We're down to about 30 seconds.

Ms. Irmajean Bajnok: —would be moving to larger hospitals having a patient-based funding model of payment. We would like to urge that care be given so that this same proviso is not necessarily applied to rural and northern hospitals. They may need some different attention.

With that, I'd like to thank you very much and indicate that you do have a folder that has considerable information in it related to our best practice guidelines and our presentation today.

The Chair (Mr. Lorenzo Berardinetti): Thank you for your very thorough presentation, and thanks for coming here today.

ASSOCIATION OF ONTARIO MIDWIVES

The Chair (Mr. Lorenzo Berardinetti): We'll move on to our 2:15 deputation, which is the Association of Ontario Midwives. Good afternoon, and welcome.

Ms. Katrina Kilroy: I'm Katrina Kilroy. I'm the president of the Association of Ontario Midwives and I'm a practising midwife at Mount Sinai Hospital, down the street. This is Kelly Stadelbauer, who is the executive director of our association.

I want to thank you for the opportunity to address the standing committee today and to let you know that, generally, we are supportive of this bill. Many of the broad concepts that are in this bill are an inherent part of midwifery care. Overall, we applaud the efforts of the government to make health care providers and executives accountable for improving patient care and experiences. We agree with much of what the RNAO said. You'll see that reflected in our written submission, which will be coming along in a few days.

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There are a number of components in the act that we think will contribute to the goals you've stated. Today, I want to focus on four considerations that we think would strengthen the act.

Number 1, we would like the act to consider and address any potential unintended consequences that may decrease access to services, specifically pregnant and labouring women having to travel further distances to access care.

One of the dangers we are concerned about in the legislation is that it may unintentionally give an incentive to CEOs to divest their organizations of those health care services that are perceived to be too challenging to make the necessary quality improvements. For example, birth units, which are very complex, are already under pressure to close due to costs. They could now become even more vulnerable to closure because their rates of C-section, epidural, breastfeeding etc. are poor when compared to other Ontario hospitals. If a CEO's performance is measured by quality indicators, then there may be an incentive to get rid of the outlier indicators by shutting down the service completely. We know that the closure of birth units forces pregnant women to travel further for labour and delivery impacts negatively on quality-based outcomes. Yet, these impacts would not be measured by the hospital of the unit where it was closed and, therefore, would not negatively impact on CEO pay. There needs to be protection for communities and for patients so that these services with poor or fair quality indicators cannot be shut down; rather, they must work to improve those indicators so that there must be some disincentive or penalty for simply divesting your hospital of those services. This comes from a general concern about trends to close maternity units, so we are seeking reassurance it won't be an unintended consequence of this act that more maternity units are closed.

Birth unit closures force pregnant women to travel farther for care, and we know that when birth is not close to home, quality is sacrificed. There is clear evidence demonstrating that, when women travel away from their community to one centralized hospital for maternity care, undesirable results ensue, not just in terms of the poor outcomes for women and newborns, which we know, in fact, can be the case, but also the atrophy of other aspects of women's health care, the subsequent withdrawal of family physicians from the community and a loss of skill set in remaining health care providers. We are very opposed to the practice of centralizing maternity care services and would not support the closing of birth units as a solution to human resource or budgeting difficulties.

Number 2, we would like the act to clarify that the role of the Ontario Health Quality Council is not to develop universal clinical practice guidelines, but rather to be a clearing house for and to promote the use of clinical practice guidelines. I'm going to refer to them as CPGs from now on for simplicity.

The AOM has a key reservation about the development of universal CPGs. Each health profession should be able to establish and rely upon its own CPGs based on the best available evidence and consultation with its own practitioners. For example, as experts in low-risk preg-

nancy, it is midwifes who should and, indeed, do develop clinical practice guidelines for our profession, and these guidelines benefit midwifery clients. We support an approach to CPGs that reflects all of the values of informed choice: that the woman is the primary decision-maker in her care, choice of birthplace, diversity, appropriate use of technology—things that are a very intrinsic part of midwifery care. Using this approach, CPGs and adapted protocols would be the application of evidence in context.

It's the integration of clinical expertise, physiologic knowledge, patient preferences, clinical findings, the woman's and family's goals, their values, social context, geographic location, cultural, legal and community factors. You get the point? It's very complex. These contexts may be specific to the midwifery model of care or to the local community; they're not necessarily universal.

There may be clinical situations where different professions choose to collaborate on a common CPG, but this is best determined by the professions when they know they share a common approach and philosophy to care, a common client base, as well as other key factors. Midwifery clinical practice guidelines would always support the lowest-intervention approach to care based on the best available evidence.

We do think that it might be useful to have a high-level overview that ensures that CPGs are based on good evidence and that they're being appropriately applied, but we also believe that when health care professions develop their own CPGs, as is the case for midwives, quality and patient experience can be supported and enhanced.

The council could act as a clearing house and promote the use of clinical practice guidelines, examine them etc., but we want to ensure that the act does not erode the excellent quality and client experience that women in midwifery care already have access to, partly as a result of midwifery-specific CPGs.

Number 3, we would like the act to reflect an expectation that hospitals enable providers to work to their full competencies.

Let me give you an example of how this plays out in obstetrics. In spite of the provisions of the Midwifery Act, some hospitals place limits on the procedures that midwives can perform. We're talking about very simple things here. These include situations such as maintaining care of women whose labour is induced or augmented or something as simple as where an epidural is in place for pain relief. These policies are, by and large, determined by physicians within an individual hospital. As a result, there's a duplication of services, and unnecessary transfers of care are taking place. Moreover, there is absolutely no clinical evidence to indicate that a transfer of care is medically necessary. This is a clear example of an inefficiency that is produced in the system as a result of midwives being prevented from practising to their maximum competencies, and this impacts on the quality of care.

In fact, in 2001, a coroner's jury, in an effort to improve patient safety, recommended that all hospitals follow the scope of practice as outlined by the College of Midwives of Ontario when they're establishing the scope of midwifery practice in their obstetrical units. But we knew in 2007 that still half of the hospitals in the province restricted midwives' scope in these ways. Expecting hospitals to facilitate working to full scope of practice would facilitate consistency of midwifery care across the province and the appropriate use of midwife and physician providers. Hospitals could operationalize this expectation through the quality improvement process by, for example, setting benchmarks and improvement indicators related to scope of practice. This is a measurable index of quality that can be improved upon year after year. We'd like you to consider that.

Number 4, we would like the act to reflect a commitment to reducing interventions that do not lead to improved outcomes.

Giving birth is the leading reason for hospital admission in Ontario and, as such, maternity care provides many opportunities for quality improvement in hospitals. There are many interventions in maternity care that do not lead to improved outcomes, and we would like to see this specifically addressed in the act. One such example can be found by looking at rates of C-section, which have been increasing quite dramatically in the past decade without any evidence of improved overall outcomes. In fact, an increased rate of C-sections has been indexed to poorer maternal outcomes.

A large Canadian study looked at more than two million women over a 14-year period and found that planned C-section was associated with higher rates of complication—no surprise there. While C-sections are a critical procedure for many birthing women, according to the World Health Organization, Caesarean section rates should not be above 15% overall, yet the data from Ontario indicates the rate of C-sections varies considerably among LHINs, as well as between hospitals within a LHIN. Some LHIN rates are as high as 25%, and some hospitals have rates above 35%. Certainly, as midwives, we do not believe that one third of women cannot safely give birth vaginally. We believe that these high C-section rates are unnecessary and must be improved to ensure quality and increased patient safety. We feel that it is important that the act reflect a commitment to reducing interventions that do not lead to improved outcomes, such as C-section rates and routine electronic fetal monitoring.

In conclusion, we are hopeful that the Excellent Care for All Act will improve quality and patient experience, and we encourage the government to consider following the four recommendations we've made in moving forward with the act.

We may even have a few minutes for questions; right?

The Chair (Mr. Lorenzo Berardinetti): Actually, it's a couple of minutes we have, so let's say one minute per party. We'll start first with the Conservative Party and Mr. Chudleigh.

Mr. Ted Chudleigh: The quality standards committee is an important aspect of this bill. How do you see the composition of that committee being struck?

Ms. Katrina Kilroy: The quality committee within the hospital or the Ontario Health Quality Council?

Mr. Ted Chudleigh: No, within the hospital.

Ms. Katrina Kilroy: You will see in our written submission some comments on that. We definitely agree with the RNAO that it would not be useful to have a physician-only committee, for example, and that it is very important to have all of the providers working in the hospital represented on that committee. We've seen the challenges presented by a medical advisory committee that is only physicians in determining policy for a number of other—for midwives, we're primary health practitioners, and we certainly feel like we have a role to play on the—

Mr. Ted Chudleigh: What about the general public from outside the hospital?

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Ms. Katrina Kilroy: Absolutely. So there's a role, I think, for the public, and this bill clearly is looking for more input from the public. Midwifery really comes from a consumer-based movement, so we're very comfortable with consumer involvement. Who exactly and how would have to be thought about a bit more in detail, but we would be in favour of that.

Mr. Ted Chudleigh: Thank you.

The Chair (Mr. Lorenzo Berardinetti): We'll move on to Ms. Gélinas and the NDP.

M^me^ France Gélinas: It's a pleasure to hear you. I fully understand what you're trying to achieve—your profession struggles at many levels in this province, although you're doing excellent work and women and families love you.

The recommendation that the CPGs be profession-specific goes completely against all of the best practices that already exist in chronic disease management, where we talk about interdisciplinary care. I fully understand that this would not work for midwives, but how do you reconcile this, that most of the other professions are going to be pushing for interdisciplinary care, which means interdisciplinary CPGs as well?

Ms. Katrina Kilroy: In terms of hospital protocols, having interdisciplinary protocols that all the practitioners in that hospital agree with is critical.

Our concern about clinical practice guidelines arises from what we've seen over the last decade or two. It's a highly political process. It is not simply based on scientific evidence, and medical-legal factors come into play very profoundly. These guidelines have largely led to higher and higher rates of intervention. That is our concern, and we are fairly reserved about the possibility that we might be able to come to consensus amongst all the practitioners providing care in obstetrics; for example, when an induction of labour should take place, according to the evidence. It's just not that crystal clear.

The Chair (Mr. Lorenzo Berardinetti): Okay, we're going to have to move on to the Liberal party. Mr. Balkissoon?

Mr. Bas Balkissoon: Good to see you again, and thanks for being here.

Do you think the Ontario Health Quality Council, in the enhanced role that is being proposed in the legislation, is best suited to include the clinical practice guidelines that you talk about to ensure that you have that interdisciplinary role within the hospital sector? Do you think that what the bill is doing with that particular council and changing its mandate is not going to give you the opportunity to get the outcomes you're looking for?

Ms. Katrina Kilroy: Let me just say that I have a lot of concerns that that wouldn't be the case. The issue is: Who's on the council, how is it constituted and how are decisions made? That's why what we are suggesting is a higher-level overview of CPGs: reviewing CPGs, ensuring they are based on the best scientific evidence and that they are being applied etc. It takes the political component out of it and allows it to be a clinical oversight.

Mr. Bas Balkissoon: And you don't think the Ontario Health Quality Council can achieve that?

Ms. Katrina Kilroy: It may be that they could. Perhaps it could be structured in a way that there would be equitable consideration of all views, but the reality of numbers and power etc. in the province makes us concerned about that.

Mr. Bas Balkissoon: Okay. Thank you very much.

The Chair (Mr. Lorenzo Berardinetti): Thank you for your deputation.

COUNCIL OF ACADEMIC HOSPITALS OF ONTARIO

The Chair (Mr. Lorenzo Berardinetti): We'll move on, then, to our next presentation: Cancer Care Ontario—I'm sorry. My apologies. The next deputation is the Council of Academic Hospitals of Ontario. Just getting ahead of myself there.

Dr. Bob Bell: Thank you very much. My name is Dr. Bob Bell. I'm the president and chief executive officer of the University Health Network. I'm here representing the executive of the Council of Academic Hospitals of Ontario, or CAHO. With me is Karen Michell, the executive director of CAHO. Thank you for the opportunity to present to the committee.

As some of you may know, the Council of Academic Hospitals of Ontario is the association of Ontario's 25 academic hospitals and their research institutes. CAHO provides a focal point for strategic initiatives on behalf of our member hospitals.

As research-intensive hospitals, CAHO members are fully affiliated with a university medical or health sciences faculty. Our hospitals provide the most complex and urgent care to the sickest patients in Ontario. We teach the next generation of health care providers and foster health care innovation derived from discovery research.

These discoveries include the development of the first artificial kidney machine, identification of a critical gene that causes colon cancer, and the development of digital mammography for early detection of breast cancer in young women. These types of discoveries have led to

widespread improvements in ensuring healthier and longer lives for Ontarians.

From research in the laboratory to real-life experience at the bedside, CAHO hospitals focus on improving the delivery of care and developing new and better ways to treat patients and cure disease. A 2008 national report attributed 77% of Canadian medical breakthroughs to Ontario research hospitals.

Ensuring that all Ontarians continue to benefit from the discoveries of CAHO hospitals, we need to ensure that Ontario remains a leader in harnessing this health research and innovation. CAHO will vigorously pursue the aspiration of making Ontario the premier health enterprise in the world.

By supporting an environment that produces evidence-based world-leading health research and innovation, patients will continue to benefit from the discoveries of CAHO hospitals, in turn driving quality improvement for both patients as well as the health care system.

For this reason, we're pleased to see the Ontario government moving forward with legislation that sets a framework to enable evidence and best practice to drive quality improvement which will ultimately lead to a more accessible, safe and sustainable health care system for all Ontarians.

With our time today, we'd like to focus our remarks on three key areas of this legislation: first of all, leading by example; secondly, commenting that one size does not fit all; and finally, emphasizing the importance of getting it right through collaboration.

Leading by example: Research hospitals are already doing most of what the government is trying to achieve with this legislation. CAHO hospitals have been at the forefront of efforts to drive quality improvement in health care for some time.

For instance, at my hospital here in Toronto, comprising the Toronto Western and General hospitals and Princess Margaret Hospital, we have had a quality of care committee established under QCIPA, the Quality of Care Information Protection Act, that has been established for some time. This committee is tasked with reviewing critical and severe incidents, ensuring quality patient care and improving the safe environment for patients, visitors and staff. This multi-disciplinary committee meets a minimum of 10 times a year, is chaired by the CEO and provides quarterly updates to our board. I know we're not alone; many CAHO hospitals have a similar model of quality-of-care review.

In addition, UHN has a quality committee of the board since the Public Hospitals Act deems the volunteer board accountable for the quality of care delivered in the hospital. The purpose of this committee is to review the quality of patient care offered by all our programs and service delivery at UHN and make recommendations to the full board as required by monitoring key indicators set annually and negotiated with the board, setting targets for management achievement. This committee employs an annual performance improvement plan with measurable goals. In our hospital, as with many others in the province, and certainly within CAHO, we already have executive compensation tied to achievement of performance objectives.

Many research hospitals also have extensive patient relations processes. The Ottawa Hospital, for example, has a patient advocacy and clinical risk management program. This program is designed to address the concerns that patients and their families have about the care they receive. Not stopping there, Ottawa's program systematically uses these interactions with patients to learn how to make hospital care more responsive and better for all patients.

This is by no means an exhaustive list. My peers within CAHO have implemented many similar objectives across this province.

We undertook these initiatives not because we were required to do so; rather, it's ingrained within the culture of the spirit of research hospitals to strive for continuous improvement. Of course, we do this because it provides our patients with better care. As research hospitals, we develop and use evidence and best practice to drive quality improvement, ultimately leading to a more accessible, safe and sustainable health care system for all.

It's important to note that one size does not fit all. Ontario's research hospitals are world-class. We compete on a global scale for research partnerships, with industry for top clinical and research talent, and for investments. We have a unique role within Ontario's health care system.

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The mandate of a research hospital includes providing the most complex and resource-intensive patient care in the health care system, including 100% of organ transplants and 83% of neurosurgeries, to name two examples.

In addition, 80% of health research in Ontario takes place in academic health sciences centres—research hospitals—with the balance occurring at universities. As the fourth largest biomedical research centre in North America, Ontario employs 10,000 researchers in a variety of disciplines across the research hospital sector. This is an outstanding achievement for Ontario when our economic future is recognized to be tied to knowledge and innovation.

CAHO hospitals serve all Ontarians, regardless of what community a patient lives in and no matter what local health integration network the patient comes from. Hospitals serve patients from across the province.

As the government develops regulations and guidelines as described in this legislation, we caution the government against a one-size-fits-all approach to the development of quality indicators that don't make sense in all hospitals. For instance, our colleagues who operate rural hospitals have very different issues and challenges than we have at our research hospitals.

Research hospitals should have different metrics for performance than community hospitals, reflecting the different roles we play in the system. For example, our executives should be accountable for outcomes relating

to specialized care, teaching and research, but this is obviously not true for all hospitals.

We applaud the government's intent of greater transparency and accountability. Most boards of CAHO hospitals have already set performance targets for their institutions and their executives. We would encourage the government to ensure that efforts are complementary to these existing best practices already in place.

We believe that you cannot improve what you don't measure. We also believe that the baseline for measurement needs to be realistic and applicable to the local context. By taking a balanced approach to measurement, improvements across the system are certainly achievable.

As the government moves forward with regulations and guidelines for increased transparency and accountability, we would recommend that they work to ensure that hospitals, and ultimately all health care partners, measure what matters and ultimately what will drive continuous improvements. No one benefits, especially patients, from unnecessary red tape that creates process for the sake of process.

We think it's important to get it right through collaboration. As I mentioned before, we're extremely supportive of this legislation and the potential it has to use evidence and best practices to drive quality improvement. I think all members of the committee would agree that the intention of this legislation is a tremendous step forward. However, the legislation sets the framework from which these changes would occur. The details—the reality of what this legislation will do and how it will be done—will be prescribed in the subsequent regulations and guidelines.

We're extremely encouraged that the minister has stated her intent to be collaborative and consultative with CAHO hospitals and others in the Ontario health industry as the ministry develops the regulations and guidelines to support this legislation. We feel that it's important that the minister and the ministry draw on the expertise existing in CAHO hospitals as well as other places in the health care system to ensure that the details of this legislation enable the success of the intent of the legislation.

We certainly reiterate our offer to lend our expertise and guidance where regulations, policies and guidelines are developed. Through CAHO, we can ensure both the breadth and depth of engagement the government is seeking and to learn from those who have already implemented many of these changes that the government is pursuing.

In closing, we applaud the spirit of this legislation and welcome the opportunity to work collaboratively with the government and all members of the Legislature to ensure that the intent of this legislation is respected and works to provide the world-class care that all Ontarians need and deserve.

CAHO hospitals are privileged to serve a unique leadership role in our health care system, based on the fundamentals of research and innovation to drive quality improvement for patients and the health care system. We have an excellent health care system in Ontario, and we plan to do our part to make sure that future generations have access to an even better health system.

I'd like to thank you for your time today. Karen and I would be happy to answer any questions you might have.

The Chair (Mr. Lorenzo Berardinetti): Thank you very much. We don't really have much time—about a minute. The NDP are allowed to go first in this round. France Gélinas, if you have a question.

M^me^ France Gélinas: Thank you for coming, Dr. Bell. I just heard your presentation, and I'm left with the impression that a lot of what the government is trying to achieve is something that is already in place. Am I reading too far in thinking that the bill could actually set some of our leading hospitals, members of your association, a step back, rather than a step forward?

Dr. Bob Bell: Certainly not. I think the legislation actually puts forward a very strong framework for quality improvement. I think that this is already present in many of our hospitals, but the spirit of continuous quality improvement is that the process is in place. It doesn't hinder us from moving forward within the same process.

M^me^ France Gélinas: Would you support FIPPA being applied to hospitals, freedom of access—

Dr. Bob Bell: Yes, freedom of information. What we know is that this would be a resource-requiring step for the hospitals, of course, ensuring that we protect patient confidentiality while supporting that spirit of accountability and transparency. I think it needs to be something that's carefully studied and staged in its implementation to ensure that the resources are not required to be taken away from patient care and that these resources would allow us to protect patient privacy.

The Chair (Mr. Lorenzo Berardinetti): Thank you. We're going to have to move on. Any other questions? Mr. Balkissoon?

Mr. Bas Balkissoon: Thank you for your input. I just have one quick question. Do you think that the role of the Ontario Health Quality Council, as demanded and as is being expanded in the bill, is best suited for developing those clinical practice guidelines used in research and best practices available?

Dr. Bob Bell: Absolutely. There's certainly tremendous talent in Ontario in developing best practice guidelines, and the role of the quality council in interpreting which should be applied and which are most effective to be applied is very appropriate.

The Chair (Mr. Lorenzo Berardinetti): Thank you. We'll move on to Mr. Chudleigh.

Mr. Ted Chudleigh: Dr. Bell, do you see this bill as helping to control health care costs at all?

Dr. Bob Bell: I think that any time we improve quality, we contain health care costs and improve sustainability. So yes, I'd certainly say this is a step forward in sustainability.

Mr. Ted Chudleigh: I don't think that has been true in the past, but we have hope for the future, I suppose.

Dr. Bob Bell: Thank you. Yes, we do.

The Chair (Mr. Lorenzo Berardinetti): Thank you, Dr. Bell, for your presentation, and also to Karen Michell, thank you.

CANCER CARE ONTARIO

The Chair (Mr. Lorenzo Berardinetti): We'll move on to our next deputation, which is Cancer Care Ontario.

Dr. Terrence Sullivan: Good afternoon.

The Chair (Mr. Lorenzo Berardinetti): Good afternoon. Welcome.

Dr. Terrence Sullivan: Thank you. Thanks for this opportunity to speak with you. You should have all received a copy of our presentation. My name is Terry Sullivan and I'm the president of Cancer Care Ontario. This is my colleague Dr. Carol Sawka. Dr. Sawka is head of our clinical programs and a medical oncologist by background. Both Dr. Sawka and I have appropriate university appointments, as detailed in the background material. I might also add that Dr. Sawka actually provides the executive support to the quality guidelines and standards committee of the board of Cancer Care Ontario.

Let me start by saying that Cancer Care Ontario fully supports the government's Bill 46 and its embedded objectives of advancing quality in the health care sector and holding executive management accountable for its achievement within their individual health care organizations. We believe that, with modest adjustments, the legislative amendments in Bill 46 will assist health care organizations to advance a stronger quality committee in the province on behalf of our patients. In our own work, we are committed to driving a quality agenda across the cancer system within Ontario based on the same principles of transparency, accountability and the adoption of best practice.

Just a very brief background on what we are doing as an agency: We are the provincial agency that steers and directs Ontario's cancer services and prevention efforts so that fewer people get cancer and patients are able to avail themselves of the highest quality health care. We do this by acting as a contractor for in excess of $700 million for cancer services. Those dollars are tied to data, quality, access and volumes in the cancer sector, and we report completely and fully on an annual basis, in a public way, about how we're doing with respect to cancer services.

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We also operate screening and prevention programs and we have a very large range of activities using electronic information to support health care professionals and organizations to improve the safety, quality, accessibility and accountability for our cancer services. In this regard, Cancer Care Ontario also leads the access-to-care portfolio, which includes all of the data collected on wait times within Ontario, including cancer and non-cancer areas, and extending now to emergency room data.

We also plan services to meet current and future patient needs and work with providers in every LHIN. We promote measurable and accountable cancer care by measuring and reporting to the public about the performance of cancer services on a regional basis, and we work with doctors, hospitals and other health care practitioners to ensure continuous performance. Finally, we are the government's chief adviser on cancer-related issues.

In the last year, we've also taken on a role to advance improvements in the management of chronic kidney disease, through the Ontario Renal Network, and we're just in the initial stages of building out that capacity as an organization.

Let me tell you briefly what we are doing with respect to the quality agenda, and then I'll jump to our recommendations.

Our program in evidence-based care, which operates out of McMaster University, works to improve the quality of care for patients through the development and dissemination of evidence-based practice guidelines serving disease site group leaders for cancer in specialty care areas like breast and colon at each of the disease sites across Ontario. They continuously scan, filter, summarize and publish guidance standards for professionals, with practice leaders in Ontario leading the field.

In a world of just-in-time information, we need machinery of this type to be able to determine what are the best treatments available to patients, and also to advise clinicians on moving in a just-in-time fashion to new and better treatments as they become available.

In addition, this same body advises Ontario on how to fund and schedule drugs in the Ontario drug formulary. Through the new drug funding program at Cancer Care Ontario, we advise the provincial government on which drugs should be funded, what their benefits are, which are cost-effective. The program of evidence-based care is an important resource for this entire operation.

We are working, in short, at every step of the cancer journey to collect, disclose and improve quality of care in the areas of pathology, surgery, diagnostic services, radiation, treatment and palliative care. This morning we saw the release of the annual cancer statistics. In the last few years we have built a network of palliative care provision, and we collect and report on symptoms in palliative patients across Ontario now to improve the management of their pain and distress.

Finally, we report annually, as I mentioned, through the Cancer Quality Council of Ontario on 30-plus quality and performance indicators. That release will actually occur this time next week. This is a Web-based report in which you can go and look at where Ontario sits, region by region, on a whole set of measures for performance on quality.

Let me turn, then, to the recommendations that we're proposing today.

We wholeheartedly support quality committees initially within every hospital and subsequently within other publicly funded health care organizations subject to Bill 46. We believe that in order for quality committees to be successful in carrying out their responsibilities, the membership must include at least one senior clinical practice leader within the organization and at least one person with expertise in quality improvement, including the measurement of quality indicators within their organizations.

We support, within the inclusion of subsection 3(3), which directs a hospital-based quality committee, that at

least one senior clinical practice leader from within the organization be present and that at least one person with expertise in quality improvement, including the measurement of quality indicators, be present.

With respect to annual quality improvement plans, section 8, we support the requirement that health care organizations develop annual quality improvement plans and make these available to the public, as outlined in section 8.

Bearing in mind Dr. Bell's previous injunction about not one size fits all, we believe that the principles of transparency and accountability would require that the Ontario Health Quality Council actually work with the sector to develop a minimum data set and begin to capture and report annually across the sector on how we're doing, hospital by hospital; and maybe some hospitals would enrich that data set, but at least we'd have one comparable picture across the sector on how we're doing from a system level and allow for meaningful comparisons between and among different organizations.

Our recommendations:

—that section 8 be amended to provide that health care organizations provide their annual quality improvement plan to the council in a format to be established, which permits province-wide comparisons in reporting on a minimum set;

—that section 12, which sets out the function of the council, be amended to provide that the council, in consultation with organizations with experience in the development of indicators, develop a minimum set of quality indicators to be used by health care organizations in their annual quality improvement plans;

—that section 12 be amended to provide that the council be mandated to develop an annual report on system performance based on the information provided in such annual plans; and

—that section 13 be amended to provide that in its annual report to the minister on the state of health care in Ontario, the council include recommendations regarding improved system performance.

CCO also supports in principle the addition of the following function to the council's mandate as set out in clause 12(1)(c), namely,

"(c) to promote health care supported by best available evidence by,

"(i) making recommendations to health care organizations and other entities in the system respecting clinical practice guidelines and protocols; and

"(ii) making recommendations to the minister concerning the government of Ontario's provision of funding for health care services and medical devices" based on such evidence.

CCO believes the council membership, as reflected in subsections 10(3) and 10(6), probably needs to be augmented given the new mandate of the council to ensure a sufficient range of competency to carry out its expanded mandate. We recommend, therefore:

—that subsection 10(3) be amended to suggest that in appointing members of the board, regard will be had to the desirability of persons with expertise in the development and implementation of clinical practice guidelines and protocols and persons with expertise in quality improvement, including expertise in the measurement of quality indicators;

—that clause 10(3)(d) be amended to provide that, in appointing the members to the council, regard should be had to the desirability of appointing persons from the community with a demonstrated history of interest and experience in health service and clinical service evaluation; and finally,

—that subsection 10(6) be amended to clarify that former members of the board and former chief executive officers of the system may be a member of a council, such that we have a presence of people who are entirely familiar with the routine operations of organizations within the sector.

We note that it's slightly unclear in the wording of 12(1)(c) whether the council is to support the development of practice guidelines or work with other health care organizations and develop them directly. We support a role for the council in the development of clinical practice guidelines in consultation with other organizations with substantive experience in such development to ensure no duplication of effort.

In conclusion, the staff and board of Cancer Care Ontario welcome the arrival of Bill 46 and look forward to working with the Ministry of Health and Long-Term Care and our partners in the hospital and community sector to advance the quality agenda in respect of cancer control and chronic disease management. Thank you.

The Chair (Mr. Lorenzo Berardinetti): Thank you, Dr. Sullivan. We have about a minute per party. We'll start with the Liberal Party: Mr. Balkissoon.

Mr. Bas Balkissoon: Thank you for your presentation and thanks for being with us today. Based on your comments, am I to interpret overall that you see cancer patients receiving better service in the health care system if this bill is implemented in a proper fashion?

Dr. Terrence Sullivan: I certainly do. I think there are many ways in which the bill will cause a common and a higher standard to be advanced, which is our objective as an organization.

Mr. Bas Balkissoon: The only reason I raise this question is that during second reading debate, the quality committees in the hospitals—the issue was raised that these things already exist, but from your experience, do they exist in every hospital today?

Dr. Terrence Sullivan: I can't speak with authority about how they function in every hospital, and they work quite differently from hospital to hospital across the sector.

Mr. Bas Balkissoon: So you would agree, then, that the bill, in putting these committees in place and then the regulations to direct how they function across the entire system, is a good direction to go in?

Dr. Terrence Sullivan: Absolutely.

Mr. Bas Balkissoon: Thank you very much.

The Chair (Mr. Lorenzo Berardinetti): We'll move to the PC party. Mr. Chudleigh.

Mr. Ted Chudleigh: Thank you for being here, Doctor. You started out talking about some of the research and treatment practices that are being done in various hospitals and how best practices are passed from hospital to hospital. How long does it take for a new treatment like that or a new concoction or whatever to become implemented in the system? You mentioned the word "publish," and that says to me there's a long delay.

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Dr. Terrence Sullivan: Every June at the American Society of Clinical Oncology a big flight of trials are dropped, and Dr. Sawka will explain briefly what happens from there.

Dr. Carol Sawka: Our program in evidence-based care has a process that rapidly reviews evidence in a systematic way, converts those into guidelines and then disseminates them to all of the practitioners in the province. The publication is generally on our website, and later, in journals. The intention is for rapid dissemination of the evidence. For treatments that are extremely compelling, there is a very good process in place to make those treatments available as quickly as possible. In the case for Herceptin, for example, the treatment was made available within a matter of six weeks.

Mr. Ted Chudleigh: Otherwise, if you wait for the publication date, it could be a year?

Dr. Carol Sawka: It could be up to a year, but the evidence that is being used is submitted for wide practitioner feedback to ensure that there's endorsement across the jurisdiction, across the province. So this information is actually out in the clinical domain very quickly. The publication is not required for a practice change to occur.

The Chair (Mr. Lorenzo Berardinetti): We have to move on because of the time to Ms. Gélinas of the NDP, if you have any questions.

M^me^ France Gélinas: Very quickly: I was curious, on page 5 of the document we have you say, "CCO supports in principle the addition of the following function to the council's mandate as set out ... " and then you say, "to promote health care that is supported by the best available scientific evidence by ... making recommendations to health care organizations and other entities in the health" care system. Who did you have in mind by those other entities?

Dr. Terrence Sullivan: They're to be enumerated, but they would include home care organizations; they might even include family health teams, for example.

M^me^ France Gélinas: So you really see it as broad.

Dr. Terrence Sullivan: Yes.

M^me^ France Gélinas: I think we're out of time. Thank you for coming.

The Chair (Mr. Lorenzo Berardinetti): Thank you for your presentation.

COLLEGE OF CHIROPRACTORS OF ONTARIO

The Chair (Mr. Lorenzo Berardinetti): We'll move on now to our 3 o'clock deputation, which is the College of Chiropractors of Ontario. Good afternoon, and welcome.

Mr. Joel Friedman: Good afternoon. My name is Joel Friedman and I'm the director of policy and research at the college of chiropractors. I apologize; there is no written submission at this time. I'm not a chiropractor but a lawyer by training.

The College of Chiropractors of Ontario, or CCO, is the regulatory body for approximately 3,900 chiropractors in Ontario. CCO's mandate is to regulate the chiropractic profession in the public interest. CCO registers chiropractors in Ontario and develops standards of practice to which the profession must conform. The public interest mandate is exercised through two arms of the college, that is, the complaints and discipline processes and the quality assurance processes.

The complaints and discipline processes protect members of the public by disciplining chiropractors who are guilty of professional misconduct or are incompetent to practice, while the quality assurance process aims to continuously improve the competencies of chiropractors through programs like continuing education, self-assessment, and peer and practice assessment.

Just by way of background, chiropractors are primary health care providers who assess, diagnose and treat dysfunctions and disorders of the spine, nervous system and joints. Chiropractors use a variety of diagnostic tools such as X-rays to provide this diagnosis.

Chiropractors work in a variety of health care settings, including private clinics, multidisciplinary clinics, rehabilitation facilities and hospitals, and collaborate with other health care professionals such as physicians and physiotherapists.

As a professional regulator, CCO strongly supports the mandate of Bill 46. CCO believes that the health care system must be centred on the needs and choices of the patient. An accessible, appropriate, effective and collaborative system is essential to a high-quality health care system. As well, it is essential that patients be able to access high-quality health care, no matter what health care setting or facility they are in.

My comments specific to Bill 46 will be very brief and relate specifically to the functions of the quality council under section 12.

CCO supports the bill's focus on the Ontario Health Quality Council. The council's mandate of monitoring and reporting to the people of Ontario on access to health care services, health human resources and health systems outcomes is in the public interest and consistent with the mandate of CCO.

CCO supports this patient-centred system that will address the essential issue of access to care and strongly believes that central to the health care system is a patient's right to choose and access the health care provider of their choice, no matter what the setting.

One of CCO's mandates under the Regulated Health Professions Act is to promote and enhance interprofessional collaboration among health care providers within the entire health care system, both private and public.

CCO strongly supports the quality improvement initiatives of Bill 46 of the quality council in the hospital setting and looks forward to when the initiatives of the quality council would be expanded to other health care settings and sectors across Ontario that will be enumerated in the regulations and guidelines of this bill.

As well, CCO recognizes the importance of monitoring and reporting on health human resources in the health care system in the context of improving efficiencies and improving access to care within the entire health care system.

CCO, like all other health regulatory bodies, is involved in the health professions database in Ontario, which is a comprehensive database of health practitioner information aiming to improve health human resources planning in Ontario. CCO recognizes and supports health human resources planning. It is an essential component of operating an effective, efficient and accessible health care system.

CCO strongly supports the quality council's initiatives of promoting health care that is supported by best available scientific evidence. Chiropractors in Ontario utilize a wide variety of evidence-based assessments and treatments in providing care within their scope of practice. Upon this point, CCO recognizes the importance of the development of clinical practice guidelines as part of the quality council, and has actually been a partner in the development of such guidelines in the chiropractic profession for several years. As well, CCO understands that such guidelines must be presented to health care professionals in a practitioner-friendly manner and be relevant to clinical practice. Guidelines, as well, need not be profession-specific and may apply to different health care professions with similar scopes of practice across different health care settings.

An example of a past guideline that CCO has been a part of is the guideline on adult neck pain not due to whiplash, which was published in 2005. This guideline has provided chiropractors throughout Canada with important guidance in this area, including a patient handout, clinical decision algorithm and cervical spine manipulative therapy decision algorithm, all elements that are practitioner-friendly and relevant to clinical practice.

As well, CCO has partnered with the Chiropractic Professional Association, the Ontario Chiropractic Association and the educational institution, the Canadian Memorial Chiropractic College, along with the Institute for Work and Health, to facilitate the use and dissemination of clinical practice guidelines by chiropractors in Ontario.

From these points, CCO applauds the quality council's focus on the development and integration of clinical practice guidelines and protocols within hospitals and, again, looks forward to the extension of these guidelines across other health care sectors that will be enumerated in regulations and guidelines.

Finally, CCO supports the council's mandate of seeking advice from the public in doing its work. The mandate of CCO is to regulate the chiropractic profession in the public interest and strongly believes that health care must be patient-centred and respond to the needs and choices of the public. It is the position of CCO that members of the public have an opportunity to dictate and access the health care provider of their choice in a variety of health care settings.

In conclusion, CCO supports all of the mandates of the quality council and is excited to see it start in the hospital setting and disseminate into other health care settings in the regulations and guidelines.

Thank you for allowing CCO to speak today, and I'm available for any questions at this time.

The Chair (Mr. Lorenzo Berardinetti): Thank you, Mr. Friedman. We have a couple of minutes per party. We'll start with the Conservative party. Mr. Chudleigh?

Mr. Ted Chudleigh: No questions.

The Chair (Mr. Lorenzo Berardinetti): No? Okay, we'll move on to Ms. Gélinas of the NDP.

M^me^ France Gélinas: Thank you very much for coming, Mr. Friedman.

We had a presentation this morning from the association, and I would say that both the college and the association seem to be singing from the same songbook, as far as I could understand. I wanted to ask you: What would be some of the consequences of not moving forward with the suggestions that you are making in this committee today?

1510

Mr. Joel Friedman: Well, it would definitely be in the public interest to have these quality councils work, from a chiropractics perspective, not only in hospital settings but across all health care settings. Whether that's accomplished in the current bill or regulations and guidelines is a different issue, but it would definitely be in the public interest to have consistency among all health care settings. That consistency among different health care providers is definitely an important factor for the college in protecting the public interest.

M^me^ France Gélinas: Would you have a preference whether the changes be made in the bill or in regulations?

Mr. Joel Friedman: The college doesn't have a specific position on that, just that it would be in the public interest for these initiatives to apply to all settings at this time.

M^me^ France Gélinas: Thank you.

The Chair (Mr. Lorenzo Berardinetti): We'll move on to Mr. Balkissoon.

Mr. Bas Balkissoon: I don't have any questions. I just want to say thanks for coming forward and presenting to us today.

Mr. Joel Friedman: Thank you very much.

The Chair (Mr. Lorenzo Berardinetti): Thank you for your presentation.

MS. PATRICIA FORSDYKE

The Chair (Mr. Lorenzo Berardinetti): We're a few minutes early, but our 3:15 p.m. deputation is listed as

Patricia Forsdyke. I hope I pronounced that properly. Good afternoon and welcome.

Ms. Patricia Forsdyke: Good afternoon. Thank you for having me. I'm probably going to speak against the act. I know I'm going to.

I think I'll read what I have, but I'll just make a preface. I have a knee-jerk reaction to this bill, which is, why would you spend more and more money and time policing the system when, really, some of the bits of the system need kick-starting and need more money allocated to them? Obviously, I'm coming from a certain perspective, and I don't see that the area that I'm coming from is going to benefit at all from this at this particular time. Anyway, I think I'll read what I've put. I decided not to read it, and then I decided I would because everybody's saying the opposite to what I believe.

I speak as a private citizen and not for any group. I have spent a lot of time, I would add, on masses of boards and masses of committees over the last 30 years. I just have a gut feeling that this is more of the same. I was a nurse by training. I spent almost 30 years advocating on behalf of the seriously mentally ill, and continue to do so. Last year, I gave an oral and written presentation to the Select Committee on Mental Health and Addictions, and I've put the web pages that I have below. It's actually a Queen's site, but I'm not at Queen's. It's my husband's site.

The reason I came is that I noticed this advertisement in the paper this week announcing public hearings, that they would follow in three days. That was a bit of a shock. To my astonishment, I realized that there was little time to study the bill. I have looked at some of the debates in the Legislature on this bill, and it would seem that I am not alone in my concerns. I did know of the issue of CEO bonuses being linked to performance. This was reported in our local newspaper, the Whig-Standard. I can only say that when I read the bill, it sounds a little bit Orwellian or Kafkaesque: It's another layer, it seems to me.

It seems to me that more and more committee work would not necessarily lead to better health care delivery. It also struck me that this bill was being rushed through the Legislature at lightning speed and is full of bureaucratic talk. The usual phrases that come out, they're quite decent things, but my problem is always, how can you deliver certain things? It seems to me neither realistic nor profound. Since it interlocks with other pieces of legislation, it should be scrutinized carefully. Many MPPs were given little time to come to grips with it, I understand, when it came to the floor.

"Excellent care for all" sounds like utopia, but is it really deliverable? In the area that I am familiar with, this proclamation seems utter nonsense. Presently, the seriously mentally ill are lodging on the streets or in cockroach-infested rooming houses, and psychiatric beds are now in abundance in the prisons, where there is little care for mental illness. The reality on the ground, with fiscal restraints dictating all circumstances, is that it really does seem pie in the sky to me.

In order to improve this situation, it will take more properly trained professionals; an amendment to the Mental Health Act along the lines suggested by Dr. Gray to the select committee, which addresses the nature of serious mental illness; and recognition of the lack of insight that is characteristic of this patient population and why treatments need to commence promptly.

The proposed quality committees sound highly suspect to me. My hunch is that we will see more circular committees at a time when Rome is burning in this particular area. I see it all the time with the LHINs: Nothing is being fixed there, and there's not the kind of representation I would like to see at the LHINs on serious mental illness.

The legislation will lead to more useless surveys, and the bureaucrats will make—I'm sorry to be rude to bureaucrats. We need them, but basically what comes out of the surveys, obviously, sometimes reflects what they want for the outcome. In current parlance, we will have more bean counters and less money spent where it is needed: direct patient care.

The CEOs should receive decent salaries, but it seems quite an extraordinary stretch to believe that they will work harder if they are given more money. Making this equation seems to me folly. There is also the question of bureaucrats who are working under the CEOs. The disparity in salaries may lead to some resentment and be counterproductive. The Premier of this province is poor by comparison to some of the salaries that the CEOs gain.

As for the bonus for performance, I view this as highly suspect. Good, honest work is surely the objective. Wall Street fiascos on the bonuses surely have taught us something on this matter.

We have ample examples of this in the mental health field. There are hardly any beds. Because there are so few, these are not used as beneficially or wisely as one would like. Compassion has evaporated, and budgeting to the bottom is the order of the day, leaving much tragedy and suffering in its wake. This, in the long run, is short-sighted, and I believe it's expensive. It's just being transferred to another system: the courts and the prisons.

This is just because I've been on various committees and a lot of these forum things: I note that the black boxes in the system do not make it easy to be open and transparent. I know that the information is there, but actually getting that information to the right people is sometimes difficult. These two words are fairly meaningless in the scheme of things. We live in a time when the Ombudsman, when receiving a complaint, has little access to the relevant information. At least, this is what I've been told.

Is health care nothing but a pack of cards, smoke and mirrors, signifying nothing, while the bureaucracy creates more and more power for itself? I'm very critical. I'm sorry, but I have to say it the way I see it.

Is health care dancing to the tune of ideologies? It certainly is in mental health, mental illness. For example, in another area, some self-appointed patient groups

believe they have the holy grail of wisdom. I put the wellness brigade under this heading. Such groups are often able to influence the LHIN activities quite substantially.

What is a quality committee? I assume that hospitals have quality committees already. A quality committee is just another layer, it seems to me, in this whole scheme. Again, it seems a little Orwellian of Kafkaesque. Surely professionals should have more say in health care decisions. I would add the professions are already regulated. You can bring complaints to those professions, to the hospitals and to the system.

Not everything is fixable, but the best outcomes are often commensurate with the skill of the professional. In the land of the blind, the one-eyed man sees furthest. These are often those who are trained and actually deliver the services. Is this another attempt to muzzle hospitals and let the community organizations tell of their exaggerated achievements? By the way, I was told that by someone; that's why I put it in.

1520

The LHINs are part of the problem. Certainly, I think they're part of the problem in the mental illness section. Hospitals may be whipped into cost-cutting, to the advantage of some of the agencies who deliver services, but the cost may be too high for patients. The bill seems utopian, and utopia explored can lead rapidly to dystopia.

This legislation, in my view, is unnecessary. I've heard some things today that could persuade me, but they're not in the areas that I know most about. Bear in mind that I do know a fair bit about the whole hospital setup.

So that is it. I did note one of the things that someone else said—how many minutes do I have?

The Chair (Mr. Lorenzo Berardinetti): Five minutes.

Ms. Patricia Forsdyke: "One size does not fit all": I would echo that.

Leading by the right example, to me, seems like a very good way of doing things. On the whole, I do feel that you have to be mindful of what money is in the pot, and whether this is going to be another exercise in which you spend more money and achieve what's already being achieved in certain areas. There are clearly very big faults in some places, but it seems that some people are doing a good job, and they should be encouraged to continue doing it.

The Chair (Mr. Lorenzo Berardinetti): We have about three or four minutes left for questions. We'll start with the NDP. France Gélinas?

M^me^ France Gélinas: I want to thank you very much, Ms. Forsdyke, for coming. I understand the passion you bring to mental health and the seriously mentally ill, and how we are failing this population group, and to say that an excellent care for the seriously mentally ill act would be a huge—it's utopian. It's not happening. I can fully understand that if I put on the lens that you look at this bill through, I would be just as unhappy as you are.

This bill is not targeted at bringing excellent care to people who are seriously mentally ill. So I will ask you: If you were to make one, two or however many suggestions as to how we can bring excellent care to the seriously mentally ill, what would you say?

Ms. Patricia Forsdyke: First of all, I would say that you've got to put some—not too many—but you have to put some beds back in the system, because the beds, as I said, are in the prisons. I think it's reasonable to assume that early interception brings a better outcome. I don't believe that the incidence is going up of serious mental illness, but I do believe that we're going to have more chronic people with major mental illness; I'm talking about the two high-incidence ones—schizophrenia and manic depression. I do believe that those people are going to need more services in the system because they're not getting services up front. I would want more trained professionals and I would really want to put some emphasis on the medical schools. They've got to not neglect this population. I said it all in my submission, really.

M^me^ France Gélinas: That's okay, but is there—

Ms. Patricia Forsdyke: I want the money spent on them, rather than—

M^me^ France Gélinas: I understand that, too.

You've seen that there's quite a bit of support for this bill from some of the big players in the field, so I'm telling you that this bill will go through. Are there amendments or changes we could do that would mean that the seriously mentally ill are not left behind, that they are part of this excellent care for all? Are there steps to salvage this bill so that it means something to seriously mentally ill Ontarians?

Ms. Patricia Forsdyke: I don't know that I think that there are steps that can be taken. It may benefit the ones who are receiving services at the moment, because there are some checks and balances in the system, but it won't remedy what I'm talking about: the overflow that's elsewhere and outside of the health care system. So I'm not very optimistic; I just felt I had to come. The title of it, really, was something that bothered me.

M^me^ France Gélinas: I appreciate that you came. I will look through it and try to see if I can come up with anything so that the seriously mentally ill are part of excellent care for all.

The Chair (Mr. Lorenzo Berardinetti): I'm just going to move on to questions from the Liberal Party and Ms. Sandals.

Mrs. Liz Sandals: Yes, and thank you very much for coming. As you mentioned, we have had a chance to chat before, at the Select Committee on Mental Health and Addictions. I'm just wondering if this were applying to psychiatric hospitals as well, and I believe it does, that—

Ms. Patricia Forsdyke: I assumed it did, as well as acute care.

Mrs. Liz Sandals: So would the notion of the quality control council and looking at provincial standards of care—would that be helpful, from your point of view, when you get into the treatment of seriously mentally ill patients?

Ms. Patricia Forsdyke: Yes, but you see, I think the system has been so withered down now that what you're

looking at is just the remnants of a system rather than what people need up front to access top-quality care. Deinstitutionalization, in my view, has been a total shambles. It's not that it had to be the way it used to be, because there are better treatments; they're not perfect. But I'm very skeptical at this point that you can rush in with a bill like this and benefit—obviously, the monitors have to be there, and through complaints they have to be there.

Thinking about what you just said, one of the things that is problematic to me with the seriously mentally ill who have no insight is that we're saying "patient-centred," "patient-this"—that's not really the way that the problem is answered at all, because if you're that ill and you have no insight, you're not going to want what the system needs to give you.

Mrs. Liz Sandals: It's okay. The three of us that are on the select committee noted your suggestions on page 2. We're hearing this through a different filter, but your comments have been heard.

The Chair (Mr. Lorenzo Berardinetti): We'll move on to the Conservatives. Mr. Chudleigh.

Mr. Ted Chudleigh: Thank you for coming today. You're the only contrary voice in the proceedings—

Ms. Patricia Forsdyke: I am at home, too.

Mr. Ted Chudleigh: —it's always welcome to hear. I used to think the same thing when I was on the government side.

I'm wondering if you had an opinion as to where this started or how we can solve the problem. It seems that almost every cost that is involved in the hospital sector is twice what it is anywhere else. If you're buying a piece of equipment in an operating room, the cost of a drill, the cost of whatever, is two or three times what it would cost in any other place. The CEOs' salaries are twice what they are in any other discipline. If you look at a CAO in charge of a large municipality, they'll be handling about the same amount of money as a hospital would handle, they have a much more diverse area of expertise and yet they get paid, in general, less than half of what a hospital CEO makes.

If you go to the other end of the scale, the cleaning and maintenance staff generally have contracts that are twice what is paid in the private sector, as do the food workers who deliver the food to the wrong room in the hospital; they get paid about twice what other people outside the hospital would get paid, a lot of the time. I always got the wrong food when I was there.

Any idea as to how that happened or any way to solve those problems in health care? This is driving our health care costs to the point that getting the money to the patient is getting very difficult. I think that's your concern, if I hear you right. You want the money spent on the patient.

Ms. Patricia Forsdyke: I want the money spent on the patient. I want the money spent on the professional training and delivery of systems. I think that's not cheap. In the area that I'm talking about, it's very expensive, and they're not doing it properly. In my view, it's because they've downsized too quickly and they've listened to ideological stuff. Now we've got: "One in five people have a mental illness." That's stretching it, as far as I'm concerned. We have mental troubles—

Mr. Ted Chudleigh: I'm just checking the room. I'm wondering if one in five is right.

Ms. Patricia Forsdyke: I'm waffling now, but I really think that you've got to spend money on the patient and on delivering services that will at least stabilize them so they can avail themselves of other services.

1530

Serious mental illness is a long time. It doesn't come on at 50; it comes on in the prime of life. You've got all those years in which to deliver, and if you don't do right at the beginning—and that's where the money should be spent, and then some support services afterwards.

By the way, many of the people with serious mental illnesses whom I know have not needed much follow-up, apart from seeing their psychiatrist and two years seeing a psychologist to help them manage their system. They're not dependent on the system once the medication is working. They may be taken into hospital in another acute episode, but it's cost-effective to do it front-end and not picking up the mess.

I suspect that sooner or later, the system is going to wake up and they're going to have to open more chronic beds.

The Chair (Mr. Lorenzo Berardinetti): Okay, we've reached the time limit—

Ms. Patricia Forsdyke: In Kingston, it's a nightmare walking down the street at the moment. I'm very compassionate, but I don't like walking around somebody who's hallucinating.

The Chair (Mr. Lorenzo Berardinetti): Thank you very much. We have your notes as well. Thank you for your presentation.

ONTARIO MEDICAL ASSOCIATION

The Chair (Mr. Lorenzo Berardinetti): We're now moving on to our 3:30 presentation from the Ontario Medical Association. If you'd like to come forward, please. Good afternoon, and welcome.

Dr. Mark MacLeod: Thank you.

The Chair (Mr. Lorenzo Berardinetti): You know the format. It's 15 minutes to present. Any time that's not used during that 15 minutes is shared amongst the parties in asking questions.

Dr. Mark MacLeod: Thank you very much, Mr. Chair and members of the committee. Thank you for agreeing to allow the Ontario Medical Association to make a presentation to you today. My name is Mark MacLeod and I am the recently installed president of the Ontario Medical Association.

The OMA, as you know, is the professional association for the province's 2,500 physicians. I am an orthopedic surgeon in London, Ontario. I have a practice that is exclusively in a hospital. I have a sub-specialized

practice in foot and ankle surgery and the management of adult orthopedic trauma.

First of all, let me begin by saying that the OMA supports the government's efforts to rebalance our system to require hospital boards and administrators to actively consider and attend to the quality of health care with the diligence that they devote to the fiscal stewardship of the institution. Health care delivery in today's system is simply too complex to continue to rely exclusively upon individual practitioners doing their best. We need a systemic approach to quality that is led by the board that effectively harnesses and values the input of physicians and other health care providers. The OMA supports the government's attempt to place patients and patient experience at the centre of the system.

The OMA notes that the preamble of Bill 46 describes the elements of a high-quality health care system and it uses eight of the nine attributes described by the Ontario Health Quality Council in its vision for the system. The OHQC talks about the need for the system to be appropriately resourced, where Bill 46 merely says the system should be "appropriate." Given that resourcing can be a major driver of quality or a significant inhibitor of quality, the OMA believes that it is important for the government's quality agenda to fully and accurately reflect the OHQC values. We recommend that Bill 46 be amended to acknowledge that the system needs to be appropriately resourced.

The government is not placed at any risk by this amendment since the legislation requires the OHQC to take into account implications for the health system resources when making its recommendations to the minister about funding. It also clearly states that the government is not obligated to act upon the advice of the OHQC.

Most stakeholders have considered Bill 46 as it applies to hospitals, and most of the requirements seem reasonable. However, given that the reach of Bill 46 is clearly intended to extend to other sorts of health care organizations, we need to examine the impact of certain obligations. The OMA wonders whether it will be administratively feasible for small organizations to conduct both a patient and staff survey every year and then effectively translate that information into a quality plan which they then must act upon.

The OMA recommends that the act be amended to allow surveys to be completed every other year, or perhaps to stagger the requirements so that the patient survey and staff survey are done on alternating years. The annual quality plan would then be refreshed annually, using updated information as it becomes available.

We also question the capacity of smaller organizations to be able to consult the public regarding their declaration of patient values. We recommend that this provision be amended to require health care organizations to consult with their patients and families, and then to make the information available to the public.

The OMA notes that the mandate of the OHQC is expanded so that they will make recommendations to health care organizations about clinical practice guidelines and protocols. Local quality committees will then be required to translate best practice guidelines into information that is distributed to health care providers, and the committee will monitor the use of these materials.

Although it appears that the intent of this provision is to allow some adaptation at the local level, the OMA is concerned about the capacity of smaller hospitals and non-hospital organizations to undertake this very significant task. Our experience, through several years of partnership with the government on the Guidelines Advisory Committee, has demonstrated to us that development of guidelines and the subsequent knowledge transfer are very resource- and labour-intensive activities.

In addition to questions about the feasibility of local adaptation and dissemination of guidelines, the OMA has concerns about the provisions stating that the quality committee of the hospitals will monitor the use of such guidelines. The whole point of guidelines versus practice standards is that they are just that: advice that must be capable of being modified based on clinical circumstances. The OMA does not believe that the quality committee should judge practice at the level of individual clinicians.

We recommend that Bill 46 be amended so that the quality committee shall refer queries regarding individuals' compliance with best practice guidelines to the appropriate clinical leader for review and action, if warranted. Clinical leaders should then be required to report back to the quality committee on the outcome of their reviews.

The last matter that the OMA would like to comment upon relates to the provisions tying executive compensation to performance. While we support this notion in theory, we are troubled by the lack of detail provided in the legislation. Virtually everything about this scheme is left to regulation, with little opportunity for input. We ask that the government formally commit to a consultative process that goes beyond the mandatory 30-day posting and input process. This represents a major policy decision and should be fully discussed in advance of implementation.

In closing, Mr. Chair and members of the committee, I would like to thank you for the opportunity to be heard, and I applaud the government's initiative to improve the quality of our health care system for patients. Thank you very much.

The Chair (Mr. Lorenzo Berardinetti): Thank you. We have just under six minutes. This time, we'll start the rotation with the Liberal Party. There are two minutes per party. Mr. Balkissoon.

Mr. Bas Balkissoon: Thank you for your presentation. I just want to go back to one of your questions. It said that you "question the capacity of smaller organizations to be able to consult" with "the public," but you recommend that these organizations consult with patients and families. I'm struggling to understand the difference. Can you give me a further explanation?

Dr. Mark MacLeod: Small organizations, obviously, will have direct care and direct contact with their patients and the families of those patients. We think it's a relatively easy thing for them to regain or gain information from those groups as patients transit through the system. It may not be logistically as feasible for small organizations to do a broad consultative process with the public at large. That's our only point.

Mr. Bas Balkissoon: Okay; thanks very much.

The Chair (Mr. Lorenzo Berardinetti): On to the PC Party. Mr. Chudleigh.

Mr. Ted Chudleigh: I was interested to see that you're a foot and ankle specialist. I have a twisted ankle. Maybe you could have a look at it later. It has been giving me some problems over the last couple of days.

The Chair (Mr. Lorenzo Berardinetti): That'll take up your two minutes if you do that.

1540

Mr. Ted Chudleigh: Do I have to work that into my two minutes?

The Chair (Mr. Lorenzo Berardinetti): Yes.

Mr. Ted Chudleigh: Do you see this piece of legislation as driving costs or controlling costs?

Dr. Mark MacLeod: Ultimately, if we improve the quality of the care that we're currently providing, we should reduce costs. If we can improve the quality of the care that we currently deliver, we should be able to do things like reduce readmission rates and reduce serious errors. Those types of things ultimately will benefit both patients and the system. So I think of it more as, rather than costs, an addition of value. I think improving the value of the current system should be something that we all strive for.

Mr. Ted Chudleigh: We heard earlier from Dr. Bell that much of what's proposed in this legislation is already being done in the University Health Network. Would the same be true in London? You're a teaching hospital as well.

Dr. Mark MacLeod: I think many of the academic hospitals have started to move in this direction already. This bill does present some new takes on some of that work. The addition of the quality council in the hospital is a distinct change. But I think the idea of looking at quality and reporting on quality is something that physicians and hospital administrators have been working on together on many fronts, and the medical advisory committee has, to this point in time, worked closely with administrations on quality issues specifically.

So I don't think this is new. I think this is a new slant on it and it places a larger emphasis on it within an organizational structure and operations, but it's certainly not new, and it's not new from a physician's perspective in delivering quality care.

Mr. Ted Chudleigh: Certainly the areas that it will drive, cost-wise—first of all, the quality committee: There will be a cost associated with that. Hopefully a small cost, but it's a new cost, and of course that's not patient-driven; it's money coming out of the patient system and going to bureaucratic spending. Hopefully there will be a payback on that if the system operates properly, but many of the hospitals are doing that now in a perhaps less formal but perhaps less expensive way too.

I wonder about this bill formalizing some of those costs; whether there's going to be any real change other than allowing CEOs an opportunity to drive their salaries. I would make anyone a bet who wants to make a bet that the CEO salaries will increase by 15% or 20% over the next five years because of this bill.

Dr. Mark MacLeod: With respect to the outcomes, yes, undoubtedly there will be an increased administrative cost. Physicians have historically been very conscious of the rising administrative burden of delivering health care. However, if an outcome, per se, of this would be that we could reduce hospital-acquired pneumonias or ventilator-acquired pneumonias in a hospital—that's a very expensive additional expense to the system. If those are the kinds of things that we can prevent by having a quality council, then I think we are more than likely to make up the cost.

Having said that, we need to be very conscious of how much it costs to deliver health care in all segments of health care delivery, not just at the local level but throughout the system. It's a big bundle of money—

The Chair (Mr. Lorenzo Berardinetti): We need to move on. It's almost time for the next deputation. Ms. Gélinas for the NDP?

M^me^ France Gélinas: I wanted to congratulate you, Dr. MacLeod, on your installation as the new president of the Ontario Medical Association, and thank you for coming to Queen's Park.

Dr. Mark MacLeod: Thank you.

M^me^ France Gélinas: You made some good arguments, and you almost have me convinced about the "every other day for small." I don't want to put words in your mouth, but if we were to have two sets of rules, one applying to all of the hospitals except the ones that belong to the small hospitals group, so the hospitals will have to do their two surveys and the annual plan, but if you are smaller—and then we define what "small" means by number of people, size of budget etc.—then we would go to every other year, with a plan every year, but one year you do the survey of the staff—would you agree to that?

Dr. Mark MacLeod: That's an interesting thought, and it's one that we hadn't collectively thought of. I think it would require some discussion with hospitals, first of all, to find out what "small" would mean and just exactly how many resources they would have to devote to doing this survey, so that we could have an idea of who would be really caught having to take a chunk of money from patient care to do this work. I think it requires a little bit more exploration with the hospitals, sure. A two-level plan might not be a bad idea. I'm surprised to hear that today I almost have you convinced. It's better than my last record.

The Chair (Mr. Lorenzo Berardinetti): Thank you—

M^me^ France Gélinas: One more?

The Chair (Mr. Lorenzo Berardinetti): Okay.

M^me^ France Gélinas: When you talk about the consultation process that you want, I agree with you fully that everything left to regulation makes this process not transparent at all. Do you have more specifics as to what would be an acceptable consultation process before the regulations are drafted and the 30-day mandatory thing happens?

Dr. Mark MacLeod: Well, it's a very complicated piece of legislation. I don't think I have enough experience to say it should be this amount of time, but I think there are so many factors at play here. We do need to have an adequate consultation period on the regulations before we move it into the implementation phase. For complex problems, there's a simple solution and it's always wrong. I think, in a matter that's this complex, it behooves us all to be very careful about how we go forward so that we don't end up with unintended consequences that affect patients, cost the system money and make us all look like we didn't do our thinking up front. I think we can work together on that.

The Chair (Mr. Lorenzo Berardinetti): Thank you very much for your presentation.

Dr. Mark MacLeod: Thank you.

The Chair (Mr. Lorenzo Berardinetti): And thank you for coming here today.

MR. DAVID SMITH

The Chair (Mr. Lorenzo Berardinetti): Our next presenter is David Smith. Good afternoon, and welcome.

Mr. David Smith: Good afternoon. Thank you for the invitation to be here today. Mr. Chairman and ladies and gentlemen, before I even introduce myself, let me sound a contrarian note right off the bat. I believe that, as currently drafted, Bill 46 holds out the potential for becoming really part of the problem instead of part of the solution.

Having said that, let me go on and introduce myself, and I'll come back to that point.

I make these submissions today as a life-long resident of Ontario who has experienced Ontario's health care systems over the years and has followed the longstanding struggle to provide publicly funded, quality health care. Most recently, my exposure to Ontario's so-called mental health system, through a family member's involvement in that system, has given rise to me becoming involved with the newly-formed family council at Ontario Shores Centre for Mental Health Sciences in Whitby. I appear today, however, in my individual capacity and not as a member of that council.

In years gone by, I have personally lived the experience of receiving treatment in our local general hospital where I began to learn first-hand of the unmet need for integrated and patient-centred health care in Ontario. In addition, my experience has included advocating for and supporting my now 92-year-old mother as she has been so often challenged in navigating a health care system which I have come to conclude is far from being integrated and far from being patient-centred.

While I had been somewhat aware of the Bill 46 initiative, it was only just this past Monday that today's hearings came to my attention, so it has been a very steep learning curve since Monday.

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From my quick reading of the bill, it became quickly apparent to me that I might have some thoughts to offer the committee as it considers Bill 46, the purpose of which—that is, the purpose of the bill—presumably is to promote and further the provision of high-quality care in the province of Ontario.

It's against that background that I've developed the following thoughts and some proposed amendments to Bill 46, amendments of which—suggested amendments—I have provided copies to the committees, for indeed—and I'll just ad lib here a bit—that's where the rubber hits the road. We can talk all we like and wax poetic about who we are and what we like and all that sort of thing, but you're here to consider a piece of legislation. The rubber hits the road in the wording of that legislation, so I ask us to look at and turn our attention to the question of whether or not the legislation is going to do what we want it to do.

I start from the premise that Bill 46 provides the opportunity to move from proselytizing to action in our desire for a cost-effective, high-quality health care system. In particular, I see Bill 46 as an opportunity to demand more of our health care organizations than simply the vacuous compilation of so-called data and, frankly, propaganda, which so often is the result of our organizations' reviews and ongoing commitments to quality.

I see Bill 46 as a vehicle of change through which Ontario may truly move towards higher-quality health care that is integrated, patient-centred and cost-effective. If Bill 46 is to perform that role, however, you will need, in my opinion, to move the sentiments of the bill's preamble into the very body of the legislation so as to move us from plaintively hoping for change to actually providing for and demanding that change.

Again, as currently drafted, the bill, I fear, holds out the possibility of becoming part of the problem as opposed to part of the solution, and I'll touch on that again a little later.

If, after Bill 46's laudable preamble, the actual legislative provisions require nothing more than the consumption of resources in the production of more self-serving eye-wash reports, we will have failed to use Bill 46 as an opportunity to actually procure change.

Our health care organizations must be held accountable for providing high-quality care. The committee needs to appreciate that the time has come to actually move our health care organizations into providing integrated and patient-centred care.

We must demand, through Bill 46, that health care organizations operate as part of our broader health care systems and our communities. They must be held

accountable for operating in an integrated way, with all parts of the system and the community. Health care organization administrators must be held accountable for providing high-quality, cost-effective health care.

We must put the patient at the centre of health care. Patient-centred health care is not just about spending or not spending money, it's not about having or not having the latest and greatest technology and it's not about settling for care, using whatever resources are left over after ever-expanding administrations have taken their cut of the funding.

It is with the above thoughts in mind that I've drafted my proposed amendments to Bill 46, submitted herewith.

Before I go to those in a couple of minutes, I'd like to ad lib a bit and pick up on a couple of thoughts that came to mind as I listened to the previous speakers.

The concept of quality is too often reduced to quantifiable measurements. "You can't improve what you can't measure," we heard today. That's often the refrain. But what constitutes measurement? Surely, measurement isn't restricted to counting, e.g. critical incidents, deaths etc.

I've taken the measure of today's weather and the temperature. I couldn't tell you what it is in actual degrees; I don't have a thermometer, but I've taken the measure of it. I know it's warm; I know it's humid. I don't have a barometer; I know the pressure is, I think, fairly low. So I can measure, and measurement doesn't necessarily reduce always to things you can quantify. I'll just leave that point with you. Unfortunately, I think that if we reduce our notion of quality to merely those things that you can quantify in that fashion and count, we'll never get to quality. It does us a disservice in our understanding of quality and what we demand of the system.

If I could take just a couple of minutes to look at the suggestions that I've made—and you have copies of that, hopefully—the actual red-lined changes that I've suggested to the bill. I will highlight in the preamble, again, the notion that the government wishes to "recognize that a high quality health care system is one that is accessible, appropriate, effective, efficient, equitable, integrated, patient-centred." What I'm saying is, take that stuff out of the preamble, put it into the body of the bill and start building quality accountability into the actual bill. Otherwise, it will simply get reduced to the bean counting.

I would then go so far as to add a purpose to the bill up front, which I have provided you with. Then I would have a definition of high-quality health care in the interpretation section for reference to later on.

I would suggest "The purpose of this act is to promote, and further the provision of, high-quality health care in the province of Ontario."

I would say under "Responsibility of health care organizations" in section 2, "every health care organization shall"—and I've added the following—"continuously strive to improve the quality of care provided by it in the interest of providing high quality care in concert with the broader health care systems in communities of which it is a part." Again, the integration, the notion of building the requirement and the call upon these organizations to provide high-quality health care are part of the legislative requirements.

I don't think I need to go on and run through all the suggested amendments. They were put together quickly—I hope, thoughtfully. I hope that you will consider them. On that note, thank you.

The Chair (Mr. Lorenzo Berardinetti): Thank you, Mr. Smith. That pretty well uses up your time. Thank you for your presentation. We have your package here that you presented.

ONTARIO HOSPITAL ASSOCIATION

The Chair (Mr. Lorenzo Berardinetti): We'll move on, then, to our 4 o'clock deputation, which is the Ontario Hospital Association. Good afternoon, and welcome.

Mr. Tom Closson: Good afternoon. Shall I begin?

The Chair (Mr. Lorenzo Berardinetti): Yes. Please identify yourself. The process is, you have 15 minutes, and any time that you don't use of that 15 is shared among the committee to ask you questions.

Mr. Tom Closson: Thank you very much. Good afternoon. My name is Tom Closson, and I'm the president and CEO of the Ontario Hospital Association.

I want to begin by saying that the OHA strongly supports Bill 46. Ontario is home to the most efficient, transparent and accountable hospitals in Canada. We all recognize, though, that the public expects even more. If passed, Bill 46 would reflect their expectations by mandating that certain activities that are currently in place in many hospitals be extended to all hospitals and by providing needed clarity regarding quality improvement obligations of health care professionals and leaders. However, we believe that certain aspects of Bill 46 warrant some additional consideration by this committee.

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Bill 46 requires hospitals to conduct annual surveys of patients, their caregivers, and hospital staff. The OHA supports the concept of surveying patients and staff. In fact, 70% of hospitals currently utilize standardized surveys to measure patient satisfaction on a voluntary basis, at a cost of about $3 million per year. Generally speaking, only smaller facilities don't gauge patient satisfaction in this way, mostly for reasons of cost and administrative burden. Approximately 35% to 40% of hospitals currently measure staff satisfaction. Again, the OHA recognizes the value of staff surveys, and we actively promote their use. That said, there are issues related to surveying patients and staff that legislators should consider.

First, it will be important that relevant regulations clearly define the patient and caregiver population to be surveyed and that consideration be given to challenges and costs inherent in surveying special patient populations like mental health patients as well as individuals for whom English is not a first language.

Second, we must recognize that expanding patient, caregiver and staff surveying will cost money. Each patient satisfaction survey costs $8.50—this is what's paid to the survey company—a survey for a single mental health patient can cost as much as $70 or more, and staff surveys cost approximately $11 each. These costs are in addition to the associated administrative costs to the hospital. If you applied this across all patients, their caregivers, and all hospital staff, these costs can be very significant, especially for smaller facilities. Therefore, we strongly recommend continuing the current practice of surveying a statistically-valid representative sample of patient, caregiver and staff populations, rather than adopting a blanket approach.

We also recommend that Bill 46 be amended to require that hospitals survey their staff on a biannual rather than annual basis. This would give hospitals the ability to collect the data from staff, fully implement any changes, and then measure the effect of those changes before they're surveyed again. We strongly encourage legislators to amend Bill 46 in that way.

As you know, Bill 46 would tie the compensation of certain hospital executives to the achievement of performance targets set out in a hospital's quality implementation plan. Clarity is needed regarding who, in addition to hospital CEOs, would be captured by this provision, and we expect to work with the government on regulations in this regard.

Further, given the freeze on non-union employee compensation introduced as a result of Bill 16, individuals whose current contracts do not include performance-based compensation schemes would have their compensation effectively reduced. While the OHA fully supports and promotes the use of performance-based compensation, it is important that this model be implemented fairly and in a way that does not cause undue harm to employee pensions. We recommend that the government give very careful consideration to the legal and practical effects of this provision in Bill 46 before it's implemented.

As you are aware, Bill 46 would provide the legal framework within which the quality committees, patient and staff surveys, declarations of values, quality improvement plans and performance-based compensation would be created. It is to their great credit that the Ministry of Health and Long-Term Care chose to draft Bill 46 as a framework, avoiding being prescriptive in the legislation, and left many of the associated operational details to be implemented through regulation and by way of policy.

I would also like to thank ministry civil servants for their openness and willingness to consult with stakeholders during the development of Bill 46. Their efforts were appreciated, and we look forward to working with them in the weeks and months ahead.

Should it be approved by the Legislature, Bill 46's effectiveness will largely depend upon its associated regulations. Currently, the minister has the authority to set out most regulations associated with Bill 46 without consultation. Given their potential impact on hospitals and the broader health care system, we recommend that section 15 of Bill 46 be amended so that consultation take place on each regulation. We believe that public consultation on Bill 46's regulations can only improve its effectiveness.

I would like to note that the government has already adopted related regulations that are obviously not part of but are associated with Bill 46, the most prominent of which is an amendment to regulation 965 under the Public Hospitals Act. This amendment prohibits appointed staff, including physicians, or any hospital employee, including the CEO, from being voting members of the board, but allows them to sit as ex officio members.

In our opinion, this is completely consistent with the Auditor General's recommendations regarding the promotion of skills-based hospital boards; advice from multiple, independent governance experts; and the recommendations of a review of the Public Hospitals Act that was done in the early 1990s. This will give hospitals the flexibility to ensure that their board is comprised of individuals who have the skills, competencies, experience and independence needed to execute their roles and responsibilities. As such, this regulation has our full support.

This morning, Ontario's Information and Privacy Commissioner suggested that Bill 46 be amended to extend freedom-of-information laws to Ontario's hospital sector immediately. As you know, the OHA called for hospitals to be brought under the freedom-of-information umbrella last year, and that remains our position. However, we do not believe that Bill 46 is the appropriate vehicle for this purpose.

The government has promised in its throne speech that the Public Hospitals Act, the primary law governing hospitals, will be reviewed. It has been widely acknowledged that specific exemptions and amendments will be needed to take into account the unique circumstances of the hospital setting and that great care and consideration will be needed to ensure that hospitals are adequately supported through this transition in terms of implementing freedom of information. For these reasons, we believe that a stand-alone bill, written with reference to the Public Hospitals Act review and fully considered by all relevant parties, is the appropriate way forward. Frankly, this issue is too important for a back-of-the-envelope approach.

These and other issues will be discussed in more detail in the OHA's written submission, which will be provided to the committee next week.

I'll conclude by reiterating that the OHA supports Bill 46, and we look forward to working with the Minister of Health and Long-Term Care to implement it effectively if it is passed by the Legislature. With that, I'd like to thank members of the committee for your time, and I'd be happy to answer any questions.

The Chair (Mr. Lorenzo Berardinetti): Thank you. We have about two minutes per party, and we'll start with the Conservative Party this time. Ms. Elliott?

Mrs. Christine Elliott: Thank you very much, Mr. Closson, for coming and presenting today.

I did have a question just in noting that the OHA will be providing written submissions next week. Will you be providing specific amendments that you're asking the committee to consider?

Mr. Tom Closson: We'll be giving more detail about the kinds of things, but not legal language. Perhaps we'll be giving some legal language.

Mrs. Christine Elliott: All right.

Mr. Tom Closson: We will now.

Mrs. Christine Elliott: That would be very helpful, if you could. Thank you.

Mr. Tom Closson: We'll focus on that, yes.

Mrs. Christine Elliott: Thank you very much.

The Chair (Mr. Lorenzo Berardinetti): Thank you. We'll go to the NDP. Ms. Gélinas?

M^me^ France Gélinas: Thank you for coming, Dr. Closson.

Mr. Tom Closson: I'm not a doctor, remember?

M^me^ France Gélinas: I keep forgetting.

I certainly appreciate the fact that you have quantified how much it costs to do well-done patient and staff surveys. You're not the first presenter who talks about alternate years, where one year you would do the client survey or—are you suggesting that, no matter the size of the hospital, we should be going to every second year?

Mr. Tom Closson: For staff-satisfaction surveys or staff-engagement surveys because—I've worked in a lot of hospitals. By the time you do the survey, you analyze the results and you work with staff to make the change, if you were then to do another survey before you made any change, they become quite cynical. This isn't even really a cost issue; it's more—you've got to show progress. So every two years makes sense for staff surveys.

For patient surveys, we would suggest it be done on a continuous basis, but done on a sampling basis so you sample a certain percentage. That's what we do right now. About 104 of the 154 hospitals are collecting patient satisfaction data, using a standardized form. We would just like to keep it on a sampling basis so that it doesn't become overly expensive, and you'll get the same information you need to be able to make changes.

M^me^ France Gélinas: If we are able to bring some amendments, what specific type of consultation would you like to see before some of the regulations—I agree with you that this bill is a framework, so there's very little in it. It will be in regulations. What type of consultation are you hoping for or would you like to see?

Mr. Tom Closson: We're not suggesting that we're the only people who should be having input on the regulations, but normally, if there were regulations proposed, we'd take them out to our membership very quickly and get their feedback.

One of the things is that we have hospitals in this province that have budgets of $5 million and we have hospitals that have budgets of $1.5 billion. There's such a huge difference in their ability to implement changes, so it's really important that we hear from particularly the smaller hospitals and rural and northern communities to make sure that we've got this right in terms of the regulations.

M^me^ France Gélinas: I notice that you didn't comment at all on the notion of patient-centred care. Is there a reason for that?

Mr. Tom Closson: No, not at all. Certainly, the patient satisfaction surveys that we've been doing have tried to get at, "Are we providing care to patients in a patient-centred way?" One of the big issues here, though, is not just what goes on in the hospital; it's the continuity across the continuum.

We've recently established a partnership with the Ontario Association of Community Care Access Centres. We're looking at how we can actually look at patient flow into the hospital and out of the hospital and look at the patient experience across sectors. I think that's something else that needs to be looked at as we move forward.

The Chair (Mr. Lorenzo Berardinetti): Thank you. We'll go to the Liberal party. Mr. Balkissoon?

Mr. Bas Balkissoon: Mr. Closson, thank you for coming.

The Information and Privacy Commissioner was here this morning, and she seemed to imply that hospitals are ready for FOI and it should be something that could be implemented without any resource implications. She indicated this too by saying that she had been in constant contact with the OHA and the ministry. Would you agree with that statement, or do you have some reservations?

Mr. Tom Closson: If you remember, we came forward and suggested that hospitals be subject to freedom of information. We subsequently had discussions with the privacy commissioner and with the ministry, but there has not been a lot of detailed work done since that time. If you look at Bill 197, which was the privacy legislation for colleges and universities, it's five pages long. What the privacy commissioner brought forward to you today is two lines, and we actually believe hospitals are more complicated than colleges and universities when it comes to privacy because we're dealing with patient information and all sorts of other things.

So we want to sit down with the Ministry of Health and the privacy commissioner and really work through this in some detail. We do believe that the more appropriate legislation is attached to the Public Hospitals Act changes. The government has already indicated they want to do a review of the Public Hospitals Act, and we'd like to do the work on freedom of information as part of that review.

Mr. Bas Balkissoon: Have you had discussions with the privacy commissioner and the ministry in a collaborative way to make this move forward?

Mr. Tom Closson: We had initial discussions with them a number of months back, and I've talked to the privacy commissioner within the last 48 hours as well.

Mr. Bas Balkissoon: Okay. Is there a commitment by all parties to make this happen?

Mr. Tom Closson: I can only speak—certainly, I guess the privacy commissioner spoke for herself. You'd have to ask the Ministry of Health. But there certainly is from the Ontario Hospital Association.

Mr. Bas Balkissoon: Thank you very much.

The Chair (Mr. Lorenzo Berardinetti): Thank you for your presentation.

That completes deputations for today. For the committee's information, administrative deadlines for amendments are due by 12 noon on Thursday, May 27, and this committee will go through this bill clause by clause on Thursday, June 3, starting at 9 a.m.

The committee now stands adjourned. Thank you.

The committee adjourned at 1613.

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