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SP-10

Standing Committee on Social Policy

Your Health Act, 2023

1st Session
43rd Parliament

Tuesday 21 March 2023

Chair: Goldie Ghamari
Clerk: Lesley Flores

Journal des débats (Hansard)

SP-10

Comité permanent de la politique sociale

Loi de 2023 concernant votre santé

1re session
43e législature

Mardi 21 mars 2023

Présidente : Goldie Ghamari
Greffière : Lesley Flores

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Tuesday 21 March 2023

Mardi 21 mars 2023

The committee met at 0900 in committee room 2.

YOUR HEALTH ACT, 2023
LOI DE 2023 CONCERNANT VOTRE SANTÉ

Consideration of the following bill:

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

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

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

The Clerk of the committee has distributed today's meeting documents with you virtually via SharePoint.

As a reminder, witnesses have been scheduled into groups of three for each one-hour time slot. Each presenter will have seven minutes for their presentation. Following all three presentations, there will be 39 minutes of questioning for all three witnesses, divided into two rounds of seven and half minutes for the government members, two rounds of seven and half minutes for the official opposition members and two rounds of four and half minutes for the independent member.

Do we have anyone on Zoom?

Interjection: Yes.

The Chair (Ms. Goldie Ghamari): Okay. To ensure that everyone who speaks is heard and understood, it is important that all participants speak slowly and clearly, especially if you are on Zoom. Please wait until I recognize you before starting to speak. For the virtual participants on Zoom, after I have recognized you there may be a brief delay before your audio and video are ready. Please take a brief pause before you begin speaking. In order to ensure optimal sound quality, virtual participants are encouraged to use headphones or microphones if possible.

As always, all comments should go through the Chair. Are there any questions before we begin?

GREATER TORONTO HEALTH COALITION
SEIU HEALTHCARE

The Chair (Ms. Goldie Ghamari): I will now call upon Greater Toronto Health Coalition to please come forward. Please state your name for the record and then you may begin. You will have seven minutes for your presentation.

Ms. Michelle Robidoux: My name is Michelle Robidoux. I am the co-chair of the Greater Toronto Health Coalition. Can I begin now? Thank you.

Thank you for the opportunity to present to you on behalf of the Greater Toronto Health Coalition. We are a non-profit advocacy organization that regroups individuals and organizations in the greater Toronto area concerned with maintaining access to not-for-profit, publicly funded and publicly managed health care. Our organization was founded in 1995 by the late Shirley Douglas, a tireless advocate for Canada's public health care system, who built on the legacy of her father, Tommy Douglas.

Bill 60 is sweeping legislation that will forever change the trajectory of our public health care system if it becomes law. I want to address some of the key ways this legislation will further undermine single-tier health care in this province and quite likely across the country. But it first has to be acknowledged that this government has consciously chosen to underfund our system to the point that Bill 60's private for-profit clinics can be offered as a solution to the dire state of our health care system.

Ontario has the lowest levels of beds and funding per capita in the country. According to the Financial Accountability Office of Ontario, health spending per person in Ontario was $4,800 in 2020, the lowest in Canada and 10% below the average of other provinces. The number of hospital beds per capita is the lowest of all provinces and low in comparison to OECD countries.

Low levels of beds are a marker for low levels of staffing. According to a 2021 report by the Ontario Council of Hospital Unions, if Ontario hospitals had the same staffing as hospitals in the rest of Canada, there would be 45,000 more hospital employees in Ontario. The same report shows how low hospital funding and few beds has meant that hospital patients must be discharged more quickly. Ontario has the shortest length of stay in Canada.

This is part of the backdrop to discussing the impact Bill 60 will have on an already underfunded and overstretched public health system. I want to focus on three key concerns we have regarding this bill: It will accelerate and worsen staffing shortages, it will expand already widespread upselling, and it will mean more profit-taking and less oversight.

On the first point, Bill 60 will accelerate and worsen staffing shortages: Ontario is facing the worst hospital and health care staffing shortage in memory. The combined impacts of COVID and deliberate wage suppression by the provincial government have left health care personnel exhausted and demoralized. Not only does Bill 60 not provide relief to front-line workers who are struggling every day under crushing workloads, it will aggravate the situation by siphoning staff from public hospitals to work in the proposed new private clinics.

At the Ottawa Hospital's Riverside Campus, private corporation Academic Orthopedic Surgical Associates of Ottawa is operating an after-hours surgical clinic privately within the hospital, using the hospital's operating room, supplies and hospital staff. This shows that there are not two different pools of staff to work in parallel; there is one under-resourced pool of staff that the private clinics will draw from. It is shameful that private clinics will be able to poach people away because they won't be under the laws that deliberately underpay and create intolerable pressure on staff.

Despite assurances by Minister of Health Sylvia Jones that applicants for these new licences would be required to submit staffing plans meant to "protect our public hospitals and to ensure that they are not in any way impacted," there are no teeth in this process and no indication of how an applicant would be rejected if their staffing plan fails to ensure public hospitals are not impacted.

Number 2, Bill 60 will expand already rampant upselling: Profit for the investors in private for-profit clinics has to come from somewhere. Everybody knows that. Some of it will come from cream-skimming the less complex cases, concentrating the most complicated cases in public hospitals. But another obvious source of the profits will be upselling patients, which is already happening in Ontario. As was noted in the Auditor General's report on outpatient surgeries in December 2021, private clinics upsell publicly insured patients: "The ministry has no oversight mechanism to prevent patients from being misinformed and being charged inappropriately for publicly funded surgeries."

Number 3, Bill 60 will mean more profit-taking with less oversight: There are no standards in the legislation. There is no protection against corruption and conflict of interest. The inspections process, if there is one, is left to regulations made by cabinet after the legislation has passed. While public hospitals are subject to the Public Hospitals Act, currently, private clinic inspection reports are contracted out to a third party, so are not liable to freedom-of-information laws, for example. Concerns about cost-cutting and poorer outcomes for patients in private clinics not subject to the oversight that covers public hospitals are not misplaced. A recent study published in the Lancet looking at the privatization of public services in the NHS in England found that "private sector outsourcing corresponded with significantly increased rates of treatable mortality."

Premier Doug Ford has stated that this legislation aims to clear the backlog of surgeries that have been delayed, something which is argued our existing hospitals have no capacity to deal with. Yet the Ottawa Hospital deal with AOAO shows there is a solution at hand, ironically, one that doesn't require further incursions of profit-taking in our public system: utilize the underutilized infrastructure, the operating rooms, with existing personnel within the public system. In hospitals across the province, there are operating rooms that are not being used—in some cases, that are closed—because of lack of funding and staff. That is the problem to tackle.

Provincial governments could pay to schedule more surgeries at night or on weekends. This would require investing in the public system and developing a strategy for recruiting and, critically, retaining health care personnel. This would require the provincial government spending the funds—

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

Ms. Michelle Robidoux: —that have been allocated for health care instead of sitting on $1.25 billion, as the Financial Accountability Office has revealed. It would mean respecting the court decision which found Bill 124 unconstitutional instead of spending public funds on fighting this decision in the courts.

The Ontario government has a choice: either properly fund a public system that provides care based on need or fund private institutions which operate based on extracting profit. Bill 60 is going to set Ontario on a terrible course that will undermine public health care. This is a situation the majority of people actually oppose in this province. That is why Bill 60 should be withdrawn.

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

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

Mr. Tyler Downey: Good morning, committee members. My name is Tyler Downey. I serve as the secretary-treasurer of SEIU Healthcare, and I'm joined by SEIU's director of government relations, Michael Spitale.

The Service Employees International Union represents two million members across the United States, Puerto Rico and Canada. In Ontario, SEIU Healthcare proudly represents 60,000 workers on the front line of care. Our vast jurisdictional representation is relevant because our members on the front line know first-hand the best of what a system represents as well as the risks.

Erika Watanabe, a certified surgical technician who works for America's largest hospital conglomerate, tells us of the failure of HCA Healthcare, a $72-billion corporation that pays out nearly $700 million in cash dividends to shareholders every year and refuses to invest its massive resources in safe staffing to guarantee dignified care at her hospital in Nevada. Erika is overworked, burnt-out and is

experiencing depression over the ugly experience of her patients. The for-profit hospital chooses to understaff shifts to maximize its profits. Prioritizing profits is what corporations exist to do. I know that Ontario can do better than open the doors to for-profit American health care corporations.

0910

SEIU wants Ontario's health care system to succeed and deliver in quality care. We believe that we share that mission with all the members of this committee. That can only happen when our health care workers are supported. But in Ontario, health care workers are not supported, and health care unions representing over 300,000 workers on the front line of care are telling this government that Bill 60 is more risk than reward.

Part of our job as a union is to amplify the voices of our members—members like Briar Moore, a registered practical nurse from Niagara. She works on the in-patient oncology floor where staffing ratios for her cancer patients should be four to one, but are more often only half-staffed, with ratios reaching seven to one or greater. Emotional care for her cancer patients is an impossibility under current staffing conditions. She told me of a sweet elderly woman receiving chemotherapy coming to her floor with blood on her gown, smelling like sweat and her hair in a tangled mess. And her response to Briar's shocked face: "Oh, the poor nurses are running around. They don't have time to do this kind of stuff. My daughter will be in later, and she will help me, but she couldn't come yesterday." Let me repeat: An elderly mother being treated for cancer, covered in sweat, her gown stained with blood, her hair tangled for days, going through hell—right here in Ontario, in Canada, without proper hygiene or human dignity because staffing ratios were nearly half of what it should be. Dangerously low staffing levels, poor conditions of work and inhumane care delivery are driving nurses like Briar to the breaking point mentally.

In the American system, staff and patients are shortchanged to maximize profits. In Ontario, staff and patients are shortchanged due to a lack of public investment. Meanwhile, Bill 60 will not add a single new health care worker into the system, and that is the fundamental problem with Bill 60. As a blueprint for business interests that put profit before patients, it does more to funnel care into a private system where big investor-led corporations can profit than it does to support abandoned staff in the public system, like RPNs like Briar.

I urge you not to dismiss health care workers crying out with warnings from the front line, because there is nothing wrong with our public health care system that can't be fixed with what's right about our public health care system.

I'll now turn it over to Michael Spitale for more on the health care staffing shortage.

The Chair (Ms. Goldie Ghamari): You can begin.

Mr. Michael Spitale: Thank you. Good morning. My name is Michael Spitale, and I work as director of government relations for SEIU.

We often say at SEIU that our members are the people on the front line of care. The reality of our system today is that we don't have enough people to provide care, and what Tyler described is staff who can't safely keep up with what we ask of them.

There is a direct correlation between access to quality of care and the level of health care spending. The nonpartisan independent Financial Accountability Office of Ontario recently said the following about the health care system: "It's not necessarily that there are no beds, but there are no staff for those beds." He went on, "We think they're going to have trouble—not building the beds, but staffing the beds. The volume of folks going into ER is actually lower, yet they're waiting longer. That's a staffing issue," he said. If everything the government intends goes to plan, the health care system will be short 33,000 nurses and PSWs in five years.

Finally, the FAO report from March 2023 reads, "Increases in capacity will be more than offset by increases in demand for these services from Ontario's growing and aging population. Relative to projected growth in demand, by 2027-28, Ontario will have less hospital capacity, similar home-care capacity and less long-term care capacity compared to what it had in 2019-20." The conclusion is that health care will be worse in 2028 than it was in 2018.

Now, SEIU does come with solutions:

(1) Send a positive signal to health care workers and don't fight them in court over Bill 124 or attempt to deny them the pay equity they've already won in court.

The Chair (Ms. Goldie Ghamari): Forty-five seconds left.

Mr. Michael Spitale: Thank you.

(2) Create sectoral bargaining tables with government as a partner to pay health care workers equal wages across sectors for the same work.

(3) Raise the wages for all nurses, starting with an immediate $35 minimum wage for registered practical nurses.

(4) Fully fund health care so wait times could be addressed in already unoccupied trusted public hospitals.

Finally, learn from the disaster of long-term care and do not turn the keys to hospital services over to the same kinds of big corporations that delivered substandard care, as the business model shows. Thank you for your time.

The Chair (Ms. Goldie Ghamari): Thank you very much. We'll now turn to our first round of questions, starting with the official opposition. MPP Gélinas, you may begin.

M^me^ France Gélinas: Thank you to all three presenters for your deputations this morning.

Madame Robidoux, I will start with you. There is a quote from Dr. David Urbach, who is the head of the department of surgeries at Women's College Hospital in Toronto and professor of surgery and health policy, management and evaluation at the University of Toronto. He says, "There is no reason why additional surgeries could not be done in Ontario public hospitals. There are many operating rooms in Ontario hospitals that are unused—but could be used—due to lack of funding and staffing, especially nurses.

"From a business and quality of care perspective, it would be a much better strategy for Ontario to maximize delivery of surgery in our existing public hospitals."

Would you agree with the statement from Dr. David Urbach?

Ms. Michelle Robidoux: Yes, I very much would agree with that. If I recall, when I read that statement by Dr. Urbach, he was speaking in the context of an unused operating room himself. So I think he knows very much what the situation is of unused operating room space, and he has recommended, as you say, a public solution and not a for-profit solution.

Mme France Gélinas: There's also an example that exists at the London Health Sciences Centre right here in Ontario, where across the street from the hospital they built a surgical suite that does outpatient surgeries only. The Auditor General tells us they're able to save about 50% in costs and are able to see 30% more patients with the same. The surgical suite that is outpatient only is staffed by the hospital and rotates in one week at a time. So one week you go and work in the outpatient surgical suite, which means you work Monday to Friday day shift, and then the next week you work your regular shift in the hospital.

Would the Greater Toronto Health Coalition be open to models like this, where a hospital, not-for-profit delivery, opens basically community surgical suites, staffs them with the regular staff and offers outpatient surgery? Would you be open to that?

Ms. Michelle Robidoux: Certainly. I think what that shows is the capacity to find solutions that will better integrate instead of fragment our health care system and to do so within the public system. It is a much more efficient use of public money. There are many models we can look to—as the one that you're talking about—but there are many models that provide that kind of solution to the problems that exist. So yes, we would.

Mme France Gélinas: What you're saying is, with Bill 60, the only thing we are adding is that now basically the private for-profit, investor-owned corporations will be able to invest. It's about $2 million to build one of those suites, plus a whole bunch of other costs to get it to run. So they'll be able to invest millions of dollars to build those suites that, according to Dr. Urbach and yourself and many more, we do not need, and then staff them. If Ottawa is any example, they are paying double what nurses or anybody else who works in OR gets paid, all at the taxpayers' expense. So what I understand is, it's this idea that people want to make a profit off of sick people that you oppose, not the concept of being more efficient and having outpatient surgery.

0920

Ms. Michelle Robidoux: Absolutely. The question of why this bill is being proposed in the way that it is, in the conditions I described across the province of horrendous, horrendous stress on the staff, the infrastructure and so on—the purpose is to open it wide up to profit-taking. The problem is, the government can't say that openly. In fact, before the election, when it came up and Christine Elliott, the Minister of Health at that time, said, "We will be opening up to private hospitals," the apparatus inside the government ran out to say, "This is not true. This is not true. Do not worry. We will not have for-profit, private health care." That was before the election.

Now, with Bill 60, it's so clear, and the Ottawa Hospital shows it the most clearly because of the attempt to recruit the staff within that hospital to work in the after-hours clinics, the private clinic. It clearly is the same people that are being offered much more money. And they should be offered more money, but why not do it within the public system, which currently is sitting on one and a quarter billion dollars of unspent health care resources?

So yes, I think there are solutions possible to the problems facing the health care system, within the public system. But as our founder, Shirley Douglas, told us many, many times, since the founding of medicare, which her father had a role in creating, there have been privateers waiting, and waiting with great desperation, to make money off of this incredible achievement of Canadian society, which is the institution of public medicare. So it's not surprising this is happening, but the shock of COVID has really, I think, opened the door to ramming this through.

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

Ms. Michelle Robidoux: Thank you for your question.

Mme France Gélinas: My last minute to SEIU: How much of an impact has Bill 124 had on your members and your members' willingness to continue to work in the public sector?

Mr. Tyler Downey: A major impact. I think when we hear from our members, what we hear is fatigue, frustration. They have been waiting for a sign, a message that someone is going to take care of them, that someone is going to recognize their efforts and someone is going to do something.

Bill 124 was a real slap in the face for many of them. You've seen, probably, the statistics that many of our nurses have left the profession and moved on to other careers because of Bill 124 and the like. So it's had a major impact on the care delivery in our province, but it's also had an impact on how health care workers view health care in this province and the career that health care used to be. It's no longer the same, so that's a big part of it.

Mme France Gélinas: Are you able to give us stats—

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

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

Mr. Adil Shamji: Good morning, everyone. My first question is to Mr. Downey and Mr. Spitale from SEIU. First, thank you very much for the incredible work of your members under the most trying circumstances during the pandemic. You spoke eloquently of the importance of having adequate and dignified staffing, and particularly staffed beds in health care. Is there anything in Bill 60 that, in your opinion, meaningfully addresses this? And what, if anything, can be added to Bill 60 that might satisfy that requirement?

Mr. Tyler Downey: So maybe I'll just answer really quickly and I'll it hand over to Michael. The answer is no, Bill 60 doesn't address the critical staffing shortages that we're experiencing right now in Ontario. Part of why we

are here is to really send a warning to this government and this committee that we are experiencing dangerously low levels of staff—like, serious. If you haven't been on the floor of a hospital or nursing home to see, you wouldn't know what I was talking about. It's extreme, and Bill 60 does nothing to address this issue.

I'll pass it over to Michael to talk specifically about the policy in regard to the second part of your question.

Mr. Adil Shamji: Thank you, sir.

Mr. Michael Spitale: Thank you for the question. I think, as you heard from Tyler in our opening remarks, the single greatest worry on the minds of our members is, can they deliver work safely and get home in one piece, both physically and mentally? There's nothing in Bill 60 that addresses the single greatest concern of our members, that being staffing levels. They're unsafe. Part of the inability to deliver care in health care and public institutions today is not because the public institutions are not working. It's that we don't have enough people. Health care is about people.

We would love to be joining with this committee and talking about how we could add more people to the system so that people could get care in a trusted public institution, but Bill 60 is not the vehicle that is going to add a single new health care worker to the system.

What we're sharing today is that our members are concerned about the single greatest worry on their mind, and they would like for this committee to know that they are seeing nothing that is going to help them in their everyday jobs.

Mr. Adil Shamji: Thank you very much for that.

Ms. Robidoux, I wonder if I could ask you a question. Thank you for your deputation this morning. In your remarks, you cited some evidence that for-profit health care leads to poorer health outcomes. I think some of the government members missed that; others believe such evidence does not exist. So for their benefit, could I ask you to repeat some of the evidence, including what you were citing about the landmark Lancet study?

Ms. Michelle Robidoux: Yes. I will try and pull up some of the information. The Lancet study was conducted—it was a study over a number of years, I think a decade, that looked at the privatization of public services within the national health system in England.

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

Ms. Michelle Robidoux: What they described was the reality of private sector outsourcing corresponding with significantly increased rates of treatable mortality. They said that it was potentially as a result of a decline in the quality of health care services. I think that would be a fair conclusion to draw, because if mortality is going up under this new system, then one has to ask: Is it because quality is being driven down? Why would quality be driven down? Well, cost-cutting. If you introduce profit as a motive in health care—in any business, there's always cost-cutting and trying to find so-called efficiencies—

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

We'll now turn to the government. Who would like to begin? MPP Rae.

Mr. Matthew Rae: Thank you to the witnesses for their testimony and providing their perspectives on Bill 60.

My question is for the Greater Toronto Health Coalition. I was just wondering: Do you believe the Alberta and BC health care systems undermine health care in Canada?

Ms. Michelle Robidoux: Are you asking me do I believe that the inclusion of for-profit clinics in Alberta and BC undermines Canada's health care system? Is that the question you're asking?

Mr. Matthew Rae: I was simply asking: Do you believe that the Alberta and BC health care systems, as it currently is provided in those provinces, undermine Canada's health care? Because you alluded to Bill 60 undermining health care in Canada.

Ms. Michelle Robidoux: I think there are vast problems with the introduction of for-profit clinics in both Alberta and British Columbia, and I think that they do undermine the provisions of the Canada Health Act, definitely.

Mr. Matthew Rae: For the record, Chair, I'd just like to point out that 17% of the procedures performed in Alberta and BC are currently in non-hospital settings. This has been occurring for many years now. In Ontario, it's only 3% currently, and our health care system is very strong.

Thank you, Chair. I believe other colleagues have questions.

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

0930

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

Mr. Downey, you indicated that Bill 60 won't add a single health care provider. What I wanted to ask you was: Are you aware that Bill 60 contains provisions for as-of-right recognition of the credentials of health care providers from other jurisdictions?

Mr. Tyler Downey: For the specific parts of the policy, I'm going to defer to Michael, but what I will say is this: We see no evidence of Bill 60 adding any health care workers to the extremely low staffing levels that we are experiencing. What I'm here to address as the treasurer of the union and what I take pride in is listening to the members of our union. What they tell me is that we are at an extremely low level of staffing in this province—dangerously low levels. They don't see how this bill addresses that.

If Michael can speak to the specifics of the bill, I'll hand it over to him, but from my perspective, my message to this committee is that there's no evidence of any new health care workers being added to the extremely low level of staffing in this province in this bill.

Mrs. Robin Martin: Just before Michael goes on, I wanted to ask about the as-of-right provisions and whether you were aware that the as-of-right provisions are part of Bill 60, with a view of trying to make sure that we expedite new health care workers coming into the province of Ontario from other jurisdictions, a national licensure system being a goal that we would have in mind at some point.

But also, of course, no single piece of legislation addresses every issue. I can add to the question before Michael—Mr. Spitale—responds: Are you aware of other efforts to recruit health human resources that the government has engaged in? We have engaged in the largest health care recruitment, retention and training initiative in Ontario's history, and last year alone, the largest number of nurses have registered to become licensed nurses with the CNO. I think the number is something like 14,000 registrations. Are you aware of that as well?

Mr. Michael Spitale: I'm happy to answer your initial question and your follow-up question there. The issue of as-of-right, I would say, is an issue that is helpful, truly. It would be helpful. I think our worry is what would happen when other provinces do the same thing, and then health care workers make a determination of where they can support and raise a family: Which province has cost-of-living issues, affordability issues, housing issues? Currently, I think we're seeing a net outflow of people out of the province of Ontario for some of those reasons, and so if you gave health care workers the flexibility to choose which province they might live in, what we're seeing generally in the province of Ontario is actually an outflow of people, an outflow of workers.

The policy is not in itself a bad policy; it's that when Canada does that, when other provinces do that, our health care workers are going to choose jurisdictions where their pay is better, where staffing levels are higher, where cost of living is lower. That is a reality that we would frankly love to work with you on: How do we attract more health care workers?

In terms of the retention and the recruitment, we welcome efforts to recruit as many health care workers as necessary. We obviously know—I don't think there's a dispute from anybody's side—that we have a shortage, and so we need to bring in more and more workers.

I think what Tyler described in his anecdote from one of our members in particular is that the job itself is so difficult that we're actually losing existing health care workers today. They are at a mental health place in their working careers where it's literally breaking them down. We can tell you—and it's not just anecdotal, but in the research that we do with our membership—that the number of health care workers who cry before or after their shift—

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

Mr. Michael Spitale: —is really quite heartbreaking. So what we're worried about is we're actually losing more people than we're gaining. We'd love to gain the numbers that you cited; that's a terrific thing. We think we need to grow that substantially. I think the FAO report says that in five years, we'll be short an additional 33,000 nurses and PSWs, even on top of the goals that the government may have currently. Those are things we'd love to work with you on.

Mrs. Robin Martin: Thank you very much, Mr. Spitale. I just want to add that 25,000 students applied to nursing programs in Ontario, which is also a record number of students, so I think there's hope for the future. We're certainly working very hard to recruit health human resources on a number and range of initiatives across the health ministry, because we know how important that is to deliver health care. But we're also bringing forward this piece of legislation, which we do think will improve our health care system and ensure people get access to care quicker.

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

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

Mr. Wayne Gates: I'll start with the SEIU. Was there any consultation between—I took a look at your numbers: two million members across North America, 60,000 workers, front-line workers who I know.

Before I lose my train of thought, Michael, I'm certainly aware of nurses sitting in the parking lot at Niagara Falls hospital, breaking down, crying before they go to work. That's the stress they're under. Under Bill 124, it eliminates their help for mental health as well, which people don't talk about.

To you—either one of you can answer—was there any consultation from this government? We had the OFL here yesterday. We had Unifor here yesterday. This is a party that tries to say they're working for workers. We know they're not, but that's what they put into all their bills. So maybe you can help me: Were there any consultations with yourself on this bill before this committee hearing?

Mr. Tyler Downey: No. Part of the reason why we decided to participate in this committee hearing today is to bring the voices of our members to this committee and the concerns that they have. We weren't consulted, so we wanted to take this opportunity to share what's really going on, what's on their minds and the fear that they are working through and living through—the fear that because of the extremely low staffing levels, they can't deliver the quality care that they want to deliver. So no, we weren't consulted.

As a union, we hear from members all the time. I talk to members every day, so we know what's going on, on the front lines. We know how the poor conditions that they're working in affect their lives and their communities. That's what we decided to bring to this committee.

Mr. Wayne Gates: You talked about profit before care. I've gone through it with long-term care as the critic, and I've watched 5,400 of our moms, dads, our grandparents die. Seventy-eight per cent of them died in for-profit long-term-care facilities, including—and maybe I can offer my condolences—some SEIU members who passed away during COVID. I offer my condolences for that. It shows just how dangerous that job is, how hard they're working. And I believe this government is going to be defeated in 2026 because of privatizing of our health care. Every corporation has been wanting to get the money that's going into health care and put it into profits. They've been trying to do it for a number of years.

To our speaker from Toronto, Shirley Douglas lived in Niagara Falls. I knew her quite well. I went to a lot of conferences with her. I'll tell you, Tommy Douglas and Shirley Douglas would be rolling in their graves today knowing

what this government is trying to do to our publicly funded health care and what they're doing to workers right across the province.

You represent workers in the States; your union does. I know 45 million Americans every year claim bankruptcy because of the cost of health care—45 million. That is why Tommy Douglas brought in a publicly funded health care system. It's why we have to do everything we can to protect it.

I want to say to SEIU, I'm glad that you're here today. I'm glad that you are taking this fight. Do not let this government get away with it. We need to organize. We need to bring every single union together to take this bill on, Bill 60, just like we did against the "notwithstanding" clause, because when we're united, we can win. We've got to do it for our members.

I'm a union member. I'm out of CAW, Unifor, and then UAW, by the way, which will probably bring a smile to your face.

The one thing that my colleague would like me to ask, as well—you didn't get a chance to talk about the turnover and the stats on turnover. How many of your members, within reason of what you can give us, are leaving? Would you have that stat, or maybe Mike would have it?

0940

Mr. Tyler Downey: Maybe I'll pass it to Michael to answer that question.

Mr. Michael Spitale: Sure. Thank you for the question. I think the figures differ depending on which classification of health care worker you're talking about and may differ when you take a look at which sector of the health care system they're working in. We're seeing the greatest number of turnover in home care.

What we're hearing from our members who deliver home care services is the stability of employment in home care is the worst. When you think of the three general big health care sectors—home care, long-term care and hospitals—in home care, they're the most precariously employed. In long-term care, we're seeing turnover. In some cases, it's a PSW moving to the fast food industry because, frankly—the best way to describe—it's safer. In hospitals, what we're seeing is a real decline in mental health. We're seeing some of the older, more experienced health care workers in our union and in hospitals leaving because they can't take it mentally anymore. I think that's really our concern. The number one issue, just to repeat, that we're hearing from our members in terms of quality of life, safe staff and the ability to look a patient or a resident in the eye and know you're doing everything you can for them—they feel like they can't do that.

We can get you some of those specifics about turnovers for each sector and each job classification, but I can tell you: The more precarious the employment, the higher the turnover is.

Mr. Wayne Gates: Thank you very much. I'm going to read a long question, because I think it shows where the Conservative government really is.

Conservative governments in this province have a terrible track record when it comes to health care investment and operations. During the Harris government, Ontario saw a major rollback of our public health care system. The government closed 43 hospitals; 11,400 beds were cut, including one in three Ontario acute-care and chronic-care hospital beds. Now, we face a crisis, and this government has decided to privatize health care. What do you think is motivating this move to funnel millions, and probably billions, of dollars—of health care dollars—into private hands?

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

Mr. Wayne Gates: Do we have other options that are being purposely ignored? And I'll start with SEIU and hopefully get to the labour council as well.

Mr. Tyler Downey: Michael, do you want to—

Mr. Michael Spitale: Sure, and I'll just be really quick. I don't want to speak to anybody's motivations because, as Tyler said, we think all members of this committee have the intent to deliver better health care. What we're bringing to the committee today is just our experience across the vast jurisdictional area about what works and what doesn't work. Bringing in large, corporate shareholder-led institutions to deliver care does not work. That's really what we're saying today.

If there was more time, I'd like to go over again some of the solutions that we're bringing to the table today. We'd love to work with all committee members on how we might actually deliver on those, but perhaps this is not the time or place for that long discussion.

Mr. Wayne Gates: Go ahead.

Ms. Michelle Robidoux: I think—well, I agree with what was just—

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

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

Mr. Adil Shamji: Ms. Robidoux, when we were last chatting, we were discussing the 2022 study in Lancet Public Health, one of the most reputable journals in the world. And in it, I believe, in the study that you're referring to, the final statement—because it's important to be evidence-based, not ideological, and I appreciate that you've brought that evidence-based perspective. The summary statement in that study was: "The privatisation of the NHS in England, through the outsourcing of services to for-profit companies, consistently increased in 2013-20. Private sector outsourcing corresponded with significantly increased rates of treatable mortality, potentially as a result of a decline in the quality of health-care services." Is this the reason that you're concerned about Bill 60?

Ms. Michelle Robidoux: Yes, it's definitely a main reason, that it is going to harm the outcomes, and critically it's going to starve hospitals of staff, of resources. We think that's a terrible misuse of public health care resources.

So yes, definitely, that is one of the things that we're very concerned about. And we're deadly serious how concerned we are, because our organization was founded under another Conservative government that proceeded to amalgamate hospitals, cut hospital beds. They even instituted a private, for-profit cancer care clinic inside Sunnybrook hospital, which it was later found—that was in 2001, and it was later found that it would cost $500 more for each treatment than

if it was done under the public structure. They quietly closed it in 2003. We fought like hell over that, pardon my language. But that was what was going on then.

So we know from experience what this means. It is a misuse of public funds that will be funnelled to profit, and if that was clearly stated, I think most Ontarians would be in an uproar about it. Unfortunately, trying to get at what is really happening here with Bill 60 is going to be our number one job for the next foreseeable period. Of course, it will be rammed through very quickly. We understand that.

Mr. Adil Shamji: Thank you.

Mr. Downey, Mr. Spitale, earlier we heard about some of the government's efforts to bring in more health care workers. Do you or your members feel as though any efforts are being made to retain health care workers?

Mr. Tyler Downey: Maybe Michael can respond first.

Mr. Michael Spitale: Sure. I would say that largely what we hear—and thank you for the question—is the idea that a couple of years ago, people were being acknowledged as heroes, and then Bill 124 remained in place. I can tell you in the nursing home sector, ONA and SEIU won a victory in court for pay equity in the nursing home sector that the government is now challenging. So there are these signals that health care workers are not as important—

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

Mr. Michael Spitale: —as this government is saying they are. So we'd like to see Bill 124 gone. We'd like to see sectoral bargaining, with government at the table as a partner, so that we can actually eliminate the discrepancies in pay across sectors and across job classifications. And we'd like to see an immediate $35 minimum wage for registered practical nurses. We think those things will actually help with retention, as opposed to continuing to ignore their cries for help about unsafe staffing levels.

Mr. Adil Shamji: Thank you.

To any of the speakers: Does anyone see any benefit to this bill forbidding the public from knowing any information about who licensed applicants would be, and for not having—

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

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

Mrs. Robin Martin: Thank you very much, Chair. Thank you to the presenters again. For the Greater Toronto Health Coalition—I'm sorry, I didn't catch your name.

Ms. Michelle Robidoux: Michelle Robidoux.

Mrs. Robin Martin: Michelle—

Ms. Michelle Robidoux: Robidoux.

Mrs. Robin Martin: Robidoux. Enchantée.

You mentioned a clinic that was a private, for-profit cancer care clinic in Sunnybrook in 2003, I believe—2002-03. I am very aware of that clinic. It was called the CROS clinic. It was run by a former president of the UHN. It was publicly funded breast and prostate cancer radiation treatments in Sunnybrook hospital—publicly funded, using publicly funded equipment in a public place—to clear the backlog of breast and prostate cancer radiation treatments that Ontario had at the time. What we were doing instead of treating patients here who had cancer and should have been treated close to home, at the time, before we set up that clinic, we were sending patients to Buffalo and Rochester, at a time when they're very vulnerable, when they have cancer and need cancer treatment. Ontario was unable to keep up with the demand for breast and prostate cancer radiation, which is very difficult. So what the Ontario government did at the time was that it set up the CROS clinic to operate at Sunnybrook hospital.

0950

It paid the same fee to the CROS clinic for breast and prostate cancer radiation as was being paid to public hospitals to do it at other hours, and the breast and prostate cancer radiation backlog was eliminated within two years. That was why the CROS clinic was closed down two years later, in 2003. There was an incentive payment for the last 500 cases of an extra $500 per case to encourage them to clear the backlog. But most of the cases were actually paid the same rate as at public hospitals.

I worked in the Ministry of Health at the time, and Cancer Care Ontario—most of the cancer centres; I think there were eight across Ontario at the time—were unable to provide this treatment. They did not run breast and prostate cancer radiation treatments after hours. But the best part of this story is that at the end of the CROS clinic, every cancer centre started to use their equipment after hours to treat patients, which had historically not been done. So it changed behaviour in a way that was very positive for Ontario patients. It helped patients not have to go to Buffalo and Rochester for treatments, which, by the way, was costing the system significantly more—like three or four times as much per case to go to Buffalo and Rochester.

I think that's an excellent example of why what we're doing is so important to Ontario patients. I don't know if you're aware, but the Ontario government has given approximately a billion dollars—I think it's $880 million—in total since the beginning of COVID to our hospitals to try to increase the number of cases that they can deal with in their surgical suites so that they can help us clear the surgical backlog. Despite the best efforts of our hospitals, which have been doing everything they could, they have been unable to clear the backlog. They've brought it down. It is still around 207,000 or 203,000 people, down from about 270,000. But there are still 203,000 or 207,000—I'm not sure of the exact number—Ontarians waiting for surgeries and diagnostic procedures who could be having them if we could get more services out to these people.

So what this bill is about is improving access to health care for Ontario patients, which we think is really important. I just wanted to ask you if you don't think that that is an important objective and therefore something we should try to do.

Ms. Michelle Robidoux: I think the objective of dealing with the problems in the health care system is a good one. I don't think Bill 60 is going to achieve that, and I think that isn't the purpose of Bill 60, because—

Mrs. Robin Martin: All right, well, thank you—that's fine. Thank you.

Ms. Michelle Robidoux: Well, I think I should have a chance to respond to—

Mrs. Robin Martin: You just told me the answer to the question is you don't think that—

Ms. Michelle Robidoux: If the CROS clinic is the model that you're using, using equipment after hours—

The Chair (Ms. Goldie Ghamari): So committee members—once their question is answered, they're allowed to continue on. And given that there's only one minute and 40 seconds left, I think—MPP Martin, if you want to continue your line of questioning?

Mrs. Robin Martin: Yes, sure. I just had another question, which was—I don't know if you've noticed, but what the bill does is it replaces independent health facilities with integrated community surgical centres. So the objective of this bill is to take all the 900 independent health facilities we currently have and reconstitute them as integrated community surgical centres. I can't see how anyone could say that Bill 60 isn't improving our health care system by bringing our health care—

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

Mrs. Robin Martin: —facilities under one roof and integrated. I would think that would be something you would support. So is that something in Bill 60 that you feel you can support?

Ms. Michelle Robidoux: Integration, to my mind, to my understanding of what that means, is that there is some kind of conscious oversight of the apparatus. It's integrated; we see how it works together. The provisions in Bill 60 are not about providing oversight, and so I don't see how you can claim—

Mrs. Robin Martin: But in fact, they are. In fact, Bill 60—

Ms. Michelle Robidoux: By regulation by the cabinet after the legislation passes—that is not providing proper oversight. So I don't see how this misnomer of private clinics being called integrated, community-based, whatever—I think it's bafflegab.

Mrs. Robin Martin: Because they will be overseen by the director of Ontario Health through this process.

The Chair (Ms. Goldie Ghamari): Thank you very much. That's all the time we have. At this point, I would like to thank our presenters for joining us.

At this point, the committee is going to recess, and we will resume at 3 p.m.

The committee recessed from 0956 to 1500.

CONGRESS OF UNION RETIREES OF CANADA, HAMILTON, BURLINGTON AND OAKVILLE CHAPTER

THE NEIGHBOURHOOD GROUP COMMUNITY SERVICES

DR. VIK AGARWAL

The Chair (Ms. Goldie Ghamari): Welcome back. The Standing Committee on Social Policy will now come to order. This afternoon, we will resume public hearings on Bill 60, An Act to amend and enact various Acts with respect to the health system. As a reminder, witnesses have been scheduled into groups of three for each one-hour time slot. Each presenter will have seven minutes for their presentation. Following all three presentations, there will be 39 minutes of questioning for all three witnesses, divided into two rounds of seven and a half minutes for the government members, two rounds of seven and a half minutes for the official opposition members and two rounds of four and a half minutes for the independent member.

To ensure that everyone who speaks is heard and understood, it is important that all participants speak slowly and clearly. Please wait until I recognize you before starting to speak. For the virtual participants on Zoom, after I have recognized you, there may be a brief delay before your audio and video are ready. Please take a brief pause before you begin speaking. In order to ensure optimal sound quality, virtual participants are encouraged to use headphones or microphones if possible. As always, all comments should go through the Chair.

Are there any questions before we begin?

Mr. Malcolm Buchanan: Yes, I have a question, if I may. During our presentations, will we get a heads-up? Say, 30 seconds?

The Chair (Ms. Goldie Ghamari): Yes, we'll provide you with a one-minute—

Mr. Malcolm Buchanan: Okay, thanks.

The Chair (Ms. Goldie Ghamari): I will now call upon our first presenter, Congress of Union Retirees of Canada, Hamilton, Burlington and Oakville chapter. Welcome. As a reminder, each of you will have seven minutes for your presentations, followed by questions from the committee members. I will provide reminders of the time remaining during the presentations and questions.

Congress of Union Retirees of Canada, Hamilton, Burlington and Oakville chapter, please state your name for Hansard and then you may begin. You will have seven minutes.

Mr. Malcolm Buchanan: My name is Malcolm Buchanan, and I am the president of the Hamilton, Burlington and Oakville chapter of the Congress of Union Retirees. Health care is a major concern for seniors and retirees across Ontario. This is why we're here today before the standing committee. We are concerned about the media reports that Ontario's health care system is in crisis and the only solution is more privatization, such as public funding for private for-profit surgery clinics. We're also concerned that there has been no public consultations about the plan to privatize core public hospital services prior to the tabling of Bill 60 in the Ontario Legislature.

The present underfunding of health care has pushed public sector health care workers to burnout and early retirements, resulting in staffing shortages across the health care system. Bill 124 has also added to the problem in retaining nurses and other health care workers. This is directly linked to hospital and emergency room closures and skyrocketing wait times across the province.

The solution proposed by the government is more privatization. Privatization is not the answer. Funding taxpayers' dollars into private for-profit clinics will result in

further starving of funding to the public system. The primary obligation of for-profit clinics is their fiduciary responsibility to maximize shareholder value. This priority is clearly incompatible with the delivery of necessary health care services, where the first and overarching priority must be to ensure the health and well-being of patients.

To justify private for-profit surgery clinics, the government argues that public hospitals have a capacity problem—not enough operating rooms—therefore adding to the backlog of surgeries that urgently needs to be addressed. That is incorrect. There is plenty of capacity in hospital operating rooms. What the problem is, is a shortage of staff and funding.

I'd like to focus on two major issues. Rather than private surgery clinics, as proposed in Bill 60, there are better models of health care services that our government should embrace to help take the burden off public hospitals. First, the Ontario Medical Association has proposed its own plan calling for stand-alone but non-profit specialized surgical centres across Ontario to help ease the burden on public hospitals. Robert Bell, former Deputy Minister of Health for Ontario, proposes that the province expand the network of non-profit community surgery centres, which are specifically designed to handle high volumes of low-complexity operations, such as cataract surgery and knee and hip replacements. Community surgery centres are generally overseen by public administrators and have close links with local hospitals.

Under the Canada Health Act, patients are protected from extra billing and user fees. Such charges are banned, and all necessary hospital and physician services are covered by public medicare, OHIP. A patient cannot be charged for a needed surgery, no matter what facility performs it.

Some existing Ontario private for-profit clinics have violated the Canada Health Act by charging patients for unnecessary, uninsured medical treatments. The government has chosen not to fine them. Why? Will they in the future?

Bill 60 contains no reference in the establishment of a regulatory body to regulate private for-profit clinics. The government claims that there will be enhanced oversight for private clinics but does not specify what body would actually regulate them or do inspections.

In my written report, you will find a whole lot of other different arguments that support our contentions that Bill 60 is not required and should be withdrawn by the government. I will conclude my remarks by stating the following: HBO CURC urges the provincial government to willfully withdraw Bill 60, the Your Health Act, on the following grounds:

—increasing medical costs and worsening patient outcomes;

—the absence of regulations to meet safety, quality of care, inspections and reporting standards;

—poaching health care workers from public hospitals;

—only accepting patients who have no underlying medical conditions;

—cutting corners and putting shareholders' interests ahead of patients';

—delaying establishing a regulatory body to regulate for-profit surgical clinics or do inspections;

—being silent on details on how to enforce banning extra billing, upselling, or charging patients extra fees for unnecessary medical services;

—appointing a director who is not an employee of the Ministry of Health, who will have the power to create new private for-profit clinics and expand privatization to new classes of private clinics—total discretion;

—creating schedules that deregulate a range of health care staff, from physicians through nurses to health professionals, throughout the entire health care system. What are the unintended consequences of that action?

HBO CURC urges the provincial government to do the following:

—immediately invest the $7.5 billion into the public health care system that the Financial Accountability Officer has identified as being unspent;

—fund more non-profit community health care service clinics, which have proven to be cost-effective and are able to provide medical treatment and diagnostic services;

—implement the Ontario Medical Association's proposal to establish—

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

Mr. Malcolm Buchanan: —stand-alone, non-profit, specialized surgical facilities across the province;

—educate and train more doctors, nurses, nurse practitioners and personal support workers;

—fast-track professionals with foreign training to work in Ontario;

—improve coordination of regional hospitals so that unused operating rooms can be used for surgeries to help remove the surgical backlogs from other hospitals in the area;

—revoke the appeal to Bill 124 and commence fair and open negotiations with public sector employees;

—use its authority under the Canada Health Act to impose financial penalties on private for-profit medical clinics that are guilty of charging extra billing and charging fees for unnecessary medical treatments; and finally

—work with the federal government to establish long-term solutions.

One solution in Nova Scotia was announced today to keep nurses: $10,000 in the first year; $10,000 extra in the second year; $5,000 first year for other health care professionals; another $5,000—

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

I now would like to turn to The Neighbourhood Group Community Services. Please state your name for the record, and then you may begin. You will have seven minutes.

Mr. Morris Beckford: Thank you, Chair, Vice-Chair and committee members. My name is Morris Beckford, and I am the vice president of EDI and poverty reduction for The Neighbourhood Group Community Services.

The Neighbourhood Group is a social service agency which provides vital services to more than 40,000 low-income people in over 32 locations in the city of Toronto. We have more than 1,000 staff and 600 volunteers, and we

provide homelessness services, housing, newcomer services, youth services, employment and training, senior services, conflict resolution and training, child care and trustee services. Our mission is to work with people at every stage of their lives, provide access to innovative and effective programs, and collaboratively build and advocate for an equitable, just and vibrant society.

In 2021, my appendix ruptured. It was perhaps the most amazing pain I've ever felt in my entire life. That pain forced me to call an ambulance, which took me to Mississauga General. I went in on Thursday, had major surgery and was out on Monday, good as new.

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Research shows that I could have walked out of the hospital with a $45,000 bill, but thanks to a public, accessible health care system funded by taxpayers from across the country, I paid a mere $42. That is still far too much for many people. While I think I now have access to more resources than the average Canadian, a $45,000 bill would have caused me considerable mental and financial stress. I have always been a supporter of public health care, but my ruptured appendix drove home the need to not just support but fight to protect public health care in this country and in this province.

The Ford government's latest push to drill deeper into public health care—this time, right through the heart of our public hospitals—and embed what I would call a privatization bomb at the heart of our system is dangerous. The government's failure to learn from the disaster that is privatized home care amounts to willful blindness.

While I understand that privatization has always been in our system in some capacity, I suppose an argument could be made that people should have the freedom to use their money for whatever health care—and wherever they can access health care—that they want. I would argue, however, that deeper privatization is not only short-sighted, but it is contrary to the social contract for which Canada has come to be known. Bill 60 will put us on a path to deeper inequity, because continued privatization only cares about folks who are able to afford to get heath care anywhere.

I'm also a professor at Humber College. I asked my students what they would want me to share with you when I come here. A couple of them wrote back:

Brook wanted me to share that there are significant health inequities that already exist for racialized people. Privatization will do nothing about that.

Alessandra said that her brother had a 12% chance of survival when he went into surgery. He survived, but he now has to pay for medication, which is usually costly. Privatization will do nothing about that.

Trey wants to know why the government is stretching the already thin funding to facilitate these private companies and would rather you invest that funding in the current system to enhance it.

A publicly accessible health care system is a key part of ensuring that we prevent the province from plunging more people into deep poverty and eating up the resources for people like me, trying to stay in the middle class. We already have a hard enough time fighting poverty and helping people keep more of their wages. Deepening privatization further threatens our public system, which threatens those living in the middle class and those barely escaping deep poverty.

We call on the government to listen to reason and good sense, stop this bill and focus on innovation within the public health care system, not outside of it.

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

Dr. Vik Agarwal: Thank you very much for having me today. My name is Vik Agarwal. I am a diagnostic and interventional radiologist. I currently practice in York region at the Cortellucci Vaughan Hospital, Mackenzie Health hospital system and the Southlake Regional Health Centre.

I'm a member of a group of 27 radiologists that also operates an IHF facility in York region called X-Ray Associates. We've been servicing York region for 50 years.

Personally, I'm a family doctor as well as a radiologist. I have seven years of postgraduate training after medical school. I've worked all over the province as a family doctor, emergency physician and radiologist, from Niagara to Peel region, Scarborough, northern Ontario, Thunder Bay and now York region. I'm a board member of the Ontario Association of Radiologists, and I've had numerous leadership positions over my medical career.

I come to you today in support of Bill 60 as it applies to diagnostic imaging and moving CT and MRI from our public hospitals into outpatient centres. I believe that this proposal, if implemented correctly, will decrease our waitlists, increase access to these important medical examinations and alleviate the bottleneck that has been crippling our health care system.

Just a little bit of background: MRI and CT scans, when they're ordered by your physicians, should be completed within 28 days. What we see in Ontario is that these scans are completed between three months and 12 months later. Specifically in York region, our data indicates it's 100 days. Think about that: You have your scan ordered and you wait 100 days. The delay in these scans leads to a delay in diagnosis, significant anxiety and, I'll tell you as a practising physician, worsened outcomes. I'm an interventional radiologist. I do procedures on some of the sickest patients, and I can tell you plainly that people are suffering because of the wait times. We see disease that has progressed far further than it should have.

Frankly, our hospitals just do not have enough scanners. This is despite the 27 new MRIs that were announced by the Ford government, which we commend the government for doing; that will go a long way, especially—a lot of those scanners are going to be set up in northern Ontario, so they will go a long way to helping, but it's not enough. In 2019, the Ontario Association of Radiologists called on the government to have an extra 100 MRI and CT scanners, and that was pre-pandemic, so the situation has only worsened.

The main thing that I actually want to get across today is that we all know that there have been wait times and we

need more scanners. The Ontario Association of Radiologists and myself personally believe that these should be 100% funded by OHIP. Again, this is "OHIP card, not credit card." We strongly believe that everything should be publicly funded, and that we should go one step further and say that private and non-medically indicated services such as whole-body MRI and all these things that you're going to see on the Internet should be banned in Ontario. I think that should be folded into this legislation.

One of the other more important parts of this legislation and what the government is proposing—and it's also in line with what the Ontario Hospital Association is proposing—is that there be a strong partnership between the hospital system and the radiologists who end up managing these clinics. Really, it should be the radiologists who work in the hospitals who are the ones who are doing the scans outside of hospital. The goal is really to have the same experience outside the hospital and inside the hospital. I can say that in York region, we've been reading the scans for 30 to 40 years—the CTs and MRIs—and we really believe that we've provided a high level of care and that we should be the ones to do the scans in the outpatient setting.

Additionally, one of the most important things that we need to do with these new clinics, if they're approved, is to make sure that they're physician-owned, specifically radiologist-owned. If you look at what Quebec has done, they have a policy in place that ensures that at least 51% of the clinic is owned by a radiologist, and that's also what you see across the country. The reason to do this is that what happens is that if you have non-physician owners, they're going to poach health care workers from the hospital because their interest is not necessarily the hospital. Myself, my interest is the hospital. That's where I work, so I want to have a situation where we protect our hospitals but still are able to service these patients.

One of the other things I'll say is that CT and MRI are amongst the most technically complex procedures in medicine, and the people who perform the scans, our technologists, and the people who interpret the scans have years of training. We've been doing this for years in Ontario, and to open this up to other people to actually acquire the imaging or perform the scans I think puts patients at risk. So we're very supportive of the current position that the government has to have the hospitals strongly directing this process.

We would also strongly recommend that anyone who applies for one of these clinics has a comprehensive plan to address human health care resources. I think it's critically important to make sure that we enhance the number of technologists in our system, and I think that this legislation is an opportunity for us to actually grow the number of workers in our system.

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

Dr. Vik Agarwal: Thank you. The last thing I'll say is that we need to make sure that we fund this in a sustainable way. One of the things that often happens in Ontario health care is that we announce a new project, it has some funding for a short period of time and then the program starts to languish because it's not supported. We should look at this as a long-term solution to this problem, funded appropriately, funded correctly so that it's sustainable. What I would suggest is following the Quebec model, where there is a certain amount of money that's set aside to renew equipment and to buy new equipment, to make sure that we're able to provide the best quality care for Ontarians.

In summary, I'll say that the Ontario Association of Radiologists strongly supports the current Bill 60 that's being proposed and we applaud the government for its innovative approach to solving a very complex problem. Thank you for your time.

The Chair (Ms. Goldie Ghamari): Thank you very much. That concludes our time. We'll now turn to the first round of questions, beginning with the independent member for four and a half minutes. You may begin.

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Mr. Adil Shamji: Thank you to all three of you. Dr. Agarwal, I wonder if I can start with you first. I do want to recognize your service in and around Toronto and throughout Ontario as a family doc, emerg doc and as a radiologist. Thank you very much for that.

You mentioned the importance of a plan for health human resources and preventing the siphoning of resources out of our public institutions. In your opinion, what should a plan like that include?

Dr. Vik Agarwal: Dr. Shamji, thank you for your service as well, and thank you for representing physicians at the provincial level. We really appreciate that.

I think that one of the things you'll see with—I'm going to specifically limit my discussion to medical imaging. A lot of the technologists in our hospitals aren't actually getting enough hours in terms of how much they want to work, and so part of it would be to work with the local hospital. Assuming that the local radiologists are the ones who are running these clinics, to partner with the hospitals to say, "Hey, let's optimally take our pool of workers and make sure that everyone is getting as much work as they desire"—so that would be part of it.

Additionally, one of the initiatives that the Ontario Association of Radiologists has been working on with Mohawk College is to increase the number of training spots for MRI technologists, and if you have new clinics, that's new places for these technologists to train. I can say specifically in York region, at our hospitals, the lead technologists in MRI and CT are quite keen to train more people. I agree with—I believe Morris was talking about—or, sorry, I'm not sure if it was Morris, but one of the gentlemen to my right was talking about fast-tracking people with credentials from other countries, so if they meet our requirements, definitely bringing them into the fold. And then also, there are a lot of people who are retired who would like to work more—really looking at our seniors as a potential way to solve some of these health care crises that we have by bringing them in with their experience.

Mr. Adil Shamji: Thank you very much. You were also alluding to the importance of ensuring that the individuals who are performing the technical scans—that we

be careful about expanding who is able to perform those scans, the MRIs and the CT scans. May I ask you just to elaborate on that a little bit?

Dr. Vik Agarwal: Yes, sorry. I guess what I was saying is that I'm a doctor. My interest is in treating patients. I'm not a businessperson. I look at spreadsheets when my accountant shows me a spreadsheet. I'm not a slave to a line on a spreadsheet, whereas people I know in business, they're very concerned about their shareholders and what they're paying out. So what I would say is that if you have people owning these clinics who aren't physicians, we open ourselves up to risk.

Mr. Adil Shamji: Fair enough. And then you presented a balanced argument in favour of moving some diagnostic services outside of the hospital, and I think in the right setting, it can have merit. What are some of the guardrails that you would be looking for to ensure that this protects patient safety?

Dr. Vik Agarwal: So one of the guardrails I spoke about is ensuring that it's 100% based on your OHIP card, so no private scans, no whole-body MRIs, none of that sort of stuff. And really, the main thing is to partner with the hospitals, because—

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

Dr. Vik Agarwal: —if you have the hospital wait-lists, for example, and you take one wait-list and you work off that in partnership with the hospital, then you can do a lot of really creative things to increase our throughput. For example, a lot of times, patients come to the emergency room and they need an MRI. We can't do it urgently, but if you had an outpatient clinic which reserves slots for these patients, now you're moving patients through the emergency room faster. A lot of times, pediatric patients have trouble with getting MRIs. You could, again, reserve slots for some of the patients that aren't that sick but are still unwell. So there are a lot of different things that we could do to increase efficiency with this sort of proposal.

Sorry, I don't think I answered your question. I veered off.

Mr. Adil Shamji: No, I think that was fair enough.

One of the concerns that has been expressed around this bill, and this is in the spirit of finding ways in order to hopefully improve this bill, is—

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

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

Mrs. Daisy Wai: Thank you to all the presenters. I would like to also have some questions to Mr. Agarwal. First of all, I appreciate that you realize and support why we're doing this in our bill. I just also want to say that you realize that we cannot stand and hold off not treating the people that need MRI or CT scans. You picked on the point where we also find it very alarming that people have that long wait time, because life is at stake. You highlight mostly MRI and CT scans. However, there are other surgeries, like cataract and all those minor surgeries, that could have been done separately and then ease off on the hospitals so that they can take care of the more serious surgeries.

I can see you understand why we are doing that. I just have two things I want to point out. First of all, we are not privatizing what we are doing outside of hospitals at all. Some of them are non-profit clinics; some of them are clinics, but we are dealing with them as an entity that supports us with the extra work that we have as a backlog.

I think even the minister also said that we are expecting this to be an ongoing trend, mainly because we can see the ageism. I also am from York region. Especially in York region, we have a lot of seniors. It's not just York region; overall, the population of seniors is growing. Ontario is growing: We are taking a lot more immigrants, as directed by the federal government. So we can see this is the trend as well. That's why it is important that we have this bill and it is important we set this properly.

I just wanted to clarify that (a) this is not privatization, and (b) we do not just work with private business owners. We work with non-profit organizations as well, as long as they can deliver.

The one thing that I would like to question is: You suggested that we should use more of the specialists or the radiologists that are from the hospital only. I can see the point, but do we have all of them associated with clinics, and do they have the time and hours to support what we need?

Dr. Vik Agarwal: The majority of cross-sectional imaging, MRI and CT, is being read by hospital-based radiologists. We provide a very high level of service in Ontario, and I think that this is too important to mess up. We've been doing it well. I would say: Let the hospital-affiliated doctors and hospitals drive this process. It will be successful in our hands.

Mrs. Daisy Wai: Yes, I can understand the important part of it. But do we have enough of those radiologists or specialists already linked up or owning or signed up with the clinics that—

Dr. Vik Agarwal: Yes. Yes, we do. We have enough. There's 1,000 radiologists in the province, and we believe that we can handle this challenge. If we're consulted and the legislation is prepared in the appropriate manner, we can be successful and we can get the wait times down to where they should be.

Mrs. Daisy Wai: That would be great. But I also understand that the ministry will be going through a very lengthy review to make sure that the clinics, whether they are from the hospital specialists or not, are up to providing the service.

I thank you for your information there, and we will work towards that. Thank you.

The Chair (Ms. Goldie Ghamari): MPP Pierre, you had a question?

Ms. Natalie Pierre: Thank you to today's presenters. My question is for Dr. Agarwal. Thank you for acknowledging the 27 new MRI machines; it was actually 49.

Dr. Vik Agarwal: Oh, I'm sorry. Again, I'm not the best with numbers.

Ms. Natalie Pierre: All good.

So I guess my question for you as an interventional radiologist: Can you tell us how access to additional MRI

and CT scanners in community-based radiology clinics will impact patient outcomes?

1530

Dr. Vik Agarwal: I spoke earlier about the bottleneck. Everyone knows someone who is waiting for diagnostic imaging. This is a fact. It's a sad fact in Ontario and in Canada, but it is a fact. If we are able to diagnose diseases earlier, patients will do better. It's not just their outcomes, but we're going to save the system money and we're going to decrease patient anxiety.

I used to do a lot of breast imaging, and I would tell you, the amount of anxiety that exists when you read a mammogram and you call someone—we read mammograms, and say we're suspicious of something: The way that breast imaging is set up is that we have to be ultra-careful, so the majority of the time, when we're calling women back, it's for something that's benign, but women don't know that.

I've seen this in my own family members. I've seen this in my relatives. I've seen this in my patients. There's a lot of anxiety. And now if you're waiting a week, two weeks, for your next test, that's a terrible two weeks. We just don't need to have that. We're one of the richest countries in the world, and we can do better.

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

Dr. Vik Agarwal: We really can do better. And so, if we detect these diseases earlier, then our patients will do better overall. If you partner outpatient and hospital, we can create centres of excellence within our hospitals and do the required outpatient scans, but really do advanced things like prostate MRI, cardiac MRI, breast MRI. We can really get those things done in hospital in a good, efficient way.

What we're doing right now is we're trying to do two or three different things at the same time, and so we're less efficient in hospital. If we were given the ability to optimize our system, we would be able to achieve the goals that the ministry has and our own goals as physicians.

The Chair (Ms. Goldie Ghamari): There's 15 seconds left. All right, we'll save it for the next round.

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

M^me^ France Gélinas: I'd like to thank all three presenters. I just want to make a quick comment to Dr. Agarwal—sorry for the pronunciation. What you're putting forward, we don't need a change of law to do. It's already under the independent health facilities; you could create the model you're putting forward. Bill 60 exists for one reason: It's for private for-profit, investor-owned corporations to be able to fund and own. The model you're putting forward could happen right now; the reason for Bill 60 is for private for-profit, investor-owned corporations to put in the millions of dollars needed to build the MRIs, build the CTs and have them installed.

My first question will go to Mr. Buchanan. From what you've shared with us, you see a lot of risk in having the private for-profit, investor-owned corporations building those surgical suites. This is something we don't have right now. We have 900 of those independent health facilities. Most of them are X-rays, and we do have 10 that do surgeries—that's it, that's all. We don't have hundreds; we have 10 that do. Of the ones that are there, there is a copious body of evidence that all of them upsell and all of them end up charging to their patients.

What do you figure that will do to the people you represent, if going to an outpatient surgical clinic, you will get there faster, you will have a set date that will be honoured, but you will also have all sorts of add-ons that you have to pay? Because this is the experience in Ontario so far.

Mr. Malcolm Buchanan: Thank you for your question. This is one of the major concerns of my membership, who are all retirees. Many of them are in their seventies, eighties and even nineties, and they're very concerned about this, because they are on fixed incomes. There's no way in heaven-knows-what that they're going to be able to pay for a private type of care.

I have a friend of mine who went to a private clinic for a hernia operation not so long ago, and yes, the actual operation was covered by OHIP, but part of the deal was that they had to stay in this facility for two or three days after the operation, which he had to pay for, plus meals he had to pay for and a number of other things. Medications that he may have needed, he had to pay for. That was quite a chunk of money, and that was just for a hernia operation. If you go to a public hospital, you're usually out within one day and you've got your medications and that's fine—no cost. So this is one of the concerns—just a real life experience of one of my members.

Another one of my colleagues was in hospital for an unrelated ailment which they couldn't diagnose right away. They sent him home, called him back the next day after he had an MRI and another test to say, "There's just showing up something. You've got to come back here and we've got to have an operation." So that sort of addresses some of the questions about the diagnostics and other things. If they've got those facilities in a hospital or very close to a hospital, it works very well. They've got to be in a partnership with the hospital, not a free agency out here. You've got to have controls and balances.

I'm originally from New Zealand. They used to have a health care system, cradle to grave, all paid for by the state. Then they went to privatization—this type of model. It turned out to be a disaster. It turned into an absolute disaster. So my family, who have now aged in New Zealand, have what is called a second tier of health care, which is what they call the poor persons' health care. That's the common name they call it now. The others, who are younger folks, have got coverage and health care plans and other types of insurance policies. Really, it becomes very discriminatory, and this is what really is the impact. We've got to put this in human dimensions, not the bottom line of the budget of some corporation. I'm sorry; health care is a national need and a necessity, and it should be public.

M^me^ France Gélinas: Agreed. Medicare should be based on needs, not on your ability to pay.

To you, Mr. Beckford, you talk about the people that you're trying to help, mainly people who live in poverty. What do you figure are the chances that a private for-profit, investor-owned corporation builds a surgical suite

in a poor neighbourhood focusing on Black, racialized, Indigenous people, people of colour, street people? What do you figure the chances are of that? The needs are great, but what do you figure the chances are?

Mr. Morris Beckford: If there's a lot of pollution, we will get it, right? That's the only way that we would get a nice suite for the people that I work with. We work with multi-marginalized folks. These are folks who, if they go to one of these entities, the upselling will be significant—pretty much guarantee that. These are folks who aren't going to be empowered to say no. I am very empowered to say no. I understand how to say no. It's a lot easier for me because I've got the resources to say no. The folks that we serve will not be able to.

There are two things that I wanted to call our attention to that I didn't really mention. The Ontario Health Coalition says that in Bill 60, "there is no legislated protection against for-profit privatization." And the Auditor General says that the ministry and Ontario Health do not have "oversight procedures and systems in place to monitor" right now, and the government has full control of our system right now. So if the government can't do that in a system that it—

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

Mr. Morris Beckford: —fully controls, how is it going to do that in a private system with corporations?

M^me^ France Gélinas: I agree.

To you, Doctor—sorry about the pronunciation of your name. You made it clear that you wanted 51% owned by physicians. I understand that physicians have a relationship with their patients that could help, but this is not in the bill. What will happen when a private for-profit, investor-owned corporation owns the models that you put forward, not 51% owned by radiologists?

Dr. Vik Agarwal: Yes, so that's a good point. I said a minimum of 51%. If you ask me what I would ask for, I would say it should be 100% owned by physicians, because when it's physician-owned, then it's regulated by the College of Physicians and Surgeons. Then you have oversight, you have regulation. And that's what you really need because, again, it's just too important to do incorrectly, and it's in need, this service.

To your point about the need for Bill 60, Bill 60 modernizes the current law. It allows for innovation and it allows for flexibility—

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

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

Mr. Adil Shamji: Mr. Buchanan, thank you very much for your testimony today. You expressed a concern regarding conflict of interest. This bill forbids the public from knowing any information about licence applicants, as well as doing away with the 30-day notice for licences being issued. Is there any reason, in your opinion, that a government might not want this information to be known? And why is it important for people like yourselves and the people you represent to have this information?

1540

Mr. Malcolm Buchanan: That's a very good question. I appreciate you asking it.

One of the concerns: When a company or a corporation wants to open up a facility, I think the public should have a right to know what the history of those individuals is. If it's some type of medical facility, what experience have they got in this? Do they have a record of this? What have their past practices been? Under this legislation, as I read it, under that schedule 1—that's where it's clearly stated—when they put those applications out, there is no record or no requirement that the public can actually have an input into applying and to challenge those licences. It's so wide; it's amorphous, almost.

The other thing is the director or directors or a corporation—the way in which I'm reading the legislation, it says that person or corporation can operate and open, provide licences, do this and do—total discretion. There's no control. The person is not an employee of the Ministry of Health. The whole thing is like—I equate it to putting the fox in the henhouse. They're running this thing. It is totally irresponsible, financially as well as morally.

So those are just some of the quick questions, is that this whole thing is going to be done under the radar, if allowed. If the public doesn't know what their background and so on and so forth is, the qualifications and everything else in this, I think we're buying a pig in a poke, quite frankly. It's dangerous.

Mr. Adil Shamji: In many cases, Bill 60 says that some of the questions you're posing will be answered in the regulations. Is that satisfactory?

Mr. Malcolm Buchanan: Yes—if they ever get written. The experience that I've had in dealing with legislation in my previous life as the general secretary of the Ontario Secondary School Teachers' Federation—I've had to deal with governments and regulations for years and years in my former life. They promise all of these things in regulation, but we see them, maybe, after the fact. We were never consulted on them. And now, of course, it's the classic case that you have all the regulations in play, but they're never enforced.

Look at the long-term-care home situation in this province under COVID. In the recent case in Dundas, in the Hamilton area, they've broken every rule in the book. It's been condemned as a long-term-care home because the government did not impose the regulations for safety and the well-being of those patients.

Sorry, it's very frustrating. I can see the writing on the wall. This thing is going to be a mess. It's not going to serve the interests of my members. I don't think for many people in this province—maybe people with a good credit card and a good credit—

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

Mr. Malcolm Buchanan: —that will be great.

Mr. Adil Shamji: Thank you, Mr. Buchanan.

Mr. Beckford, if I may: There are already, as you mentioned, significant inequalities across our health care system. I certainly have heard from many people and share

this concern that Bill 60 may exacerbate some of these inequalities. In your opinion, is there a way that Bill 60 can be amended to address some of the potential inequalities?

Mr. Morris Beckford: No. It's not innovative. Privatization isn't innovation. I think people like to think that privatization is innovation. We know that innovation helps to drive down poverty. We know that. The research is pretty clear on that. But if you're only looking at giving businesses more money as the way of your innovation, that seems pretty short-sighted to me. There is no reason—I keep asking this question of everybody who supports—including you; we've had this conversation a while ago—this idea of the increase in business or business peripheral into public health care—

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

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

Mrs. Robin Martin: Thank you again to all the presenters. I just wanted to start with Malcolm Buchanan. You mentioned that the OMA has proposed stand-alone, not-for-profit clinics and Bob Bell had proposed not-for-profit community clinics. From what you said, I understood that you're okay with what they proposed, which included putting low-complexity or low-acuity operations outside of the hospital proper. Is that correct?

Mr. Malcolm Buchanan: Yes. Non-profit, though.

Mrs. Robin Martin: Thank you.

Moving on: Dr. Agarwal, you operate a clinic with 27 other radiologists. Is that correct?

Dr. Vik Agarwal: Yes. We have four locations in York region.

Mrs. Robin Martin: Is it run through a corporation?

Dr. Vik Agarwal: Yes.

Mrs. Robin Martin: So it's a corporation that runs the clinics. And what's the name of the corporation?

Dr. Vik Agarwal: We practise under the name X-Ray Associates. Maybe we might have to change the name, if we get CT and MRI.

Mrs. Robin Martin: I see. Okay, yes—I was a little slow on the uptake there, but yes, okay, I can see that.

So it is a corporation, but it happens to have radiologists who are regulated by the CPSO.

Dr. Vik Agarwal: Correct.

Mrs. Robin Martin: Every radiologist who works in the province of Ontario is regulated by the CPSO. Is that not correct?

Dr. Vik Agarwal: Absolutely.

Mrs. Robin Martin: Okay. So that kind of oversight is available, wherever doctors who are regulated by the CPSO are working, whether it's in a public hospital or a clinic run by someone like yourself, including a clinic run by a corporation.

Dr. Vik Agarwal: Yes. The one thing I would say, though, is that when you have business owners and non-physicians owning some of these facilities, they're not subject to the college. So they may be pushing practices that are not in line with what the college or with what physicians would want to do. And—

Mrs. Robin Martin: Right. But our physicians obviously, in order to keep their licences, will be sure that they comply with the regulations of the college—

Dr. Vik Agarwal: Yes, but—

Mrs. Robin Martin: Otherwise, they could lose their licence to practise.

Dr. Vik Agarwal: For sure. But to speak to medical imaging, one example—I was speaking about sustained funding. Let's say you have the business owners, the non-physicians owning these clinics; they may not be keen to make the capital investments to buy new MRIs because they're looking at a spreadsheet, whereas we would be looking at the patient and what the best technology requires.

Mrs. Robin Martin: Right. Thank you for that, Dr. Agarwal. Actually, the government is also looking at what's best for patients, which is why we want to, as you said, improve—

Dr. Vik Agarwal: Absolutely. I'm only here to—

Mrs. Robin Martin: —patient access, because these delays in diagnoses lead to anxiety—which I can personally attest to, waiting for scans—and, frankly, worse outcomes for patients, which we cannot allow in our system.

This whole legislation, by the way, is 100% OHIP-funded.

Dr. Vik Agarwal: Absolutely.

Mrs. Robin Martin: All the procedures are 100% OHIP-funded, and they will be provided up to the standards and have oversight.

Contrary to what the member from Nickel Belt had said earlier, part of this legislation is actually improving our relationship with other parts of our health care system which have—up until this point, 900 exist, and I guess you have four of them—independent health facilities. Through this legislation, we're making them integrated community surgical centres. Our government looks at this as a way to improve our system.

It's also in line with our Ontario health team model, because we want to have an integrated system where all parts of the system are working together. If we left it the way it was, as the member from Nickel Belt seems to want us to do, we would have continued independent health facilities as opposed to integrated health facilities.

Part of what the government is conceiving is something you mentioned, which is the strong partnership—

Dr. Vik Agarwal: That's right.

Mrs. Robin Martin: —between all the parts of our health care system, including, in your case, hospitals and radiologists who do the scans, or in the other clinics, surgeons who are doing colonoscopies, endoscopies, cataract surgeries and, eventually, perhaps hip and knee surgeries, as we get to a year or so down the road. Do you see this integration as an improvement?

Dr. Vik Agarwal: Absolutely. I spoke about hospital radiologist continuity and working together, but the other side of this is, in the event that there are radiologist-run outpatient MRI and CT clinics, that's where you also would engage the family physicians in the community, the nursing homes, everyone else in the community, and making sure that appropriate imaging is ordered.

One of the problems we have is over-utilization. That over-utilization happens because sometimes people don't understand the appropriate time to order certain tests. By increasing the number of scans that are available, part of the responsibility of the people running these clinics is to make sure that only the best and most appropriate scans are being done.

Again, I keep harping on the same point about physicians being involved in this process, because we're the ones who are the gatekeepers and we're the ones who have been doing a good job of doing that. If that gets undermined, then you open yourself up to risk.

1550

Mrs. Robin Martin: Another part of what the government is trying to do through this legislation is to allow for—and the minister testified to this when she was here—assessments of where need exists so that we can make sure that we're establishing the resources where there is need. Not every community has a hospital, but yet, people need treatment everywhere and diagnoses everywhere. So part of what we're trying to do is to enable closer-to-home access through some of these clinics for some of the low-acuity surgeries, which even the OMA and Bob Bell have said is a good idea to move out of hospitals. Do you agree with that geographic distribution?

Dr. Vik Agarwal: Absolutely. I think the government has already moved quite strongly—

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

Dr. Vik Agarwal: —with the 49 new MRI scanners that are predominantly outside the GTA in smaller communities. I think that's going to go a long way. This is another opportunity for physician organizations like mine, the Ontario Association of Radiologists, to work with government and the ministry to figure out where to put these things so that you have access for people who are marginalized. I would advocate for some of these clinics to be in areas which have large Indigenous populations, as well.

There's a lot of opportunity here with Bill 60 to innovate and to try to fix the system.

Mrs. Robin Martin: Right. Well, we need to work with our Indigenous partners to do that, to establish them, because we want to make sure we are culturally sensitive. But I do think that's a possibility, as well.

To address the point made from the Neighbourhood Group, it's really about putting access to treatment where people need it. Nothing in Bill 60 decides who should provide the services and nothing in Bill 60 talks about privatizing anything. That's one of the potential—

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

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

Mrs. Lisa Gretzky: I'm just going to address what MPP Martin had just said about doing what's best for patients. If that was actually the case, you would have consulted with the workers. We heard time and time again yesterday that the workers within the health care system have not been consulted on Bill 60.

When you talk about Indigenous peoples, we had two different organizations here yesterday who said they were not consulted on Bill 60 and, in fact, do not support Bill 60.

I'm going to ask Mr. Beckford a question, to build on what he has said. We know that in the US, which is the direction this government is going with our health care system, 45 million people every year declare bankruptcy because of medical costs—45 million people. You had talked about how the profitization—it's not just about privatization, it's about profitization, and I cannot say that clearly enough—of health care and how that impacts marginalized people in our society, racialized people.

We heard from the Indigenous presenters yesterday about a woman in St. Catharines who went in in a lot of pain and was sent home and came back to the emerg and ended up dying from an infection because she wasn't treated. We heard of another Indigenous elder who had diabetes and went in for treatment into the emerg and there was a picture of an alcohol bottle with a circle and a cross through it, implying that he should just stop drinking rather than looking at his actual health conditions. And we know that that's not just the Indigenous community. We know because of data that it also happens to Black and Brown members of society, especially young men.

And so, I'm wondering if you could explain—or if you feel, maybe explain to the government that by profitizing health care and driving public dollars and resources into the profits of shareholders, into private for-profit organizations that really have no reporting or no accountability for instances like that, how is that actually going to support racialized or marginalized people, or people living in poverty, those experiencing homelessness? Do you think that what the government is doing is actually going to create a system that's going to reduce barriers to care, as opposed to create more barriers?

Mr. Morris Beckford: Well, no, that's why we're here opposing the bill. Listen, we're not—just to put it on the record here—opposed to making sure that we drive down the wait-list. We want to drive down the wait-list. I wouldn't want to wait for an appendix surgery or any kind of surgery. When I took my mother to the hospital, we wouldn't want her to wait. However, I'm also from a country that originally did not have public health care and I have seen where families had to make a decision between spending for rent and spending for their health care. Our concern is that this bill will drive us down that road. That is our main concern. The people that we serve—homeless folks and even folks who are in the middle class—are going to suffer considerably if we continue to go down that road.

As I said at the top of this, we're not delusional. We're a very large organization that understands public health care. We understand that there's always been a section of privatization in it there. We get that. However, we know from examples that if we privatize—we've seen that in home care—it will be disastrous for the most marginalized people that we serve. That's why we're here opposing the bill.

We can innovate within public health care. It is possible. And if a government can't innovate within a system that it controls, then I am very concerned. Our organization is very concerned that it's going to innovate within a system that it cannot control.

Mrs. Lisa Gretzky: And we share those concerns on this side.

I know my colleague from Niagara Falls has a question, but I just want to say something, because, Mr. Beckford, I think it was you who had said it—it might have been Mr. Buchanan—about how privatization is not innovation. I could not agree more. Privatization is the oldest game around. I said it in the House during a debate once that it was only about a decade before I was born that Tommy Douglas helped usher in universal single-payer health care, medicare. So this is not going forward; what this government is doing is going backwards. It is the oldest game in town, to profitize.

My colleague from Niagara Falls has a question.

Mr. Wayne Gates: First of all, I'm going to say this is all about privatization, make no mistake about it. And if the colleague really wanted to say that we want to make sure that our MRIs are being taken care of, we would never have had Bill 124, which really caused the problems on wait times. We would have made sure that in my riding of Niagara, we didn't have to fight and put motions forward to this government to try to get more funding so we could operate our MRIs around the clock, seven days a week, to get rid of the wait-list. None of that happened. We had to go out into the community and fundraise just to get the machines to put into the hospital, and then we didn't have the staff because the government wouldn't provide the money to operate those MRIs.

I want to say also to you, sir, I appreciate the fact that you were doing MRIs when it came to prostate cancer. Just a week ago, this government turned down my motion to have the prostate cancer PSA testing paid for by OHIP. They turned it down. And do you know what's going to happen today? Five men are going to die today—five are going to die with prostate cancer.

I will say to my colleague, when we're talking about seniors, you're probably aware that 5,400 seniors died of COVID, and 78% of them died in a private system—a private system. Why would we ever want to go to a system where we're going to privatize our health care? It doesn't make sense.

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

Mr. Wayne Gates: Thank you.

Canada is the envy of the world because we have a publicly funded, publicly delivered health care system. Why would we ever want a model like the one in the States? As my colleague said, 45 million people claim bankruptcy every year in the United States.

This afternoon, to show what this government is about, they're going to come with a motion to talk about Seniors Month. Do you know what's going on with our seniors today? We're living in poverty; we're dying in our long-term-care facilities. We can't find rentals for our seniors. Our seniors can't afford to pay for their medication. Our seniors can't afford the rent in their homes. That's what's going on in the province of Ontario. Do you think this is going to make it better for us if we're going to now have to start taking it out of our wallets to pay for health care? It makes absolutely no sense what this government is doing with Bill 60.

No disrespect to you, sir, because I respect radiologists; I've had lots of them take care of me over the years. But I think you're wrong. Bill 60 is not going to fix our health care system. Bill 60 is not going to take care of this gentleman's marginalized people, workers of colour, Indigenous people, and it's certainly not going to protect our seniors who are going through terrible, terrible situations when it comes to their communities. I see it—

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

I'd like to thank our presenters for joining us. You may now be released.

DR. ANDY SMITH
TORONTO AREA INTERFAITH COUNCIL
MS. FALINE BOBIER

The Chair (Ms. Goldie Ghamari): We'll now turn to our next group of presenters. Please come forward and sit at the front. Do we have anyone on Zoom?

1600

Interjection.

The Chair (Ms. Goldie Ghamari): Okay. It's all in person.

Our first presenter is Andy Smith. Andy Smith, please state your name for the record, and then you may begin. You will have seven minutes. Thank you.

Dr. Andy Smith: Good afternoon, everybody. My name is Dr. Andy Smith. I appreciate the opportunity to comment on Bill 60, the Your Health Act, from my perspective as an Ontario health care leader. I've been a doctor for 33 years. I worked as a surgeon in Toronto and New York, including 14 years as a cancer surgeon at Sunnybrook, before becoming a hospital executive 10 years ago. For the last nearly six years, I've served as CEO at Sunnybrook.

We have great health care professionals and teams in Ontario. Many examples of world-class care can be found in the organization which I'm privileged to serve at, in our Ontario Hospital Association partner organizations, and in other health care partner organizations across Ontario—

The Chair (Ms. Goldie Ghamari): Sorry to interrupt. We'll pause the time here.

I'd just like to ask everyone: If you want to have a conversation, please have it outside of the room. I am having difficulty hearing the presenters. Thank you.

Please continue. Sorry for the interruption.

Dr. Andy Smith: I am very proud of the work our teams do and the care that they provide. At the same time, I, like all Ontarians, acknowledge that we are under incredible pressure and are falling short in delivering care in our health system. We are slipping in providing access to care for patients and our capacity to deliver that care.

In Bill 60, the government is taking action to address core areas where we in the hospital sector have expressed concern about service capacity. The legislation lays out a multi-pronged, pragmatic approach. From my perspective, the Your Health Act provides us direction, support and opportunity to innovate with partners to provide better results.

All of the pillars of Bill 60 impact my team at Sunnybrook and our many partners across Ontario's hospitals and in the community. There are three areas that I will address in my remarks: enhancing surgical capacity, enhancing mental health and addictions capacity, and building and sustaining our people and our teams.

With regard to surgery and imaging capacity: We need to improve access to surgical care—now. One approach that is enabled in the Your Health Act is support to partner with community surgical centres, which I'll call CSCs. We are encouraged by this opportunity because of the successes we have observed already to this point with CSCs. We have had success in delivering cataract surgery at the Kensington Eye Institute and endoscopy services at many community centres for many years. Additionally, we have developed coordinated partnerships with community diagnostic centres to support patients with faster testing for cardiac diagnoses, for example.

Most recently, we have had success with delivering increased volumes of specialized ear surgery for patients who can't hear properly. Our team at Sunnybrook is a world-class resource for state-of-the-art surgery to restore hearing. But as the pandemic receded, we found ourselves with a greater than two-year wait-list and inability to get surgery done fast enough at Sunnybrook because of the multiple competing demands for operating room resources.

Think of this situation from a patient perspective. Imagine a frail older person living alone with minimal family support. Imagine now that they cannot hear. That robs the person of the ability to listen to CBC on the radio or to watch a favourite TV show. Deafness erodes quality of life unbearably. The care team that such people need is available. We needed to find ways to expand access immediately, if not sooner. Together with superb physician leadership, we developed a partnership with a community surgical centre, engaged government support and have been able to develop a sustained approach to getting care to the people and shrinking that wait-list.

I want to talk about a culture of collaboration and connection. Keys to success of such partnership models are many, and we have thought about this a lot with our OHA partners. Broadly, success factors include frameworks, policies and a culture that ensures collaboration and connection between hospitals and community surgical centres. An advisory panel that brings together diverse experts to support and advise Ontario Health should be considered. Collaborative development of volume targets and funding for volumes together with the Ministry of Health and Ontario Health is essential.

Meaningful connection will ensure we achieve quality outcomes, equity and integrated seamless care that the people we serve deserve. We applaud the efforts to develop common regional wait-lists. Furthermore, coordinated planning and collaboration paves the way for the professionals providing the care to be connected within an integrated system that creates a pathway for training options and for team building.

Furthermore, we must develop a privacy model that allows for the flow of people's health information between public hospitals and the CSCs. The CSCs should participate in the centralized provincial data imaging repositories that enable flow of information, continuity of care and better health experience.

Furthermore, I encourage the government to maximize the use of our current hospital resources. Sunnybrook's Holland bone and joint centre operates a physically separate ambulatory surgical centre with a dedicated focus on certain procedures, notably hip and knee replacements. The Holland centre team developed a program—it's called TRAC, the Toronto Regional Arthroplasty Collaborative—with the Ministry of Health to create a regionalized partnership model with other Toronto-area hospitals to address the hip and knee arthroplasty backlog to create a sustainable regional model of excellence. Once fully operational, the model will reduce the Toronto region hip and knee backlog by 25% by March 31, 2024.

Integration and teamwork should be our rallying cry. We must avoid parallel and disconnected pathways to care.

A couple of brief comments about mental health and addictions care capacity: I'll only be brief here, but I will say that as with surgical capacity, improving our mental health and addictions system will necessarily involve enhanced navigation for patients and families and also innovative partnerships. Our team at Sunnybrook, like many others, has partnered with the government to build and expand the capacity for psychiatric care.

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

Dr. Andy Smith: What we're going to need is integration of our resources here, just like with surgery.

Finally, with health human resources, we have terrific health care professionals and teams in Ontario. But their numbers are diminished, and they are tired as we advance through the post-pandemic period. This challenge must be faced with energy, resolve and innovation. Recruitment, retention and expanded training opportunities are important parts of the solution. There has been a real can-do attitude about this in recent months and years, and together with government, looking at lots of different aspects to enhance collaboration. All of the solutions are essential. No one is going to get us to where we need to be.

I would like to thank the committee for allowing me to participate in this process today. Our team is looking forward to continuing our collective efforts to innovate and to enhance the health care system.

The Chair (Ms. Goldie Ghamari): Thank you. We'll now turn to the Toronto Area Interfaith Council. Please state your name for the record, and then you may begin. You will have seven minutes.

Rabbi Shalom Schachter: My name is Rabbi Shalom Schachter. The Toronto Area Interfaith Council thanks you

for giving us the opportunity to make an oral presentation this afternoon.

TAIC and other religious groups strongly believe that full access to free health care is a human right, since we are all created in the divine image. We are deeply concerned that Bill 60 will severely interfere with this access for ordinary residents of the province and will place an unnecessary burden on public finances.

Privatization is not a workable solution. We have seen what it has done in both home care and long-term care. As one example, the Fixing Long-Term Care Act, covering care that is primarily provided by for-profit corporations, required the minister, under section 10(3), to report to the public no later than September 30, 2022, the degree to which the average minimum hours of care per resident per day met the increased level of three hours. The public has not received that report, and thus the minister is in contravention of the law. Either the report was never written, or it documented that the three-hour target was not achieved, primarily because for-profit providers have seriously understaffed their facilities.

In long-term care, COVID has shown that homes run by for-profit corporations have had the worst record of outbreaks and deaths. This wasn't a surprise, as reports issued by the ministry itself in the past document that homes run by for-profit corporations have the lowest level of front-line hours of care.

Privatization in home care has led to a drastic worsening of working conditions, which chased away so many health care workers from the sector. There is no way that private clinics can operate with just surgeons and diagnosticians; they will need to employ RNs and other health care personnel. Given the serious existing shortages of such personnel, any move of such personnel to the private system will severely undermine the ability of the existing public health care providers to meet the needs of Ontarians.

We call for the complete withdrawal of Bill 60. In any event, we call for the abandonment of schedule 2, which will permit deregulation of health care professional assignments without justification from peer-reviewed evidence.

Finally, on a global basis, even if Bill 60 overall will be passed along with schedule 2, the included amendments to the Fixing Long-Term Care Act should be withdrawn. These amendments have nothing to do with speeding up surgery times and will only reduce the already inadequate level of care in these homes.

1610

If the government is determined to proceed with this bill, we have some specific recommendations for amendment apart from the deletions already mentioned.

Firstly, once the government has determined that the public purse should be used to finance expanded OR and diagnostic capacity, the answer is to allocate those funds to increase that capacity within hospitals or connected clinics. In the interim, the government should direct hospitals to extend the operation of their existing ORs and diagnostic facilities to a 24/7 basis. If the government is determined to provide facility fee payments to private operators, the law should at least limit those fees to the level of the lowest fee paid to hospitals for this purpose. Similarly, in order to prevent cream skimming by the private system of taking only the most straightforward cases and leaving the more complex cases to the public system, the fee paid for surgeries and diagnostic procedures should be limited to the lowest-cost procedure in the public system.

The bill needs to be amended to prohibit upselling. I have been advised that I need cataract surgery. I may need to have this procedure done in a private clinic. I will likely be encouraged to pay for a higher-quality lens than the one that is funded under the public system. If the lens that I am offered for a fee will improve my eyesight beyond the one covered by the public system, why is that cost not also covered by the public system? The bill should outlaw all upselling, as the product will not enhance health and will only lead to pressure on vulnerable clients to agree to wasteful expenditures.

The government claims that its funding of surgeries and diagnostic procedures performed in private clinics will not decrease physician availability in the public system. The bill has no enforcement mechanism for this pledge. The law should require the government to create a registry for public hospitals to set out their unassigned OR and diagnostic procedure times and for physicians who will operate in private clinics to certify that there were no times left in the registry for them to conduct their procedures in the public system.

For any physician trained in Ontario who takes on procedures in the private system, the public will have to train a replacement physician to fill the gap left by the other physician. It is unacceptable for the private system to impose this additional training cost on the public. They should have to pay a training fee for each such procedure performed by a physician trained in Ontario. The same requirement to pay a portion of training cost should be imposed for use by the private system of any other health care personnel.

Finally, the rules for labour relations for the health care personnel employed by private clinics should be the same rules that are used in the public hospital system. Namely, the Hospital Labour Disputes Arbitration Act, which applies to all health care institutions, should also apply to these clinics, and the Labour Relations Act provision protecting successor rights when work is transferred from one health care provider to another should be extended and modified to cover the opening of private clinics, since it will not be easy to track the hospital which these clients come from.

I look forward to answering your questions.

The Chair (Ms. Goldie Ghamari): Thank you very much. At this time, we'll turn to our questions, starting with the government—

Interjection.

The Chair (Ms. Goldie Ghamari): Oh, my apologies. My apologies for that. Our final presenter, Faline Bobier: Please state your name for the record and then you may begin. You will have seven minutes.

Ms. Faline Bobier: My name is Faline Bobier, and I am just speaking as an individual. Thanks very much for letting me present today.

The Ontario government is moving forward with their hospital privatization legislation, Bill 60, which they have called the Your Health Act, which is anything but. The Ford government's plan is to cut core public hospital services, including surgeries and diagnostics, and privatize them to for-profit clinics, which are essentially private for-profit day hospitals.

This bill would replace the Independent Health Facilities Act of 1990, which is the current legislation for private clinics in Ontario. According to Ontario's Auditor General, the so-called independent health facilities are 98% for-profit and only around 2% non-profit. Thus, the title of the act was always a euphemism for private for-profit clinics.

On January 16 of this year, Premier Doug Ford announced the first phase in his plan to privatize our public hospitals. His government is opening three new private for-profit day hospitals, expanding other for-profit clinics and shunting tens of millions in public funding to private clinics and hospitals. This will devastate the services in most of our public hospitals.

In Bill 60, the Ford government retitles the private clinics as "integrated health services centres." The Ford government shouldn't try to confuse the public by choosing obscure names to cover for their privatization plans. For clarity, I think the new integrated health services centres should be referred to as private clinics, which is what they are.

The government's plan to close public hospital services and expand private clinics is not supported by the evidence. In fact, there is a significant body of academic research—could I get some water; I'm sorry—showing poor quality, safety concerns, higher user fees, cream skimming of the most profitable and easiest cases at the expense of local hospitals, higher costs and a host of other problems—

Interruption.

Ms. Faline Bobier: Thank you—that are associated with the fragmenting of community public hospital services into private clinics.

Bill 60 doesn't resolve any of these concerns. There are no standards in the legislation. The inspections process, if there is one, is left to regulations, to be made by cabinet alone—that is, the ministers in the Ford government—after the legislation is passed. The public and the Legislature will have no meaningful say. There is nothing to stop for-profit privatization of our core public hospital services; in fact, this is what the legislation contemplates. There are no quality standards. There is no oversight in the legislation; it is left to the discretion of unnamed third parties and/or regulation. There is no real protection against staff-poaching from our local public hospitals.

There is no protection against corruption and conflict of interest. In fact, the legislation opens the door widely for new avenues of conflict of interest. In Bill 60, the private clinics are actually invited to make a plan to upsell medically unnecessary services to patients. To date, across Canada, virtually all of the for-profit clinics and hospitals that have been established have located their facilities in large urban centres where there is a market of wealthy people from whom they can take extra money to make profit, and even within urban centres, for-profit clinics tend to be located in the wealthiest neighbourhoods. For-profit privatization of our hospital services takes away funding and resources from all local public hospitals and will be especially devastating to smaller and rural communities, in particular to northern communities.

In Bill 60, there is no legislated protection against for-profit privatization. Already, for-profit corporations are lining up to bid for hospital services and procedures. To be clear, the private clinics are expressly not under the rubric of the Public Hospitals Act, and therefore without the protections against privatization in the Public Hospitals Act. For-profit hospitals and clinics routinely violate the Canada Health Act and charge patients thousands of dollars for medically needed services. Not only is it illegal to do so, the prices are exorbitant. The clinics have also been caught by auditors for double-billing. That means they bill the provincial health plan, such as OHIP, and charge the patient as well for the same surgery or diagnostic test.

We should take as a cautionary tale what happened in Ontario's long-term-care sector, which is now dominated by for-profits. In fact, the move to privatize long-term-care facilities, as many people will know, was something led by former Conservative Premier Mike Harris, and it was a move that benefited Harris and his wealthy cronies, so not a disinterested move in the best interests of the citizens of Ontario. The effects of privatization in this sector became crystal clear during the pandemic, when horrendous conditions and soaring death rates in these for-profit LTCs were there for everyone to see. It's also well-documented that politicians like Mike Harris benefited hugely—

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

Ms. Faline Bobier: —from privatizing long-term care in Ontario. He made tens of millions by sitting on boards of LTC facilities such as Chartwell.

I just wanted to end on a personal note. Four years ago, I was diagnosed with endometrial cancer. Thanks to wonderful care by nurses, doctors and other health care workers at St. Mike's and Princess Margaret hospitals, I had surgery and survived my cancer, but I shudder to think what would have happened if I had to pay out of pocket for all the diagnostic testing—the MRIs, the CT scans, the blood tests etc.—or if the public system had been so compromised that I had to wait longer than medically safe for those tests. If we allow the Ford government to go ahead with their plans to gut public health care—accessible to all, regardless of your ability to pay—our future will be like our past, when there was no such thing as public health care or medicare.

1620

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

We'll now turn to our first round of questions, beginning with the government. MPP Martin, you may begin.

Mrs. Robin Martin: Thank you to all the presenters for giving us your time. I just wanted to start by addressing Rabbi Schachter. Rabbi, thank you for your comments.

Section 10(3) of the Fixing Long-Term Care Act requires the Minister of Long-Term Care to provide an annual update on our road map toward reaching four hours of care per resident, per day, which we agree to and passed legislation to do—the Fixing Long-Term Care Act—by March 2025.

This year, the minister was required to publicly report our progress on or before March 31, 2023, to provide an update for the previous fiscal year. In accordance with those requirements, on March 17, 2023, Minister Calandra provided an update during a ministry announcement which was shared via livestream as well as the Ontario Newsroom website, so it was shared with the public. In his update, Minister Calandra confirmed that the ministry achieved its 2021-22 target: an average of three hours of care per day, per resident. We also made an announcement to fund $1.2 billion in additional services this year in long-term-care facilities and $1.8 billion next year in long-term-care facilities—just to put that on the record.

Rabbi Shalom Schachter: Thank you—

Mrs. Robin Martin: I would also—I didn't ask a question. I would also just like to say that I agree with Ms. Bobier that we certainly should not try to confuse the public. I also think that it's very important that we do not scare the public, and that is why it's very important that we're transparent and we talk about what is actually in the legislation. I know that certain people believe that it would be helpful to buy up all of the facilities that are owned by private companies and stamp them public, but this would cost a significant amount of money and it would leave less resources for actually providing care to people. So our government has made a choice that we think it is more important to actually provide care to people, and more care to people, including four hours of care per resident, per day, and that is what we're going to do.

I want to just thank Dr. Andy Smith for coming here and giving us his perspective. I know you have a lot of experience, and I know that my colleague MPP Barnes has a question for you.

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

Ms. Patrice Barnes: Dr. Smith, thank you so much, and thank you to all the other presenters for coming through as well. I just wanted to say, you're with the hospital and we've had a lot of people who have spoken on behalf of hospitals. You're here today to present to us, and I just want to give you the opportunity to say why you support this bill.

Dr. Andy Smith: I think that the biggest reason is it's clear we have a problem with providing access and having capacity to provide health care right now, notwithstanding the fact that we have amazing health care workers, amazing teams. We provide amazing care, but we need to be able to do more, and we need to be able to do it now. It requires multi-pronged solutions and innovation, and some of that innovation involves working with partners. I feel that we've had a great deal of success with it. I think, for example, our work with cataracts, our work over the years with endoscopy procedures, and now, for example, in the example I showed about hearing surgery—it is simply not acceptable to say to these patients who are waiting two years so they can hear again, "Just wait some more." We need a solution right now.

We do need for them to, as I know has been said repeatedly, pay with their OHIP card, and I'm very proud of it. I'm very proud of the fact that our physician leaders have the wait-list—people of all the spectrum of socio-economic status are on that wait-list, and they start at the top and work their way down. But the fact is, we cannot do them in the operating room capacity that we don't have. We're able to do it well, at a high quality, and quite frankly, more efficiently in this instance, for this type of surgery, in the privately operated, publicly funded health care clinic.

Ms. Patrice Barnes: I'll ask you another question. What are your thoughts about how this legislation might put better supports in place for high-quality care for patients?

Dr. Andy Smith: So I think that the general statement here is as important as the specifics, and I think that I would reiterate the part that I said that we need to have both a framework as well as a culture of connection and collaboration. It's a real risk if we develop grossly disparate parallel streams. But there is an opportunity to plan this centrally together with government, with ministry, with Ontario Health, and to encourage and—in fact, indeed, through regulations and frameworks—look to have a proportion, for example, of the physicians that work in my hospital, also working at the privately operated clinic to do, for example, the hearing surgery. That way, you have connection and collaboration.

That starts when you, for example, plan your volumes for the year. If you need in the Toronto area an extra 1,000 hips and knees done, that ought to be planned separately. We ought to have a cogent idea, all involved, as to, "You do 300, you do 700 extra," because we can't afford to have people on the wait-lists.

I think that one of the other things I mentioned, and I'll emphasize again: I think there's a real opportunity for a collaborative expert panel. We've got a lot of experts, both people who are champions of privately operated, publicly funded clinics and within the health system more broadly. Get them around the table and let's make sure that we do work out the details that do, indeed, matter a great deal so that we get the integrated partner teamwork between the two streams of care delivery that we're talking about here.

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

Ms. Patrice Barnes: One final, quick question: Having sat on the committee and having read through the bill, I know the public is hearing a particular narrative around this particular presentation of the bill. If you had the opportunity to share that narrative with the public, what would your narrative be?

Dr. Andy Smith: Our narrative is that we have excellent health care workers, excellent health care provisions in Ontario—just not enough of it. We need more capacity and we need it now and we need to have multi-pronged, innovative approaches. And some—not all of that—is working with private delivery of health care, publicly funded with your OHIP card, as I've heard the minister say repeatedly, and make sure that we're working as a team to make sure that we take into consideration that equity and

quality are attended to, so that we get expanded health care and it just happens to be more diverse the way that we're preparing it.

I'm really pleased with our record to date. I think that's one of the reasons I'm most enthusiastic. We've seen it work and I'm proud of what our people and teams have done inside of this type of model.

Ms. Patrice Barnes: Thank you so much.

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

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

M^me^ France Gélinas: I would like to thank all three presenters for coming here today and taking your time, effort and energy to share with us.

I would start with you, Mr. Schachter. You opened up by making a pretty strong statement that you believe that full access to health care is a human right. I stand to fully agree with you. I come from the party of Tommy Douglas which brought us medicare, where care is based on need, not on ability to pay. You gave us examples within the long-term-care system as to what for-profit has done. The aim of Bill 60 is to allow for-profit, investor-owned corporations to deliver hip and knee surgeries and to deliver surgical suites.

In your view, is this in conflict with the first statement that you made regarding full access for free?

Rabbi Shalom Schachter: Thank you for the question. I'd first like to respond to the comment by MPP Robin Martin. I have asked the ministry staff numerous times, including the minister's office staff numerous times, for a copy of the section 10(3) report that had to be delivered within six months of the end of the fiscal year. Those requests have been not responded to, so I would welcome receipt of a copy of the minister's report. I hope that it provides the numbers to prove that the three-hour target has been met and that there is a breakdown between how much was the average provided by municipal homes and not-for-profit homes versus how much is provided by for-profit homes.

Historically, the municipal homes and not-for-profits have provided higher levels of care, so it's quite possible that the three-hour target was met, but only because the for-profits were relying on their understaffing because of higher staffing from the municipals and the not-for-profits. In terms of—

M^me^ France Gélinas: I have seen the report. That's exactly what happened. But continue.

1630

Rabbi Shalom Schachter: As I said, I've requested that report numerous times, and that has not been provided, so I would welcome if you can help me out with that.

In terms of your question, I accept that the government is not going to make people pay out of their own pockets for necessary care and that whether we get it through a hospital or a for-profit clinic, we won't have to pay, that it will be paid by OHIP. The problem is that we suspect that the for-profits will be provided with unnecessarily high levels of compensation for their facilities and for the procedures that they do, and that it will put a drain on the public funding system, leaving less money available for the public system.

More serious even than money is the staffing, the human resources question. Any staff that are going to work in the for-profit system are going to come from our limited human resources supply, and that's going to terribly reduce the already understaffing in our public system. It was mentioned earlier that one of the things that needs to be done is to allow hospitals and other existing providers to negotiate freely with their unions to provide proper compensation so that people will agree to work in the public system. The court has found that Bill 124 is unconstitutional. I would urge the government to abandon their appeal so that labour relations can take proper place.

M^me^ France Gélinas: Thank you.

Ms. Bobier, you also spoke quite clearly against the for-profit, investor-owned corporations to run those new—this is why we have this bill. You already know that we have independent health facilities. You already know that 98% of them are for-profit. They exist. We needed this bill so that now we will have private for-profit, investor-owned corporations invest millions of dollars to build surgical suites.

When a hospital—and you have a hospital CEO beside you—builds a new surgical suite, a huge part of it is fundraising. The government only pays a part of the infrastructure, and the hospital is on the hook to do fundraising. There's none of this for for-profits. With for-profits, the government pays 100% of their fees, and then some, so that they can pay their shareholders. What do you think that will do to our hospitals who have to compete?

Ms. Faline Bobier: I think part of the question is, what happens down the road? Because the province that I come from, Saskatchewan, which was also the birthplace of public health care—if you look at the situation in Saskatchewan today, it's not very different from the situation in Ontario. Now there are many for-profit clinics in Saskatchewan, but it's not true that people don't pay for them.

A friend of mine had serious back problems. She needed an MRI before they could do surgery. She was given this choice: You either wait 18 months for an MRI in the public system, or you can pay $950 to get an MRI at a private clinic—which she did, because she's able to, because she's a lawyer, because she has the money. But that is not the situation for the vast majority of people who live in Ontario or Saskatchewan. So that is what is coming down the road. It's fine for Doug Ford to say that you will be able to pay with your health card, but what he's essentially doing is helping to set up a two-tier system where if you have the money, you will be able to pay and get procedures much more quickly than most of us, who will have to depend on the public system that he's bleeding dry.

And I think the question of talking about how we don't have the capacity—

The Acting Chair (Mr. John Yakabuski): One minute remaining.

Ms. Faline Bobier: Well, why don't we have the capacity? Because—and doctors have said this, have come out

openly and said there are operating rooms that are empty, that could be functioning but are not because we don't have the staff. Why don't we have the staff? Because the Ford government has kept wages down for nurses. You saw the nurses a couple of weeks ago out in large numbers, saying, "It's not acceptable that you tell us how wonderful we are during the pandemic but you're not willing to pay us a living wage," and that is also sucking resources out of the public system, where Ford is trying to legislate and keep their pay down.

M^me^ France Gélinas: I think Dr. Smith could agree with that. There are 452 openings on his website right now for staff. You made it clear that you want collaborations with the hospital. Had you been consulted before this bill was put forward, Dr. Smith?

Dr. Andy Smith: Yes, through the OHA, we've certainly been—

The Acting Chair (Mr. John Yakabuski): Thank you very much. That concludes the time and the questioning for the official opposition.

We will now move to the independent members for four minutes and 30 seconds. MPP Shamji.

Mr. Adil Shamji: Dr. Smith, if you'd like to finish your answer, I'm happy for you to complete your thought.

Dr. Andy Smith: We have been involved in consultation, as a hospital sector, as health care leaders throughout. We've been involved and keenly interested in what goes on in the health care system.

As everybody knows, we need more health care workers. We have fantastic health care workers. And whether it's nurses, lab technicians or a wide range of superb health care workers, we need more, and we need well-supported health care professionals. I know that that's something that OHA and government are working on right now. I think that it is, however, important to emphasize that over the last few years now, it's never seen such a diverse and, again, multi-pronged effort to try to fix that problem. It's a difficult problem.

We know human resource challenges have been a problem in many sectors—very, very significant in our sector, in health care. But I think about the collaboration that we've been involved in—not just Sunnybrook, but across the hospital sector—with the ministry right now, expanding health care and education training spots; scope of practice expansion, so innovating to optimize scope, for example, of nursing; expedited pathways for international practitioners, and we've been really pleased with that effort; team-based models of care to support overlapping scope of practice; new graduate support programs; an extern program, which is sort of similar to that; and, of course, I think work is bubbling up around national licensure. All this to say, not one of those or a couple of those will get it done. We need all of them and then more because we, across this nation and certainly in this province, need health care workers. We need all hands on deck.

Mr. Adil Shamji: Thank you, Dr. Smith. I've trained at Sunnybrook. I had friends and family who have received exceptional care at Sunnybrook. So, first of all, thank you for the amazing work that you do.

I will also say, I am very impressed by the Holland Orthopaedic and Arthritic Centre. But all out-of-hospital surgical facilities will not necessarily be the same. In your opinion, what are the elements that have led to the success at the Holland Orthopaedic and Arthritic Centre and, as written, does Bill 60 have the architecture in place to ensure that every out-of-hospital surgical facility will be of the same calibre? Is there anything that needs to be added?

Dr. Andy Smith: So I do think that Ontarians, wherever they get health care, expect and deserve the highest-quality health care. I believe—and I've worked in the States—that we provide care in this country that, when you get access to it, is second to none. And I think we can be very proud of it.

I think that you have to have multiple ways that you are certain that there is quality. I think that culture as well as framework and indeed regulations that allow for insurance of quality will be important. I think it is important, if you have, for example—I'll use physicians as an example—one working in a hospital and in a community surgical centre, for example, then that sort of quality mindset, that ethos, that experience crosses over and that really drives things.

Of course, we do have regulatory colleges that are of the highest calibre in this province, and I think that that is a big, big driver of the quality of care provided by individual doctors and nurses and other practitioners. So I think that—

The Acting Chair (Mr. John Yakabuski): One minute remaining.

Dr. Andy Smith: The quality will be really important.

Now, the Holland piece: I do want to emphasize that something that is so important is that this ought not to be either/or when it comes to innovation. I'm very pleased to see the government wide open to the idea that we did find a way to get some more capacity. It's early days, but let's find a way to do that in a way that works for patients as well as for the team to make sure we're using that resource as much as we can.

So I think the future state should not abandon innovative approaches to use every single bit of resource that we have within our existing ORs. The fact is that that is a limited amount and our demand is growing at a faster rate.

1640

Mr. Adil Shamji: Of course, we know Sunnybrook, like so many other institutions across our health care system, has been faced during the pandemic—

The Acting Chair (Mr. John Yakabuski): That concludes the time for round one, MPP Shamji; I'm sorry.

We will now rotate to round two back to the government. You have seven minutes and 30 seconds. MPP Martin.

Mrs. Robin Martin: If one of my colleagues wants to go ahead, I'll stop, because I'm dominating the mike. I'm sorry.

I just wanted to advise Rabbi Schachter before I start asking questions that the release went out last Friday. The information is available on the Ontario Newsroom website. So you can find it there.

Thank you again for your presentations. One of the things I wanted to ask you is, we heard earlier from Dr. Agarwal, who is still in the room with us, about MRI clinics that he's been running as IHFs and that he likes the integrated aspect of what this is going to bring. I know you've suggested you do as well. Do you think that, for people who are waiting for diagnostics—I believe the witness Faline Bobier had indicated that she had been waiting for diagnostics. Do you think that if we had more of these clinics up and running, as Bill 60 intends, would we be able to provide faster services to people to get their diagnostics done quicker, to get their surgeries done quicker?

Dr. Andy Smith: Yes, I think that has to be the reason. When somebody has a care plan, of course, there's the diagnostic phase, and then there's the treatment phase. I think that, as we all know, when we or someone in our family is sick, many times it's the waiting and figuring out the diagnosis and the plan and uncertainty with that that is the hardest part. Having more capacity will allow people to get tests done more quickly.

Now, you've emphasized, and my colleague before me—the radiology colleague whose name I forget who spoke in advance of me pointed it out and knows very well. We now have the assets to be able to get the information online so that it can be shared across the province, so that we can have high-quality imaging done wherever it's done and that it be shared across the system. I think that that's something that we need to make sure and ensure that the system we're building out has, so that if you have that MRI done somewhere else, it's going to be of high quality. And when the surgeon who is going to do your spinal surgery sees you in the clinic, he or she is able to go online and there it is, within the shared repository that we have across the province.

The Acting Chair (Mr. John Yakabuski): MPP Jordan?

Mr. John Jordan: I want to turn the conversation back to staffing for a minute. And just for Rabbi Schachter's information, there's been $4.9 billion marked for increasing long-term-care staff to meet that four-hour commitment, so a huge commitment by this government to meet those four hours.

As Dr. Smith has mentioned, this government has introduced a range of initiatives. One of them I want to point to is the streamlining of the certification of internationally trained health care workers. What that has done is there are now 6,727 health care workers certified in Ontario who wouldn't otherwise have been, had we not streamlined that process to bring them in.

With that, I want to move to Bill 60 and the as-of-right clause in Bill 60 and just ask, what do you think the impact will be of allowing health care workers to move freely from province to province without hitting a barrier about certification when they arrive here? And there are conditions on that, of course, but we freed that up. This bill would, if passed, free that process up.

Dr. Andy Smith: So, I think that's a great move. And I know there's a lot of work still to be done. Health care workers, whether they're doctors or nurses or—the whole range—they have an independent sense, depending on where they are in their career, their life, their home situation and where and how they want to work. We need people to be able to be portable across this country, for example, as fits their life. We shouldn't put up barriers; indeed, we need to embrace. To be able to bring them in—we train the highest-quality health practitioners in this country, whether they're in Saskatchewan, Newfoundland, British Columbia or anywhere in between. There shouldn't be barriers or headaches. We need them to be able to be providing excellent, high-quality, compassionate care. So I think this is going to be one approach amongst many to be able to increase the capacity of health care workers, and it is absolutely a step in the correct direction.

Mr. John Jordan: Thank you.

The Acting Chair (Mr. John Yakabuski): MPP Rae.

Mr. Matthew Rae: Thank you to all the presenters for taking the time to present to us. My question is to Dr. Smith. We heard a lot through our deputations to the committee about the surgical backlog. Obviously, in your role, you're very well aware of that. Our government, in the last budget, committed $300 million. Now the total since COVID and the onset of that is approaching a billion—it's $880 million, I believe. I was just wondering if Sunnybrook was able to take any advantage of that funding to help relieve some of their surgical backlog and the surgical output from that.

Dr. Andy Smith: Sunnybrook, like many—it could be all, but certainly many—hospitals, has been funded to be able to advance efforts to deal with the surgical backlog and to deal with other issues in the post-pandemic period. I think we would all agree that the biggest challenge right now is the rate-limiting step. In fact, health human resources is going to be the biggest catalyst for ongoing success.

So whether it's resources to help us get more people and support our people better, or whether it's funding for OR teams—and those two things are kind of connected—that has not been the limiting factor. I think that our lived experience has been that we've been well supported by the Ministry of Health, by Ontario Health to be able to do everything we can. We measure it well. We look at it as a community. And we're doing our darndest to—

The Acting Chair (Mr. John Yakabuski): One minute remaining.

Dr. Andy Smith: —catch up.

Mr. Matthew Rae: Thank you. I don't know—Robin?

The Acting Chair (Mr. John Yakabuski): MPP Martin.

Mrs. Robin Martin: Okay, thank you. I wasn't going to ask another question, but thank you very much.

Dr. Smith, one of the things that keeps coming up is people are talking about how we can have oversight of these clinics. And I keep stressing that the difference between an independent health facility and the integrated model is that it's integrated. So can you talk a little bit about what you understand about how this will work going forward with this integration, what kind of oversight we have for these clinics?

Dr. Andy Smith: Again, I will keep coming back to the fact that it's a culture as well as framework and regs that

support it being a team game. That really is essential. I think of the health system we're in right now compared to the one—I started as a physician in 1990. It has changed. We have a lot better sense of what integration means—

The Acting Chair (Mr. John Yakabuski): Thank you very much. That concludes the allotted time for the government side.

We'll now move to the official opposition. You have seven minutes and 30 seconds. MPP Gretzky.

Mrs. Lisa Gretzky: I just want to start by saying it's really unfortunate that the government had two rounds of questions and only focused on someone who is supporting the bill as opposed to the two people—you didn't ask a single question of the two other presenters who raised very serious and valid concerns about the bill. The reason I'm saying that is because one of the government members had said, "There's this narrative out there around the profitization"—and MPP Wai is nodding her head.

So I'm going to talk about the reality as it relates to what the other two presenters had talked about. At 17 years old, I was homeless. I relied on shelter services. Had Bill 60 been in place then, me and every woman and their children in that shelter would have had reduced access to health care—that's a fact—because they couldn't pay to get to the head of the line to get surgery and care they needed, because they had complex medical needs.

Just over four years ago, I lost a brother to addiction. He died of an overdose. Had Bill 60 been in place years ago, we would have lost him long before four years ago. I agree; the mental health and addictions system is not perfect. It needs work. But profitization is not the answer, because if Bill 60 and profitization were in place, we would have lost my brother more than four years ago because he wouldn't have been able to access the supports and services he needed. And God forbid he needed surgery. These for-profit clinics wouldn't have taken him because he had complex medical needs.

So I think it's absolutely shameful that this government calls it a "narrative" and does not talk to two of the presenters who talked about very real concerns around access to health care when you profitize the system. I've lived it. I know for a fact that profitization is going to greatly decrease access to health care for the most vulnerable people in the province.

With that, I'll turn the time over to my colleague from Niagara Falls.

1650

The Acting Chair (Mr. John Yakabuski): MPP Gates.

Mr. Wayne Gates: I'm going to talk to the doctor to the best of my ability. This is from you, sir: "We have terrific health care professionals and teams in Ontario"—I agree with that.

"But, their numbers are diminished, and they are tired as we advance through the post-pandemic period"—I agree with that.

"This challenge must be faced with energy, resolve and innovation"—innovation is privatization. It's the oldest word in the book. It's the oldest thing to say.

Right now, in your facility, sir, 452 positions are open. Why are they open? I'm going to help you out: Bill 124. It was this government three years ago that came after health care workers right across the province with Bill 124, so they created a crisis. There's a crisis in your hospital.

I was at St. Mike's for health issues a couple weeks ago. The head of the department, you know what he said to me about health care with Bill 60? "I'm going to lose staff. Doctors are going to make more money, but corporations are going to make billions." How does he know that? Because it happened in long-term care.

We've got an example where we can go out there and say right away, the profit in long-term care didn't go to care, sir. I wish it did. It went into shareholders' pockets—billions of dollars. A lot of people got rich, including a past Premier of the Conservative Party. They got rich at the expense of 5,400 of our seniors dying during COVID, 78% of them dying in for-profit care.

Sir, when you stand here and you talk about how you support Bill 60 and you were consulted, I'll tell you who wasn't consulted. The very same nurses and other doctors in your facility weren't consulted on Bill 60, and they're the ones who are living it every day. They're in there. They're tired. They're exhausted. And you know this. I'm sure you do. I'm sure you're quite capable of knowing this.

I know for a fact in Niagara Falls, because I get the calls, nurses are sitting in the parking lot for 45 minutes before they go in for their shift—crying before they go in for their shifts, because of Bill 124. They don't have mental health supports, because their wages have been capped at 1%, including their benefits, when inflation is running at 7.5%. They can't pay their rent. They can't pay their mortgages. That's what's going on in our health care system by this government and Bill 124.

Sir, I agree with some of the stuff you're saying, but you left out Bill 124. If you want to support the workers in your facility, you should support them. Because every union that I'm aware of that works in health care—and they were here yesterday; it worked out to about 1.6 million workers who were represented. They're all saying the same thing: "We can continue to do public health care, but we need to get rid of Bill 124."

As this government is saying people are running to Ontario, do you know what happened in the last little while? Some 140,000 people left the great province of Ontario. Only 80,000 came in. That's on the government. There isn't anybody who doesn't want to come to Ontario, but none are in the situation that we have. When we go down the privatization road, I'm sorry, more people are going to want to get out of Ontario.

We are the envy of the world with our public health care system. You know that, sir. You know that. To come here and support a bill that's going to privatize it so we're going to go down the same way as the Americans, where 45 million people today—it may be higher than that, because that's the last number I had, and it was a few years ago—claim bankruptcy every year in the United States of America. Is that what we want for our health care? Do we want to have our marginalized people not be able to afford

health care? Do you want to see people that are on addictions or mental health—and you know mental health is running rampant everywhere.

I'm going to ask the other two presenters. Can you tell me what you think of Bill 124, please?

Rabbi Shalom Schachter: Well, the court has found that it's unconstitutional.

The Acting Chair (Mr. John Yakabuski): One minute remaining.

Rabbi Shalom Schachter: It interferes with freedom of association. It was unjustified. It was unwarranted. There was no threat to public finances that required it.

It was biased. It exempted for-profit long-term-care homes. It wasn't applied across the board. Another example of for-profit benefits is they are freed from having to disclose the salaries of their officials who get over $100,000 under the Public Sector Salary Disclosure Act.

The problem with for-profit institutions like these clinics that are going to be created is that they are not integrated. There is not going to be transparency and accountability through the freedom-of-information system. There's not going to be the public sector application of collective agreements. If they were integrated with hospitals, then the same working conditions would apply to them. There is no real integration. Bill 124 is just one example—

The Acting Chair (Mr. John Yakabuski): Thank you very much. That concludes the time allotted to the official opposition.

We will now move to the independent members for a period of four minutes and 30 seconds. MPP Shamji.

Mr. Adil Shamji: Dr. Smith, over the last few minutes, I've been reflecting on why your last answer resonated with me. To be clear, I don't intend to put any words in your mouth, but the one thing that really resonated with me about your last answer was your comment that culture is one of the central reasons behind the success of Sunnybrook's work. Culture is something that's really difficult to regulate. It's something that's really difficult to legislate. But I think it's the reason that we've had so many people come in between yesterday and today and express their concerns around for-profit models of care that may be introduced under Bill 60. Because as we've seen with Sunnybrook, there is an incredibly patient-centred vision and ambition, and many people worry that, under a for-profit model, it is more of a profit-centred model or ambition. Again, I recognize that that is not the point that you're making, but it's an epiphany that you helped me come to.

My question is actually for you, Ms. Bobier: Can we get you another glass of water?

Ms. Faline Bobier: Sure, thank you.

Mr. Adil Shamji: Lorne will take care of that for you, because, Rabbi, my next question is for you, if you would indulge me.

You raise concerns about the deregulations in schedule 2 of this act. Licences and credentials are the prerequisite to performing many medical tasks, services and procedures, and for good reason. This legislation would replace licensed and credentialed health care workers with "another person prescribed by the regulations." Who do you think "another person prescribed by the regulations" might end up being? And are you concerned about this?

Rabbi Shalom Schachter: Thank you for the question. Absolutely. We've seen in long-term care the downloading of responsibility from RNs to RPNs, from RPNs to personal support workers, and then, most recently, from personal support workers to PSAs. I'm very concerned that the legislation that requires certain levels of RN care and other care, if schedule 2 goes ahead, then the residents will be denied care from the appropriately trained professional and will be given it by someone who may care as much but who doesn't have the skill and the competence of the proper classification.

Mr. Adil Shamji: Thank you very much.

Dr. Smith, where we actually left off in the last round of questions is that I was acknowledging the health human resource challenges that have been experienced by institutions across the health care system and, of course, by Sunnybrook as well. In the health human resource plan that should accompany any licence for an out-of-hospital surgical facility, an integrated surgical facility, what would you recommend that HHR plan include as adequate protections to preserve health care capacity at an institution like Sunnybrook?

Dr. Andy Smith: I think that, as you pointed out, it starts with culture, framework and getting people at the table together to make it work. I think there should be connection, starting with the doctor team—not absolute overlap, but there should be a degree of overlap—

The Acting Chair (Mr. John Yakabuski): One minute remaining.

Dr. Andy Smith: —and one of the reasons, for example, with the example around the hearing surgery that I've emphasized is that we worked together—the people in our place, the physician leader, as well as the private provider; publicly funded but privately provided—to go to government together and say, "Here's our plan; here are the volumes. We need to have this amount of resources to make this work." So I think that that would have been a lot different scenario had we been dealing with a completely different team—different doctors, different nurses and so forth. Another thing to recognize is that we do need more health care workers. Of course, we brought many in through some of the innovative ways. We are short everywhere, around the world, and we need to work on that together. We need to have well-supported nurses, well-supported health care workers—that's for sure—but we need them in all ways for delivering health care. You may have people who, later in their career, for example—

The Acting Chair (Mr. John Yakabuski): Thank you very much. That concludes the time for this presentation.

1700

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

HEALTH PROFESSION REGULATORS OF ONTARIO

The Acting Chair (Mr. John Yakabuski): Our next presenter is the Health Profession Regulators of Ontario. The previous presenter, Tasnia Hussain, has called to cancel and will not be attending or presenting this afternoon.

The Health Profession Regulators of Ontario are here today. In person is Maureen Boon, management committee member, and I believe we have three members virtually, by remote, joining us: Dan Faulkner, the vice-chair; Shenda Tanchak, management committee member; and Beth Ann Kenny, executive director. Welcome.

As a reminder, each of the presenters will have seven minutes, followed by questions from the committee members. I will provide reminders of the time remaining during the presentations and questions. Please state your name for Hansard, and then you may begin.

Ms. Maureen Boon: Good afternoon. Thank you very much for the opportunity to be here today. I'm Maureen Boon, registrar and CEO of the College of Massage Therapists of Ontario. The College of Massage Therapists is the regulator for the province's RMTs. With me today is Dan Faulkner, registrar and CEO of the Royal College of Dental Surgeons of Ontario, the regulator of dentists; and I think Shenda Tanchak was meant to join us as well, the regulator of pharmacists.

While we each regulate individual health professions in our day jobs, we are here today representing the Health Profession Regulators of Ontario, or HPRO for short. Beth Ann Kenny, also here today, is the executive director of HPRO. HPRO's members are the 26 regulatory colleges that regulate all 29 professions. This includes almost 400,000 regulated health professionals in Ontario. The 26 health regulators, called "colleges," have a legislated duty to protect the public, making sure health care professionals are safe, ethical and competent.

We have worked alongside government for the past three years to manage the pandemic. We know how hard government has worked to provide the health care that Ontarians need and deserve. Like you, we are acutely aware of the impact of COVID on health care professionals, on Ontarians and on our health human resource capacity. As regulators, our core responsibilities lie in three areas: registering competent professionals, investigating them when necessary and running quality assurance programs to ensure they remain competent over time.

We know that Bill 60 proposes several significant changes to the province's health care system, but we are here today to focus on the as-of-right provisions. These are enabled by schedule 2 of the bill, but we understand the details will be further clarified in the regulations. Bill 60's as-of-right provisions will allow health professionals from other provinces to work in Ontario without registering and being overseen by the profession's regulator here in Ontario. Therefore, there will be a regulatory gap from the time of arriving in Ontario to practise to the time that the individual will be registered with the regulator.

We know that as-of-right will impact four professions—doctors, nurses, respiratory therapists and lab technologists—and that government is receiving input from these regulators separately. However, as government partners in ensuring safe care for patients, we want to speak to you from the perspective of Ontario's health-profession regulators as a whole.

As regulators, we support innovation and improving our registration practices. We also support speedy registration and interprovincial mobility. Individual colleges are working with their provincial counterparts to achieve these goals.

Registration requirements, including education exams and good-character provisions, are crucial to ensuring that regulated health professionals are competent, safe and ethical. As regulators, we want to reduce risk and prevent problems for patients, and these requirements help to do that. Registration requirements differ across provinces, but significant progress has been made to improve registration times and interprovincial mobility. In fact, the majority of out-of-province applicants are registered in under two weeks. We know that our counterparts in other provinces are as committed to the public interest as we are, but we also know that information exchange is not perfect, and we believe our expertise and registration processes ensure that health professionals in other jurisdictions don't try to leave their disciplinary histories behind, as we have seen in the past, with consequences for patients.

As the regulations are drafted, we want to work with government to ensure that safeguards are in place and that professionals with a complaint or conduct issue in another province are properly vetted before working in Ontario. We also want to ensure there is clear accountability once they arrive. Accountability matters, because our second core responsibility is to receive complaints about health professionals, investigate and take action as needed.

Our concern around as-of-right is that we cannot investigate a health professional who is not registered with us. Who will be accountable for the oversight of as-of-right professionals, and who will investigate complaints? Patients may expect to contact the provincial regulator, as they do today, to oversee health professionals' conduct. This is another important detail that we are hoping to work with government on to identify practical and effective solutions. Our investigation processes are legislated and can be complex for high-risk matters such as sexual abuse or professional misconduct. It is important that these investigations happen in a standardized, legislated way.

Ontario's regulators also require health professionals to carry professional liability insurance. This requirement protects the public in the unfortunate instances where patients are hurt. It is not clear to us how as-of-right will provide Ontarians with the safeguards they have today through regulation.

In closing, we acknowledge and support the need for more health professionals in Ontario. HPRO's goal is to ensure that patients can be confident that the health professionals they see are safe, competent and professional and that if something goes wrong, there is clear account-

ability. We are open to innovation, to change, and are enthusiastic about working with government to find solutions to address specific gaps in patient safety. As a next step, we hope to work with government on the regulations to follow.

Thank you again for the opportunity to be with you today and for your work on Bill 60. We are happy to answer any questions you might have.

The Acting Chair (Mr. John Yakabuski): Thank you very much.

We will now turn to round one of questions, and we will begin round one with questions from the official opposition. You have seven minutes and 30 seconds. MPP Gélinas.

M^me^ France Gélinas: Thank you to the presenters for this important part of the bill. I must say that I was even more worried than you are when I read the part of the bill, schedule 2, that talks about exempting persons from the restricted title provisions and the holding out provisions of those acts. Those restricted titles include—and you named them—the medical laboratory technologists, osteopaths, physicians, surgeons, nurses, nurse practitioners, registered nurses, registered practical nurses and respiratory therapists.

I have been a health critic for my party for 16 years. I use every single one of the 26 colleges. They have all been excellent at supporting the people that have put complaints forward.

1710

Have you been consulted before the as-of-right was included in this bill?

Ms. Maureen Boon: So HPRO was given notice of the bill. I think that the four particular professions that were particularly named—nurses, doctors, lab techs and—

M^me^ France Gélinas: Respiratory therapists.

Ms. Maureen Boon: —respiratory therapists—thank you very much—have been having other conversations. We know the government has wanted to move quickly and that the bill is enabling. So we're hoping to have more consultation on the regulations, which is where the details will be, we hope, sorted out.

M^me^ France Gélinas: You are more hopeful than I am. Regulation is not something that we see; regulation is not something that always comes, and it does not always come quickly. So in the meantime, what you're telling us is that those who have a job here can say, "Oh, I got a job at this for-profit, investor-owned corporation in Ontario, and therefore I'm a nurse"—from whatever other province. But if something goes wrong, if that nurse, God forbid, does sexual abuse on one of her or his patients, then even if they call the College of Nurses, because they're not a member, you can't take the complaint?

Ms. Maureen Boon: We only have authority over registrants of our regulatory colleges. So, yes, it is unclear who would be accountable if something went wrong if the individual health professional was not registered with the regulatory college.

M^me^ France Gélinas: So if we look—I think you told us that you are with the massage therapists?

Ms. Maureen Boon: Correct.

M^me^ France Gélinas: So let's say we have a massage therapist in Manitoba who wants to come and work in Ontario. She contacts your college. How long does it take for him or her to be able to get registered with you?

Ms. Maureen Boon: Well, our registration processes are very quick. For massage therapy it would be no more than a couple of days.

M^me^ France Gélinas: A couple of days, okay.

Would you know, if a person is a medical laboratory technologist in Manitoba or whatever—any other province—and applies to the College of Medical Laboratory Technologists, how long would it take for him or her to be recognized?

Ms. Maureen Boon: I can't speak definitively to other colleges, but my understanding is that the vast majority of colleges, as I've mentioned, can register people from other provinces where they are registered in under two weeks.

M^me^ France Gélinas: I take it that your vice-chair, Dan—you're with the college of dental surgeons. Could you answer that question specifically for your college? How long does it take for somebody from another province who practises, who is in good standing with their college, before you can register them in Ontario?

We can't hear you, but they're working on it. I can see stress—

Mr. Dan Faulkner: Can you hear me now?

M^me^ France Gélinas: Yes, we can hear you now.

Mr. Dan Faulkner: Okay. Thank you for that question. We look at all of our applicant pool in a very similar way, so it doesn't matter if an individual is from out of province or is an internationally trained graduate. If we have all of the information that we request, then we can license people in less than two weeks. We can issue that licence. I think the rate-limiting step for regulators is always getting that information from the source, whether that's outside of the province, another regulatory body in another province. If we have that information, the process can move and the decisions can be made very quickly.

M^me^ France Gélinas: Okay. Can I ask the same of Shenda? For pharmacists, how long does it take? For my example, we'll bring in from Saskatchewan this time. He's a pharmacist practising in Saskatchewan, is in good standing with his college, applies to your college to practise pharmacy in Ontario. How long will it take to get registered with you?

Ms. Shenda Tanchak: I'm sorry for my—I've been in and out with tech problems. If you are asking how long it takes for a pharmacist to get registered with us, we can usually make that happen in under 10 days—somebody from another province.

M^me^ France Gélinas: All right. So the as-of-right will now allow people to practise in our province for weeks and months without ever registering with their college. If something goes wrong and there's a complaint against them, we have no idea who could respond to those complaints.

Plus, I have this little, wee thing in the back of my mind that says—I'm a health care professional; I belong to a college—if I was about to—

The Acting Chair (Mr. John Yakabuski): One minute.

M^me^ France Gélinas: —get in a problem with my college, I may be tempted to go and register someplace else. So some of those who may be interested in coming to Ontario because they're about to get in problems with their college practise here for weeks and months on end with no supervision whatsoever? I don't like that at all. All this to save two weeks? It doesn't seem to be in the public interest to move forward with that.

Would you suggest that we withdraw this from the bill?

Ms. Maureen Boon: I think that the bill is, as I mentioned before, enabling. We believe, as HPRO, that there are existing protections with the existing regulatory scheme. However, we're willing to work with government, obviously, on the regulations, as I mentioned before.

The Acting Chair (Mr. John Yakabuski): Thank you very much. The timing was perfect. That concludes the round one questioning for the official opposition.

We will now move to the independent member, MPP Shamji.

Mr. Adil Shamji: Thank you very much, Chair.

The Acting Chair (Mr. John Yakabuski): For four minutes and 30 seconds.

Mr. Adil Shamji: Noted.

Are you able to speak to the proportion of—the as-of-right plan is specifically for physicians, registered nurses, registered practical nurses and, I believe, lab technicians. What proportion of individuals on the waiting list to get credentialed in these professions are from out of province, as opposed to out of country or in province?

Ms. Maureen Boon: I'm not able to answer that. My apologies.

Mr. Adil Shamji: Okay. Are there elements of the as-of-right plan that you would like to see in the legislation instead of the regulations?

Ms. Maureen Boon: I think that we are looking for mechanisms for clear accountability. So we are looking for a way to ensure the competence and professionalism of the people who are coming to practise and providing care. We would like there to be a clear indication of whether or not they are accountable to a regulatory college or to someone else. We believe that they should be accountable to the regulatory college via registration with the regulatory college.

Mr. Adil Shamji: Are there any elements that, in your opinion, must appear—I think you had touched on one, accountability. Are there any other elements that, in your opinion, must appear in the regulations, or else the plan couldn't be supported?

Ms. Maureen Boon: I don't think I can comment on anything else other than what I've said already, which is that there needs to be a similar mechanism to close the gaps so that there is clear accountability and that it's clear who a patient can make a complaint to in any interim period.

Mr. Adil Shamji: Thank you. Chair, I have no further questions.

The Acting Chair (Mr. John Yakabuski): Thank you very much. We will now move to the government side, and they will have seven minutes and 30 seconds to question. MPP Rae.

Mr. Matthew Rae: Thank you to everyone—Maureen, who's here physically, but to the virtual presenters as well—for taking time to present to the committee. We appreciate it very much.

My first question would be—I'm not sure who to direct it to; anyone can jump in. Under chapter 7 of the Canadian Free Trade Agreement, the CFTA, health professional regulatory colleges across Canada must register out-of-province professionals who hold the same certificate of registration, so certificate-to-certificate registration, obviously. Are the standards for health professional regulations—i.e., entry-to-practice requirements, competency—the same across all jurisdictions in Canada?

Ms. Maureen Boon: We register a lot of people under those existing rules, as you're well aware. I think the difference between—there can be differences in registration classes and registration status. There are also differences in scope for professions across the provinces and across the country. And there are differences in who's regulated where, obviously; not all professions are regulated in all provinces. So there are some challenges with respect to existing legislation and details between the professions, but registration does occur in the manner that you suggested.

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Mr. Matthew Rae: Thank you. My next question—obviously, during COVID, that was a trying time. I know there were some doctors in Manitoba who wanted to practise in northern Ontario to help out, relieve some of the pressure that was in those hospitals, and they weren't able to register in time to help in those situations. But you did mention and your colleagues had mentioned that now we are to a point where most registrations are handled rather quickly, but there are obviously some outliers; for example, the one I referred to. What are the main causes of delay that still exist for those registrations that you and your colleagues see?

Ms. Maureen Boon: To build on what Dan Faulkner said previously, I think the biggest problem is getting together the materials that we need to validate credentials and to ensure good standing in other provinces. So it's about the applicant's ability to bring those materials together.

Dan or Shenda, if you wanted to comment further on that.

Mr. Dan Faulkner: Yes, I think those are the main factors that are generally involved in terms of being able to make decisions based on materials that are available.

We also want to be clear that there has been a lot of work by all levels of government and regulators to make sure that standards and competencies across the country are looked at fairly consistently. It's not perfect; it's not perfectly aligned. What we're talking about today is the gap that we've recognized with respect to potential conduct issues, and whether there is something that's happening in another province before an individual decides to move here. Because a lot of those issues that relate to common training, common competencies that are expected to achieve licensure, they've been working quite well for many years,

but we want to make sure that there's not a gap that's left in terms of an individual perhaps leaving a situation in another province. And it does happen.

Mr. Matthew Rae: Thank you. I just have one more question. Sorry to my colleague.

Building on that pan-Canadian idea, what are your organization's thoughts on a pan-Canadian registration or licensing system for regulated health care professionals?

Ms. Maureen Boon: HPRO does not have an official position on national registration, but I think we can say that we're open to moving in that direction. It is complicated for the number of reasons that Dan has pointed out and the number of things that I've mentioned previously. Many colleges have gone as far as the current legislation will allow them. As you know, if national things were easy to develop, there would be a lot more national things in Canada. For true national licensure, we do need some coordinated discussions between the federal government, the provincial and territorial governments and colleges. HPRO and individual colleges are happy to participate in further discussions about that.

Mr. Matthew Rae: Thank you.

The Acting Chair (Mr. John Yakabuski): MPP Martin.

Mrs. Robin Martin: Thank you to the presenters. My understanding is that regulations, when drafted, have to be posted publicly for a period of time—I think it's 30 days before they are enacted—so that also gives an opportunity for people to comment on proposed regulations etc.

But I also understand with respect to this legislation that the thought is that these people who are coming from other jurisdictions in Canada are members in good standing of their college that they're coming from, so not fleeing acts that are inappropriate etc. but are members in good standing, and that they would have to have some credential to show that. I know there are still things to consider, but that's certainly what the government's intention is.

Ms. Maureen Boon: Yes, we're aware that that's the intention. I would just say that confirmation of good standing is something that regulatory colleges do. It is an area of expertise for us and something that we can certainly assist with. It's a process that needs to be carefully considered in order to make sure that it's done properly, because it is important to make sure that you're getting people who are appropriate for care.

Mrs. Robin Martin: Thank you. I don't have any other questions.

The Acting Chair (Mr. John Yakabuski): Thank you very much, Ms. Martin.

Then we will move to round two of questioning, and back to the official opposition. MPP Gélinas.

M^me^ France Gélinas: Mr. Faulkner, I would like to go back to you. You made it clear that—and also Ms. Boon—confirmation of good standing is an area of expertise and that that is something important with the as-of-right. So I'll start with you first. Am I understanding it right, that with the as-of-right, there will be no confirmation of good standing before they start to practise here?

Ms. Maureen Boon: We are only aware of what's in the bill, and—

M^me^ France Gélinas: Yes, same with everybody else. So it's not in the bill?

Ms. Maureen Boon: I am not entirely clear on what the process will be and who will be confirming good standing. That's one of the things that we're hoping to clarify as the process unfolds.

M^me^ France Gélinas: Okay. To you, Mr. Faulkner: How worried are you, because the bill does not talk about who is responsible for the confirmation of good standing, that this may open a door for people who are about to get in trouble with their college to come and apply to Ontario? Am I dreaming that up, or do you think that's a possibility?

Mr. Dan Faulkner: Well, as regulators, we're in the risk business, and obviously, there is always that risk. The vast majority of individuals who arrive are practising competently and safely, but there is always a risk that someone will not be. I think, to Maureen Boon's point, we want to make sure that we understand what those provisions are going to be so that the gaps are addressed, the gaps are closed.

We are experts because we deal with this all the time in reviewing conduct information, and so if you start to distribute that across individual units in health care—whatever that may be, wherever these individuals might practise—you're diluting the possibility of doing good-standing protective work. I think it's trying to maintain a level of consistency and standardization in how we do that work.

M^me^ France Gélinas: If you were to share with us, in the profession that you supervise, in dental work, is there a certain percentage of dentists in Ontario that are presently not in good standing with the college? How often does that happen?

Mr. Dan Faulkner: I don't think it's as easy as putting a percentage on it, in terms of how many of a profession or what percentage of a profession, because when you're talking about good standing, you're talking about a variation. You may have someone who is actually going through a disciplinary proceeding, which, in the regulatory world, is a hearing. It's high stakes. It's related to professionalism or sexual abuse or clinical incompetence. You could also have somebody who has multiple complaints about their communication skills. You could also have information about one complaint, and it's really trying to look at what those bits of information are telling you about that individual. In some cases, you might not be worried, and in some cases you might be very worried. So it's really hard to say, "This is the number or percentage." But that's where we've developed, as regulators, an expertise in terms of evaluating that kind of information.

M^me^ France Gélinas: So, right now, anybody who wants to come and practise, of the 29 professions that are regulated, you as the college would check upon the confirmation of good standing, no matter how complex it is, before you give them a licence?

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Mr. Dan Faulkner: Yes, 100%. That's a standard part of the process for anyone that is arriving to become registered with one of the 26 colleges.

M^me^ France Gélinas: Even if they come from another province or territory?

Mr. Dan Faulkner: Yes.

M^me^ France Gélinas: Would the lack of confirmation of good standing—could you deny them registration with your college because of this?

Mr. Dan Faulkner: Yes, you could refuse the application to be licensed. You could look at it in terms of whether there's an opportunity to put restrictions on their licence—what we call terms, conditions and limitations—where there might be supervision during part of their practice in Ontario. So there are a range of options for regulators as well.

M^me^ France Gélinas: But the fact that the bill is silent on it and only focuses on as-of-right, we are basically opening the door to some risk—am I understanding you right?

Mr. Dan Faulkner: If there's no way to address those conduct issues and understand if there are some and what they are, then, yes, there is a risk.

M^me^ France Gélinas: Ms. Boon, would you agree with what has just been said?

Ms. Maureen Boon: There is a risk when health professionals are not regulated and there's not clear accountability for their competence and behaviour, and it's not clear to patients where they need to go when something goes wrong. So, yes, there could be a risk.

M^me^ France Gélinas: Ms. Tanchak, would you say that applies to your health professionals as well?

Ms. Shenda Tanchak: Yes. And I think there's one more nuance, if I could just build on what Dan and Maureen have said, and that is that the ability of other jurisdictions to share information about the regulatory status of the registrants varies depending on the jurisdiction.

The Acting Chair (Mr. John Yakabuski): You have one minute remaining.

Ms. Shenda Tanchak: So regulator-to-regulator communication can be a little bit more full than it might be if a particular hospital or employer wanted to get a little bit more background. When we talk about good standing, it's not like it's a defined term that means you have As on your report card somewhere. As Dan said, it is more nuanced, but it also might require special regulatory powers to get the information you need to consider whether there is any risk.

M^me^ France Gélinas: And so I take it that the regulatory colleges have some powers that employers, such as hospitals, do not have?

Ms. Shenda Tanchak: For us, it usually works that we're allowed to share information with some organizations—other regulators—more than we are with—

The Acting Chair (Mr. John Yakabuski): Thank you very much. That concludes the time for the official opposition's questions.

We will now return to the government side. Mrs. Martin.

Mrs. Robin Martin: My understanding is—and I know there's work to do here still—that there has to be a member in good standing from another province or territory who is applying to practise here in Ontario with the college here, who is regulated by the college wherever they come from. We're using Saskatchewan today as our example, and that's good, because that's where I was born. I'm very proud of my Saskatchewan roots.

So let's just say they're coming from Saskatchewan. The idea, as I understand it, is that they have to be in good standing with their college in Saskatchewan, and they have to have a job offer here in the province of Ontario, and the new employer will have checked with the college and, presumably, the new employer will have done other things, often like criminal background checks etc. That's my understanding. I know there's work to be done, but I just wanted to put that out there.

Now, Mr. Leardi—no, he's gone. He doesn't have a question. He has left. I don't have any more questions, and I don't think anyone else does. I don't know.

The Acting Chair (Mr. John Yakabuski): With no more questions, that will conclude this round of questioning and, in fact, will conclude the presentation.

I want to thank the presenters for their presentation today and their participation. I remind them that if you would like to submit any written materials to the committee in addition to your presentation today, the deadline for written submissions is 7 p.m. Eastern Daylight Time on Monday, March 27, 2023. Thank you so much for joining us today.

Members of the committee, this concludes our business for today. Thank you again to all of the presenters. As a reminder to committee members, the deadline for filing amendments to the bill is 5 p.m. Eastern Daylight Time on Wednesday, March 29, 2023.

The committee is now adjourned until 9 a.m. on Monday, March 27, 2023, when we will continue with public hearings on Bill 60.

The committee adjourned at 1736.

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