The Empire Club Presents

DR. MICHAEL APKON, PRESIDENT & CHIEF EXECUTIVE OFFICER, THE HOSPITAL FOR SICK CHILDREN

WITH: **CANADA'S KIDS AT RISK: SYSTEMS TO IMPROVE CHILDREN'S HEALTH**

Welcome Address, by Gordon McIvor, Past President, Empire Club of Canada

November 21, 2017

Good afternoon, ladies and gentlemen, we are about to get started. From the Arcadian Court in downtown Toronto, welcome, to the Empire Club of Canada. For those of you just joining us through either our webcast or our podcast, welcome, to our meeting.

Before our distinguished speaker is introduced today, it gives me great pleasure to introduce our Head Table Guests to you. I would ask each Guest to rise for a brief moment and be seated as your name is called. I would ask the audience, please, refrain from applauding until all the Head Table Guests have been introduced.

HEAD TABLE

Distinguished Guest Speaker:

Dr. Michael Apkon, President and Chief Executive Officer, Hospital for Sick Children

Guests:

Mr. Ali Baddrudin, Managing Director, Management Consulting, Strategy Corp.; Director, Empire Club of Canada
Ms. Kate Crawford, Partner, Borden Ladner Gervais LLP
Ms. Sonia Jacobs, Vice President, Canadian Partnerships, NRC Health
Mr. Nick Pasquino, Partner, Borden Ladner Gervais LLP
Ms. Rose M. Patten, Special Advisor, BMO Financial Group; Past Chair, Board of Trustees, Hospital for Sick Children
Mr. Tony Van Straubenzee, Past President, Empire Club of Canada

My name is Gordon McIvor. I am the Past President of the Empire Club of Canada. Ladies and gentlemen, your Head Table.

On a cold spring day 142 years ago, an 11-room house was rented for $320 a year by a Toronto women's bible study group led by a certain Elizabeth McMaster. These dedicated women set up six iron cots and declared open a hospital for the admission and treatment of all sick children. Their first patient, a scalding victim named Maggie, came in on April 3rd. Forty-four patients were admitted to the hospital in its first year of operation, and 67 others were treated in outpatient clinics. And so began the story of what was to become the Hospital for Sick Children—branded simply as SickKids, fairly early on—a healthcare community dedicated to excellence and the compassionate care of children and their parents.

Twenty-eight years after the hospital's initial setup, the Empire Club of Canada, a speaker's podium set up by a group of men who did not want Canada to become part of the United States, was born. For the first decades of our history, there is no record whatsoever of SickKids in our archives—probably not surprising as it was still a small hospital that was still unaware of the vital role that it would play in later years in the history of our great city and country.

By the time the hospital located to its present location on University Ave., back in 1951, it was on the very spot where America's greatest movie star of the silent era grew up. Of course, I am referring to Mary Pickford, dubbed 'America's sweetheart', although she was Canadian.

We began to find the hospital mentioned in speeches delivered at this podium by our guests of that era. In 1986, we, of course, had one of our most legendary Canadian artists, Robert Bateman, speak to us. He actually made national news across the country by donating one of his masterpieces to the hospital, so that it could be auctioned off, and it was at the highest price ever received for a donated work.

Three years later, we welcomed the President of The Hospital for Sick Children, David Martin, to our podium. He gave a speech entitled "Swallowing the Bitter Pill," which focused on the difficulty the politicians of the year were having with the concept of co-payment. This speech led to considerable discussion on funding of the medical community in Ontario and, of course, cemented the relationship between the Empire Club of Canada and SickKids.

Fast forward to 2017, and we are now dealing with what has become the most famous and iconic medical facility in our nation, a hospital that parents around the world who have sick children have come to know, to respect and even to love. Once again, it is poised to grow and expand, ensuring that Toronto continues to be a centre of excellence for pediatric medicine and research.

Our speaker, today, has the impressive responsibility of overseeing what will be one of the largest fundraising exercises in the history of Canada. He has everything in his background and personality to ensure that this campaign will be entirely successful and will lead to a solid and bright future for the institution that he heads.

Dr. Michael Apkon is a physician executive and physician scientist who has served in C level leadership roles at several top academic hospitals in the United States and Canada. He has been the CEO of SickKids since January 2014. In that capacity, he leads a 300-bed hospital staffed by 10,000 employees, scientists, medical staff, students and volunteers with a $1 billion budget. SickKids is recognized as one of the world's top children's hospitals, as we indicated earlier, and is Canada's most research-intensive hospital, a highly successful clinical, educational, and research organization.

In addition to his role at SickKids, Dr. Apkon chairs the Ontario Provincial Council for Maternal and Child Health, a provincial program of the Ministry of Health and Long Term Care, aiming to foster the evolution of a more effective provincial healthcare system for women and children. He also

serves as a Director of MaRS Innovation, a commercialization cooperative and incubator for the life sciences and technology industries in the Greater Toronto Area.

He has had extensive international management experience in both pediatric and adult-oriented healthcare, working with organizations and governments in the UK, Europe, China, Africa and the Middle East as well as, of course, North America. He has consulted widely on business development, capacity development, and management systems as well as quality and safety improvement. He is an expert in strategy, systems development, and operations management, as well as the application of lean and high reliability organizational thinking to drive improvements in quality, safety and efficiency.

Dr. Apkon originally hails from the United States, but we know that he has come to love his new home in Toronto. If his world-class facility can be built on the site of what was the childhood home of a Canadian girl who became America's sweetheart, we know that he, in turn, can become Canada's medical hero for children, running a hospital that now truly belongs to and serves the entire global community.

We are delighted to have SickKids Hospital back with us, again, at the Empire Club of Canada. I would like you to, please, join me in a warm round of applause as we welcome its incumbent CEO, Michael Apkon, to bring us up to speed on his organization's very exciting and somewhat formidable plans for the next decade. Ladies and gentlemen, Dr. Michael Apkon.

Dr. Michael Apkon

Bonjour. Thank you, Gordon, for that really kind introduction. I only wish I had your voice. It is all so wonderful to see so many colleagues, supporters and friends here, today. I really thank you for taking the time to be here.

I am deeply honoured to speak before the Empire Club of Canada. I have come to appreciate your rich tradition, and I am humbled to have an opportunity to share my perspective on children's health and the importance of investing in Canada's future.

If you will indulge me, I am going to try to consider this a belated commentary on National Child Day, which is celebrated every November 20th since 1993, to commemorate the UN signing the Declaration of the Rights of the Child.

I believe I speak for many of you when I say how very fortunate we are to live and work in one of the most highly developed and most affluent countries in the world. Although there is considerable disparity and wealth across geography and across socio-economic groups, the mean per capita income here is high, and we have, perhaps, the wealthiest middle class.

I also feel fortunate to be a part of one of the most effective healthcare systems in the world and to lead an organization that sets the bar for specialized care for children in Canada and globally. I also take great pride and comfort in being part of a healthcare system that is built on the principles of equity and equal access for all. I have always been deeply troubled by the inequities created in my own home country south of

the border by the high cost of healthcare, many people's inability to pay, and what that means for the most voiceless and vulnerable.

I wear a lot of hats these days, and they are all important, but there are a couple that define me more than others. I am a physician, specifically, a pediatrician and an intensive care specialist. I went into medicine because I wanted to make a difference in people's lives. As a physician, I have had the privilege of witnessing and being inspired by the miracles of modern medicine, and I have also had the experience of helping some families through the most challenging and unimaginable experiences of coping with times when medicine is not enough.

I am also a physician who, today, chooses to spend most of my time as a healthcare executive, not because I wanted to move from the bedside, but because it was a means to an end, the end being better care and greater impact.

Maybe the most important hat I wear, though, is the hat of being a dad, filled with the hopes and dreams that every parent has, as well as the anxieties of parenthood, praying that my kids will stay healthy and happy, as I am sure all of you do. I can say that the way I think about being a physician and a healthcare executive has been shaped immeasurably by wanting every parent to have the joy that I have had from my kids. Since being a parent, I can also say that I feel other parents' fears and anxieties much more clearly. That has an impact in the way I carry out my day-to-day roles.

I spent my career working to make our systems of care

better and safer for children that need our help. As a society, we spend a lot of our treasure on healthcare, and we work to increase the health of our citizens. In fact, on a per capita basis, we spend $6,600 per person per year, roughly speaking, more than 11% of our gross domestic product, more than most of the countries in the Organisation for Economic Co-operation and Development (OECD).

I was speaking at an event last week and was asked whether I thought we received good value for our healthcare system. In many ways, maybe the most important ways, the answer clearly is yes.

Over time, we have seen remarkable progress in improving the lives of Canadians. Mortality rates for children under five has fallen by 85% since 1960. Over the same timeframe, life expectancy has risen from barely over 71 years to 82 years. It is among the highest in the developed world and longer than the 79 years in the U.S., despite their spending far more per capita on healthcare.

We attract visitors from all over the world who hope to learn from what we are doing well. Last month, Toronto hosted Senator Bernie Sanders as a well as a delegation from the Dutch healthcare system, hoping to see what they can take back to their own countries as they seek better value in their own healthcare systems.

Despite having a lot to celebrate, though, we do face a number of challenges that are not unique to Canada. We face rising expenses driven by new technology treatments and complexity. We have a limited ability to raise revenues

to address those expense increases. Even in an organization like SickKids, which has benefited from the incredible generosity of our community that has been inspired by our message, there is always room for more, more ideas than there is funding for.

We also, as a system, face ever-increasing demand from patients and families, demand for better quality, safer care, greater convenience, more equity, better outcomes, particularly, as information becomes more accessible. Despite universal access to services, we still experience considerable disparity when you look across socio-economic groups or between Indigenous and non-Indigenous people. For example, whereas infant mortality in Ontario is roughly about the same as the Canadian average, the mortality rates are much higher in the Northwest Territories and almost four times higher in Nunavut.

Recent studies by Astrid Guttmann, from SickKids, as well as the Institute for Clinical Evaluative Sciences, or ICES, demonstrated significantly higher childhood mortality from respiratory infections in more socio-economically deprived groups. The rate of suicide among youth in Ontario's northernmost regions are almost eight times the rates in Toronto and even higher in some communities.

We also know that some countries deliver what seems like even better value, slightly longer life expectancy, better performance on other measures that matter to people at the same or maybe even lower cost. To be sure, it is pretty tough to compare performance of our healthcare and social care systems without considering the complexity of genetic factors, environment, lifestyle and many other contributors to health. I have also learned that there is no perfect system, just different tradeoffs.

I would submit that the critical question, though, is not how do we compare, but rather how can we do better? How can we ensure that every Canadian child has the capacity to fulfil their and their parents' every hope and dreams? There is no doubt that we can do better with the will and with the focus. There are many, many opportunities to enhance value and to gauge improvement in our system, but I want to propose, however, that one of the most important and urgent opportunities is to improve the health and wellbeing of Canada's children. While there are many strategies that we could use to do so, I also believe that we need to identify a unifying objective to drive change most expeditiously.

In the time I have left, I want to share with you why I believe that addressing children's health is essential to the sustainability of our healthcare system, and I want to suggest several specific strategies, including, examining the way we look and configure our healthcare system. Most importantly, I want to suggest a unifying objective, a bold moonshot, if you will, to significantly reduce children and youth mortality as a way to organize our thinking and to gauge our progress.

There are at least four reasons to focus on children's health. The obvious argument is the moral argument that we have a moral responsibility to care for our most fragile and voiceless citizens. Second, better healthcare for today's chil-

dren will also contribute to a more secure future for today's adults. The birth and fertility rates in Canada are far lower than the so-called replacement level needed to compensate for society's rate of dying. We need to raise children to be productive taxpaying adults, and we should see the investment in Canada's children as an existential issue if taxpaying Canadians are going to continue to provide the social safety net that we rely on as we age.

Third, better healthcare for today's children is also a key to having a sustainable healthcare system into the future. By reducing the costs of caring for people into adulthood, with healthcare costs that are threatening to bankrupt government treasuries and a great burden of adult healthcare costs driven by conditions and lifestyles that are formed during childhood, investment in Canada's children is an important driver of long-term economic health. Consider the fact that 50% of all cases of mental illness across all ages first present in childhood. Children with disabilities and healthcare needs become adults with disabilities and healthcare needs. Adult obesity, diabetes and cardiovascular disease have their roots that begin as early as infancy.

Finally, poor child health creates an economic and social burden on families, including the siblings of sick children that contributes to poor long-term educational attainment, less economic success, and social deprivation that contaminates healthier siblings and spreads the impact across families and across generations.

When you consider the direct impact on health, the economic benefit of healthier adults and the amplified impact of families by relieving the burden of childhood illness, there is an incredible leverage in making investments in children's healthcare that I believe far exceed the kinds of returns that we see on other social investments.

If we are going to enhance health value, though, and extend life, we need to understand what drives health and well-being. Although I have a vested interest and probably a bias towards the impact of healthcare delivery, the truth is that healthcare delivery is a relatively small contributor. Genetics are a big contributor and explain maybe 30% or so of the differences or variation across different populations. Lifestyle and behaviour is an even bigger contributor accounting for maybe 40% of health differences. It is important to recognize that many of the important factors are defined in childhood: Eating, exercising, smoking, drinking, all those habits start pretty early in life. Social circumstances make up 20%, about twice the impact of healthcare delivery, so housing, transportation, poverty and education all are big contributors and impact the likelihood of being sick, the ability to get help and the ability to cope with injury and illness.

I did say that healthcare is not the major driver. Nonetheless, it is one that carries an awful lot of weight.

It is part of the broad social care system that sees the opportunities, has a lot of the complicated and sophisticated management and governance systems to drive change, and also has expertise in problem-solving and knowledge translation.

Involving healthcare systems, and, specifically, hospitals, seems to be a key success factor and, indeed, other jurisdictions leverage healthcare systems to drive broad change. Saving lives depends on understanding not only the causes of death, but the important contributors which serve as some of the most effective targets for intervention aimed at preserving life. It is important to realize that the approaches change over a child's lifetime and the opportunities start before a baby is even born.

Prematurity and birth injury are important contributors to mortality in the first 24 hours of life and a significant cause of lifetime disability. Three of the four top risks identified by the Health Insurance Reciprocal of Canada relate to the care of pregnant mothers in the delivery of their babies.

Birth injuries to babies are one of the top reasons for insurance claims for both hospitals and doctors. Contributors to prematurity and birth injury are clearly complex, and they are not simply a reflection of healthcare delivery. Living in rural communities, poverty, teen pregnancy, substance abuse are all important potential contributors. However, the healthcare system can build systems of care that distribute expertise more effectively, build capacity in remote centres that do not get a lot of practice with the kinds of emergencies that lead to harm, and help educate providers and the public to improve prenatal care as well as labour and delivery services.

For infants and young children, disease becomes a major cause of mortality and morbidity. For children, cancer is responsible for approximately one-third of all deaths under the age of 14, and it remains a major cause of death in childhood, despite the survival for children with cancer in North America increasing from 10% to more than 80% over just 50 years.

There continues, though, to be considerable room for improvement. One out of five children still dying from their cancer has to be unacceptable. Moreover, childhood cancer treatments cause considerable long-term morbidity that influences adult health, including the potential for secondary malignancies during adulthood. We need to continue investing in new cures and improved therapies for childhood cancers as well as research into the causes and long-term consequences of childhood cancer.

Similarly, we have to continue investing in research, seeking to change the course of the inherited and acquired diseases of childhood that are responsible for nearly 20% of the rest of childhood deaths. Emerging technologies, such as gene therapy, regenerative medicine, and tissue engineering, all of which are current realities in at least some limited way, hold the promise of a very different outcome for children suffering lifelong and life-threatening medical conditions.

Just recently, really in the last couple of weeks, we saw a paper describing a child cured of a terrible and often life-threatening skin disease. He was cured by taking a small piece of his skin, curing that little piece of the genetic defect that he suffered from, growing that piece into nine square metres of skin and then, through a series of skin grafts, replacing his diseased skin with the now normal version of his own tissue.

Here, at SickKids, we announced, together with our partners at Mount Sinai, the first Canadian repair of a spinal deformity called spina bifida while the baby was still inside her mother. That repair at 25 weeks of pregnancy likely prevented the kinds of complications that can cause a lifetime of medical difficulties and early death.

Expanding on these kinds of successes and bringing the promise of new advances to fruition requires a pretty ambitious research agenda and appropriate investments in supporting translation of science from discovery to recovery.

SickKids is clearly an organization working to increase our impact in all of these areas and, I think, the best poised in the world to advance a number of these areas, including the regenerative potential of stem cells.

Beating back the scourge of disease, however, is not, by itself, sufficient. Death and injury by accidents is a major factor even in infancy, but it increases in importance as kids get older. Death by accident and suicide account for half of deaths in Canadian children under 14, and almost 80% in teens between 15 and 19. In that older age group, suicide accounts for nearly 30% of deaths. The factors contributing to accidents or the failure to prevent a suicide are complex, but we have to consider these deaths preventable. We know that affluence and poverty are important factors with traumatic injuries significantly higher in the poorest fifth compared to the more affluent parts of society. This is particularly important, given that 1.2 million or 17% of Canadian children live in poverty.

Although healthcare delivery itself is unlikely to be the most important driver of death and injury, improvements, better healthcare delivery absolutely would help. Many of you are likely aware that preventable deaths in hospitals are all too common. Medical errors are considered the third most common cause of death in the U.S. I do not think it is much different in Canada. Kids are at particularly high risk. Regardless of how good hospitals and other providers are, some harm actually happens as a result of care, whether it is by mistakes or by complications that are not effectively prevented. As good as SickKids is—and I do think we are very, very good—we know that there are circumstances where children suffer harm within our walls. Although we do not necessarily know how to prevent every mistake, we do believe we have a moral responsibility to see what we can learn and to work hard to get better and better.

That is why three years ago, we made a commitment to reduce preventable harm by two-thirds over three years, by committing to more reliable practice, better teamwork and to learn from our failures. The approach we took is not particularly novel, but it also is not particularly easy. It does work at SickKids and many other organizations that have followed a similar route, and we have reached our goal sooner than expected. We are working hard to go even further and to share what we have learned with other partners. Systems of care are also important and are particularly important for children. It is not reasonable to expect that every healthcare-providing site provides all things to all people. The more specialized the service, the fewer the people that need it and the more it tends

to be concentrated in a few centres. Because specialization tends to lead to better outcomes for certain surgeries and treating certain diseases, we leave people having to choose between quality and convenience, particularly, when they do not live next door to the kinds of centres that we are so lucky to have here in downtown Toronto.

Care for children is particularly highly specialized. That specialization, we know, makes a difference. Children are twice as likely to survive life-threatening, traumatic injuries when they are cared for by specialized pediatric trauma teams. It is pretty challenging to provide expertise, though, when it is concentrated at very few specialized centres. Eighty-five percent of kids come to their local emergency department rather than a children's hospital when they need emergency care. Yet, it is uncommon to find children's doctors or nurses in these local emergency departments.

We know that the likelihood of surviving a life-saving emergency is better and higher in a specialized centre and in centres that see a lot of kids compared to those that have fewer visits. SickKids, as an example, sees nearly 80,000 children a year in our emergency department. In contrast, other hospitals in Ontario see as few as a few thousand or even less.

Kids also cannot come to urban centres where there are specialized hospitals every time they need to see someone for their mental health or for a clinic appointment. Kids with complex needs also need to be supported in their local communities, in their home communities, rather than having

to relocate to urban centres where specialized resources are more accessible. We have to invest in efforts to share expertise from specialized centres with those caregivers and health centres that are the points of first contact and the critical safety nets for children who are ill or injured. It is important that we begin thinking about networks of care that bring together, with some form of common governance and accountability, hospitals that span a continuum of services and a very broad geography. These networks can facilitate planning, knowledge translation and coordination in ways that distribute expertise and share care responsibilities much more effectively.

It is interesting to see the UK's national health system organize 15 academic health science networks to cover the country and act as facilitators to drive change, drive improvements and facilitate knowledge translation across the full continuum of services from home to very advanced care settings. It is also interesting to watch the networks that are developing in Southwestern Ontario around London's Health Sciences Centre and the network in the Hamilton area around St. Joseph's and Hamilton Health Sciences.

Networks can help leverage the management structures, governance and enterprise systems that are so well developed within the largest hospitals and to create a more effective approach to driving a holistic way of caring for larger populations, something that I know the local health integration networks are very intimately involved in trying to drive as well. Networks also can forge more effective connections with parts of the social care system. Cincinnati Children's,

one of our peers in the U.S., is one organization that has leveraged their network to support school-based health clinics and health-supporting connections with other sectors, including even fire departments, homecare agencies and many others.

Beyond healthcare delivery, efforts to make care generally more accessible will also help. For example, reducing the financial burdens through programs like Ontario's OHIP+: Children and Youth Pharmacare program will promote equal access to health-sustaining medications.

I have already mentioned a number of ways through which we can help children grow into productive adults. Clearly, there is no end to the investments that might be helpful in improving health and wellbeing for children. SickKids is working hard to do everything we can to have an even bigger impact. I mentioned the work that we are doing to improve safety. Our scientists are working hard to find new treatments for cancer, neurological diseases, heart disease and many other conditions. A major part of this is embracing the power of data, the power of genomics and the power of regenerative medicine to better understand disease and to save lives. We are working hard to expand and improve mental health services through telepsychiatry and through the integration of the Hincks-Dellcrest Centre, now the SickKids Centre for Community Mental Health. With the support of the provincial government, we have also created an alliance, the Kids Health Alliance, with our partners at the Children's Hospital of Eastern Ontario and Holland Bloorview Kids Rehabilitation Hospital.

The purpose of Kids Health Alliance is to collaborate more effectively between us and to enlist and engage like-minded partners, like Markham Stouffville Hospital, in improving the care of children closer to home, particularly, in emergency departments.

We have a lot to share, and we have been fortunate to be supported by philanthropy and the Government of Canada to share what we have learned with partners in Africa, in China and other parts of the world. For those of you that have supported us, and I know many of you are in the room, thank you.

Our VS campaign to rebuild SickKids is a bold campaign to change the future of pediatric healthcare and the experience of children that face injury, illness and recovery. We also know that there are many agencies, organizations, and individuals that are working to make important differences in your own ways. When we think of all the ways we can collectively have an impact, I have no doubt that different stakeholder groups are going to see opportunities through different lenses and debate the relative benefits of addressing prenatal care, poverty, education, nutrition, mental health, equal access, improved healthcare delivery or better treatments. They are all relevant.

We can also expect that each stakeholder that you engage in the discussion may well have a different measure of success in mind—less income, inequality, better educational attainment, whatever is most relevant to their perspective.

For policymakers, government and even for those intimately involved in improving our systems, it is pretty difficult

to decide what to address first or to decide how to compare the relative impacts of competing projects.

We need an organizing theme, a way to keep track. We also need to be clear where we are going with an ambitious target that would bind together various stakeholders and perspectives under one umbrella.

In 1960, U.S. President John F. Kennedy called for an effort to put man on the moon within ten years. Kennedy recognized that a moonshot was an organizing theme that would advance many different areas of science and technology as well as achieve an important strategic objective. It fostered a new age of innovation that not only achieved its goal, but also spurred advances in many areas that have improved lives globally, and we enjoy a lot of that today.

When we consider the complexity of improving the lives of children, we have to recognize that efforts to reduce mortality will benefit in immeasurable ways beyond saving lives. If we want to reduce, for example, the number of children that die from suicide, we have to improve better access to more effective services for many, many children. That will improve the lives of those countless more children than only the children whose lives are saved by those efforts.

I have always been struck by the words of Dr. Don Berwick, the former Chief Executive Officer for the Institute for Healthcare Improvement and the former Head of the Centers for Medicare and Medicaid Services in the U.S. Don was famous for saying, "'Some' is not a number and 'soon' is not a time." I believe that if we want to make an important impact,

we need a lofty goal, that is specific and timebound. We need a child wellbeing moonshot, achievable, yet ambitious.

If Canada were able to reduce its childhood deaths to the average across the G7 countries, deaths would fall by 15%. Were we able to reduce deaths to the average of all the OECD countries that are higher ranked than Canada at the number 19 position, we would have 30% fewer deaths.

Based on the examples of what has been achieved in peer countries and assessment of the trajectory of improvements that we are already enjoying and my rough assessment of the contributors to child and youth mortality, I want to propose that government, organizations, researchers and clinicians work together to take on the ambitious, but achievable, goal to reduce child mortality by 30% in five years.

The point is not the target. Ultimately, we should be aiming to eliminate childhood mortality, but let us not negotiate the ultimate goal, although we are going to have to negotiate the timeline. The point is not the time. We simply need to identify a timeframe that is short enough so that we are not delegating the responsibility to future generations and long enough so that we can see some real impact. The point is not even the objective, but we do need some way to create a big enough tent to engage critical stakeholders and an objective that is undeniably relevant, measurable and improvable. The objective of saving lives ought to be relevant to everyone interested in mental health, healthcare disparity, children's health research or the social determinants of health, such as poverty or education.

Kennedy said in his address at Rice University, "We choose to go to the moon in this decade and do the other things, not because they are easy, but because they are hard, because that goal will serve to organize and measure the best of our energies and skills, because that challenge is one that we are willing to accept and one we are unwilling to postpone, and one we intend to win."

I want to close by suggesting that we need the same lofty ambition, the same single-minded focus and the same challenging trajectory if we want to significantly advance health and wellbeing of Canada's children. That lofty ambition, again, is to reduce childhood mortality by 30% over five years. That would mean saving 1,000 children a year across Canada.

On my recent visit to Johannesburg, South Africa, to work with our partners at the Nelson Mandela Children's Hospital, one of which is here in the audience today, I was reminded of Mandela's words. He said, "There can be no keener revelation of a society's soul than the way in which it treats its children." I want to ask each of you to hear these great leaders and to build on the principles of social justice that form the foundation for Canada's healthcare system to invest in our children's health and Canada's future. Thank you. ***Merci à tous.***

Questions & Answers

Q: What would be the hospital in another country that is most like SickKids in both its governance and the services it offers?

MA: Thank you for that question. SickKids is organized like many of the other great children's hospitals around the world in that it has an independent governing body that helps guide the children's hospital's strategy and holds management accountable. I would say our closest peers around the world would include places like Great Ormond Street in London, after which SickKids was actually created in some ways. In the United States, places like Boston Children's Hospital, the Children's Hospital of Philadelphia and Cincinnati Children's would be the organizations that we would see as our peers.

What distinguishes those places from many other healthcare institutions and other children's hospitals is the ability to bring clinical care at the very highest level, that is doing everything that, today, is possible, but also seeing the gap between what we have and what we need, and then having the power or the kind of research institute that we have at SickKids to find creative solutions to that gap, and then put those solutions into reliable practice through the educational programs that we have, which train not only the next generation of Toronto and Ontario's pediatric healthcare providers, but, through the partnerships that we have and the training programs that

we have, spread that knowledge around the world.

Q: Hello, sir. This is Rakesh from Cadillac Fairview. We were discussing a lot of post-issues, like how we are going to deal with the issues. My basic question is how can we address most of the health-related issues by making children more aware at the schools of those small things like drinking water in the morning, those basic things, which can have future benefits? How we can inculcate them in our children through the school curriculum? Thank you.

MA: If I understand your question, you are asking how can we promote healthier activities and a healthier way of life by intervening much earlier in a child's life. I think that is a really important question and actually an important question to answer as part of an approach to reducing childhood mortality and improving wellbeing. Number one, I do not think there is a simple answer to that question. I would not purport to be an expert in the educational system. What I do see as being helpful when I look in other jurisdictions and even other parts of Canada, including parts of Ontario, is the connection between the healthcare system and the social care system that help drive an agenda about what the important things are to educate about; how to reach the people of influence around a young child's life in terms of not only their parents, but educators and their local healthcare providers, to be able to have a collaboration that is aimed at reaching whatever lofty objection is established, whether that is promoting earlier reading or whether that is promoting healthier lifestyles. I think that what is beginning to happen in other jurisdictions is a blurring of the lines between health and other parts of the social care system.

I mentioned the collaboration in Cincinnati Children's. They are working with all kinds of public-facing agencies in communities to try to identify what are the changes in lifestyle, behaviour, access to public services that would allow a child to not become ill and have to come to hospital. I took the statistics out of my talk in the interest of length, but that group recently published a manuscript that has had a lot of press where their public partnership across many different types of organizations, including school systems, were able to put together a number of interventions that reduced the hospitalization rate for children with asthma, a life-threatening condition of childhood, by 40% in the most impoverished socio-economic groups in their region. It was a partnership that blurred the lines between health and the social care system. I think that is part of what is necessary to drive the right kind of dialogue to address the kinds of issues that you have raised.

Q: Hi, Dr. Apkon. Abdulraheem from SickKids. I do have a question for you, something that came to mind, probably from a thought that we are probably in the back end of the OECD countries, primarily because of our 14 provinces. Nobody is willing to take accountability moving healthcare forward, which

makes it very difficult to pass either legislation or new efforts, such as building an EHR system that has been much easier in other countries. In moving forward with a moonshot goal, how do we build accountability, not only on a local level, but throughout the cascade of our provincial regulatory authorities, where we can have a sense of metric that people are held accountable to, so that we can see progress moving forward, which I think is one of the biggest challenges here in Canada?

MA: I think your question is a good one. I would say there are challenges here. There are also things that make it easier to organize the healthcare system and the connection between healthcare and social care in Canada compared to many other countries, particularly, if I look south of the border where there is a much greater degree of fragmentation and less governance and accountability around concepts like population health. I think one of the things it takes is alignment around a common objective. It is, in part, while I proposed this idea of a moonshot focused on mortality. It is a measurable, relatively quickly moveable metric that actually can be examined based on geography or socio-economic population or by disease, a child's condition. There are a lot of ways to kind of slice and dice that data to get insight into what things might make a difference. It is also the kind of thing where you can distribute the responsibility across different communities in different ways.

To address the issue, though, we have to start thinking in ways that blur our organizational and sector boundaries in some way. I was at a talk, the OHA HealthAchieve meeting a couple of weeks ago. One of the speakers was Dr. David Nicholson, who used to run the NHS (National Health Service). He was talking about governance in the age of healthcare transformation. What he said is, you have to organize your governance to get the kind of system that you want. If you want to address the health of populations, you need to think about governance and accountabilities that span populations and address the set of services that they need to have. I think there are lots of ways to do that beyond formally kind of amalgamating governance. The Kids Health Alliance that we have created is one way to create a strategic alignment and accountability among partners that commit to working in a particular way to advance a specific agenda.

I think that it is the boundaries that sometimes get in the way and however we can transcend those boundaries is going to be a part of the issue. That includes to address your thought about different provinces and different territories. That also means across provincial and territorial boundaries. There is no way for Nunavut to support the kind of specialized services that we have in Ontario. There just is no way to do that. The issue becomes how do you extend the specialized services from Toronto, Ottawa, Winnipeg and other centres that have specialized services for children into the north? We do that through

telepsychiatry now. We support poison centres at SickKids for other provinces. We need to do that more.

I think there are ways for both federal and provincial governments to help. Some of it is organizations being willing to take on the mandate and the other part is the people who need to partner have to look at places like us as being able to help and being willing to help as opposed to the division of responsibilities being narrowly defined.

Note of Appreciation, by Kate Crawford, Partner, Borden Ladner Gervais LLP

Thank you, Mr. McIvor and Dr. Apkon. As was just mentioned, my name is Kate Crawford, and I am a lawyer at Borden Ladner Gervais, which is a law firm. I would like to thank Dr. Apkon for his thoughtful presentation.

We, at BLG, are proud of the special relationship that we enjoy with our hospital clients, and in particular with SickKids, with whom we have worked for over 60 years. We aim to deliver strategic legal advice and hope to help our hospitals protect their operations, to mitigate risks, and, most importantly, to move forward in the bold type of initiatives aimed at achieving the outcomes that Dr. Apkon described today.

I have had the great pleasure of working with Dr. Apkon and many of the outstanding team members from SickKids, who are here today, on several occasions. We are very pleased to be here today to sponsor this event and even happier to be working with the SickKids team. The leadership displayed by the hospital on both a macro and a micro level continue to impress us at BLG, despite our long-standing relationship.

Today, I listened carefully to Dr. Apkon's discussion of challenges facing the delivery of healthcare, including poverty, access to the north, and costs and what SickKids proposes to do to address these challenges. Let us respond to Dr. Apkon's call to arms to enhance and improve the health of Canada's youth. BLG is proud to be a supporter of SickKids, and we look forward to our contribution to this objective.

Thank you, again, to Dr. Apkon and to the Hospital and thank you to all of you today for attending.

Concluding Remarks, by Gordon McIvor

Thank you, Kate. Thank you so much. A sincere thank you, as well, obviously, to our sponsors, Borden Ladner Gervais and to NRC Health for making this event possible, today. Without sponsors like these great companies, the Empire Club lunches would not be possible. We very much appreciate your sponsorship.

We would also like to thank mediaevents.ca, Canada's online event space, for webcasting today's event for thousands of viewers around the world. Although our club has been around for well over a century, since 1903, we have moved into the 21st century and are very active on social media. We invite you to follow us on Twitter at @Empire_Club

and visit us at www.empireclub.org. You can also follow us on Facebook, LinkedIn and Instagram.

Finally, please, join us again for our upcoming events.

We are having quite a season this year. I think we have events almost every day this week and next. We are actually sold out tomorrow for Andrea Horwath, but I do want to let this audience know about an event next week because it is germane to the folks in this room: On November 27th, we will welcome Rob McEwen and Dr. Michael Laflamme at One King Street West. They will be addressing the future of stem cell research in Canada and its impact on our future well-being as Canadians. That concludes our meeting today. Thank you very much for your attendance.

Ladies and gentlemen, this meeting is now adjourned.