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Tuesday 21 February 2006

Mardi 21 février 2006

Speaker
Honourable Michael A. Brown

Président
L'honorable Michael A. Brown

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LEGISLATIVE ASSEMBLY
OF ONTARIO

Tuesday 21 February 2006

ASSEMBLÉE LÉGISLATIVE
DE L'ONTARIO

Mardi 21 février 2006

The House met at 1845.

ORDERS OF THE DAY

LOCAL HEALTH SYSTEM
INTEGRATION ACT, 2006

LOI DE 2006 SUR L'INTÉGRATION
DU SYSTÈME DE SANTÉ LOCAL

Mr. Smitherman moved third reading of the following bill:

Bill 36, An Act to provide for the integration of the local system for the delivery of health services / Projet de loi 36, Loi prévoyant l'intégration du système local de prestation des services de santé.

The Acting Speaker (Mr. Ted Arnott): I recognize the Minister of Health to lead off.

Hon. George Smitherman (Minister of Health and Long-Term Care): It's a privilege, as always, to have the opportunity to speak in this chamber. I'm particularly proud tonight to be able to do so on the subject of Bill 36.

This is a bill that is designed very much to echo the ambitions that Ontario's patients have for a health care system, not just a loose cluster of services but one that actually performs like a system. We believe that the high expectations that the people, the patients of Ontario, have for their health care system are appropriately high.

We're a government that brings to our responsibilities for the delivery of health in our province a fundamental belief in medicare, that the system is not our system, that it's not a system that belongs to the stakeholders, but rather that it belongs to the patients. The public health care system, by its very nature and by the very words we use, is owned by the public. Accordingly, at the heart of this bill is a desire to give them more responsibility, more control, more opportunity for input and influence over that very system they themselves own and that has been seriously lacking, I say to people who will be watching from home tonight.

What we seek to create here in Ontario is the capacity to organize our health services in a regional way, along the lines of the way that the services are delivered, that recognizes the patterns people go through right now to be able to receive care. We believe that part and parcel of that is to create a better opportunity for patients, for citizens, on a daily basis to be more engaged in the

decision-making and discussions that go on around the way health care is organized.

I say that there are, I believe, a lot of pretenders out there. There are a lot of people who pretend they are the voice of medicare, but I really believe our government has a very strong case to make about the work we've done as a government since coming to office in 2003 in terms of underscoring our fundamental belief in medicare. I say all the time with pride that medicare is the best expression of Canadian values, but we back that up. If you want to call that a lofty statement or if you want to call it rhetoric, it doesn't matter to me, because we've backed up that language with serious action.

The first bill I had the privilege of introducing in this Legislature, Bill 8, the Commitment to the Future of Medicare Act, is now a bill that is seen as being particularly helpful in turning back some of the pressures that are there for private health care, but we must call attention to the reality, which is that there are two political parties in opposition in this Legislature, both of whom stood in opposition to that bill, even though it's a bill that outlined the principles we believe a vast majority of Ontarians share with their government, and that includes fundamentally the principle that a person's access to health care should not be determined by the breadth of their wallet. Indeed, it's been a disappointing circumstance in this Legislature to hear those on the opposite side offer rhetoric about their commitment to public medicare when their record shows they voted against Bill 8, a bill which has been proven effective in helping to turn back the tide of private health care.

1850

We are the government that said to LifeLine, that Ohio-based company that thought that they were going to come in and offer prospective services to patients all across the province of Ontario, "No. We will meet you at the border and we will turn you back." We're the government that has worked to repatriate MRIs into the not-for-profit sector with the view toward making sure that the provision of these important services was not left to people coordinating or operating on their own, but rather that they were tied in, in a systematic way, to health care.

A public health care system fundamentally must provide—must seek to provide—health care in an equitable way. I'm proud of many things that I have had the privilege of doing as minister of health, but what I'm proudest of are the opportunities that I have been provided, and that our government has taken advantage

of, to be able to begin to equalize the access of Ontarians to health care.

The member for Barrie–Simcoe–Bradford is with us today, and I talk a lot about the circumstances in Barrie. Barrie is not a Liberal riding, but it's a riding close to my heart because it's close to my mother's home. I don't find it a satisfactory circumstance that, in this same Ontario health care system around which so many people here today are so encouraged to cling to the status quo, we had a circumstance where the people of Simcoe county who live in and around the Barrie hospital were being asked to wait one year for access to an MRI, when in other parts of the same health care system, access could be achieved much more quickly. It was not satisfactory to inherit, as a government, a circumstance where the people of Ottawa were set back so far with respect with access to MRI. I am proud that we have been a government that has been involved in enhancing access on an equitable basis.

There is more work to be done, but if we are to use the word "system" associated with the public health care system, then the obligation is ours, the responsibility is ours to make sure that those services are more equitable than they are at present. Local health integration networks create boundaries, regional boundaries which patients can move across, but at the same time, just doing that alone creates an accountability whereby the health care providers in that area will have a clearer sense of responsibility for the patients who also live there. We take a population health basis approach to the coordination of health care because it is time at long last to put the patients at the centre of health care in this province.

I grow a little frustrated, I must confess, when I watch, in particular, organized labour in our province seek to play what I think are very dangerous games with their employees, with the employees who are part of those unions. Members in all parts of the province have come to me and repeated the stories that unions have told and retold about impending layoffs and all of that; this great spectre of gloom and doom. The only problem with it is that it stands in stark and direct contrast with the reality of health care in the province of Ontario today.

I just want to go through a list of some of those investments that we've made, investments which enjoy the mark of approval from people like Roy Romanow, someone that our government has looked to very much for solutions in terms of some of the things that need to be done at long last in health care in our province.

Community health centres: I believe everyone in this Legislature agrees that community health centres are fundamentally essential to help address the particular challenges that occur, especially in some communities. Our government is the one that's making a \$75-million advancement in bringing to life about 40 new community health centres across the province of Ontario. These are exactly the kinds of things that Romanow and others have pleaded with jurisdictions to move forward on. Here in Ontario we're well beyond the talk; we're getting it done.

We're developing 150 family health teams: interdisciplinary health care. Who told us about that? The same people, those champions of public care like Roy Romanow who, like our government, believe fundamentally that the health care system that we have is a good one but that it can be enhanced dramatically and that we can seek to achieve a better result and outcome for the people of the province of Ontario.

Midwives: We've enhanced quite dramatically access for Ontarians to midwives, and we're working hard to produce more of them. We're a government that has brought in a new vaccination program, because we think it's an honourable and appropriate thing to do to offer those newborns, those youngest in our society, the best possible way forward. That's the same reason why our government is moving Ontario from worst to first on the issue of newborn screening. We will not stand idly by while opportunities to enhance the care for our youngest are passed over.

Residential hospices: We worked with those people who bring so much love and commitment to the work that they do, mostly as volunteers, to enhance the dignity and the quality of life for those who are in their final days. We are moving forward with a \$100-million investment to create a coordinated end-of-life strategy that includes 30 residential hospices.

These are just some of the initiatives that we have been involved in, but they are a very good indication of the values that our government brings to the work that we do in health care. We believe fundamentally that it is a value-laden mission. Health care, I say all the time, is this most special public service. It's not really just a service at all. It's not just about an extension of care; it is about the contribution of love that goes alongside that care. The values that people like Roy Romanow have championed are the values and initiatives that we have championed as a government as well.

But it's time for all of us to stand in our place—and I offer this challenge to others: Stand in your place and send the signal that the status quo is not good enough. The reality is that there are two political parties. They are in opposition in this chamber, and they stand in opposition to everything. They do not share a vision with the people of the province of Ontario that recognizes the qualities of the public health care system while at the same time recognizing the tremendous opportunities to enhance the quality. We believe in medicare, and fundamentally we believe that it can be better. The obligation is ours to return some semblance of voice, to provide more opportunity and to enhance the quality of the conversation for those people, those patients, 12.5 million of them strong, who have been left on the sidelines for too long in a debate that has been controlled by those inside health care, who very often rely on the complexity and the language of health care to deny the people of the province of Ontario the fundamental opportunity that ought to be theirs, which is to be involved in the conversation.

If you are someone who's listening in at home and you take nothing else away from the presentation that I make today, then take this away: The circumstances where health care decisions have occurred that come out of the blue with no notice at all are something of the past. If this bill is passed tonight, local health integration networks will gain new opportunities, new responsibilities to engage in meaningful citizen dialogue, to be transparent in their actions and to make their decision in the full light of day with the citizenry and the patients of the province of Ontario there as well. It's time to uncloak the decision-making mechanisms of health care and to provide the citizens with more of an opportunity to influence them.

We believe in reform. We recognize, of course, that inherent in any reform, in any change, there are challenges there for people. Of course, we know it. We each go through this in our personal way. But the changes that we seek for health care are changes that are necessary on behalf of the patients of the province of Ontario.

We are not pretending. When I spoke at the committee, I had the privilege of saying that there is no intoxicating offer, no panacea here. No one here is pretending that the changes that we seek can be accomplished overnight. No one here is pretending that all of the challenges we have can be confronted at the same time. No one on this side is pretending that if you identify 1,000 problems, you can fix 1,000 problems at once. But there is a very sound principle here, and it goes like this: You cannot appropriately manage a \$33-billion operation from head office. You can try, you can pretend and you can shovel the dough out the door and try to send it in the most appropriate direction possible, but in a circumstance where Ontario's health care system has not evolved equally, it is impossible to distribute resources from Queen's Park in a fashion that is equitable for the people across the province. The reality is in, it's clear, and people have to stop pretending. It's not any good any longer to pretend that the people of Ottawa have not been disadvantaged with respect to access to hip surgery and knee surgery, because they have. Moving towards local health integration networks, collecting that data on a regional basis, is the first step in addressing some of the fundamental inequities that have been very disturbing to people in various parts of our province.

1900

We believe in change. It's necessary, in a time of evolution, to evolve. No one should pretend their way through this any longer, that the status quo of services delivered 30 or 40 years ago in a hospital is the same service that should be delivered now. I had a meeting very recently with the mayor of a small community who worries for the future of his hospital. I had to look that mayor in the eye and say, "The circumstance where your hospital delivered 63 babies last year is not a circumstance that is sustainable." The same hospital, 30 or 40 years ago, might have delivered 300, 400 or perhaps even 500 babies. We cannot pretend away the clear reality, which is that if you have to get a service done, especially if it's one that has a higher acuity, a higher risk asso-

ciated with it, the evidence is clear: You want to have that service provided in an environment not where they do it every two or three days, but rather where they do two or three a day. And we can't pretend any longer on points like that.

We believe in continuous quality improvement. The health care system provides a tremendous resource to people. It supports a variety of programs that we should be very proud of. We have good population health stats in a variety of ways that we should hang our hat on and say, "These are the benefits of the public health care system," but that does not mean we should pretend our way through many of the challenges that our patients are experiencing.

We are a government that is restless to see improvement, but we also recognize that that improvement must be marked in what I call continuous quality improvement; not the policies of the Conservative government of the past, that for the first three or four years in government cut and slashed and burned their way through every branch of the Ministry of Health, leaving hospitals eviscerated and on the sidelines, thousands of nurses chopped off at the knees and sent packing, and compared to hula hoops; nor the policies of the New Democratic Party, which closed 11,000 hospital beds on their watch. These are the policies that we cannot return to.

We have introduced, through our funding initiatives, a stability that the health care system has needed for a long time, not some magic number where people pretend their way through the idea that 10% or 15% increases on an annual basis are sustainable. None of us would pretend, if our mortgage payment or our rent payment was going up at 10% or 12% a year, that we could sustain that, year in and year out. We are not pretending. But we do believe fundamentally that if you provide sustainable, stable funding and you attach to that appropriate accountabilities, this health care system, fuelled by 250,000 people of commitment and conviction and compassion, can innovate and improve, and that together we can provide an even better benefit to the people of Ontario.

We've set about that path of improvement. We're working very vigorously to reduce wait times. It wasn't me, it was Cancer Care Ontario that reported that, through our initiatives, radiation treatment for cancer patients—people we all know and care about desperately—were reduced in one year, year over year, by 16%. This is a celebration, not of our government, but of those front-line health care providers who have reoriented the way that they do work, with a view towards enhancing access to our patients.

On the issue of more nurses and doctors, every story around here about any adjustment in a hospital environment where some workers may face layoff is promoted to the very highest level. But why have the patients of Ontario, as a result of the actions of parties in opposition and labour unions, not come to know, as they deserve to know, that on our watch there are more than 4,000 new nurses working in health care in Ontario?

It's appropriate that the people of Ontario note that last year in our province, with only one exception in our entire history, did we license more doctors. The College of Physicians and Surgeons reported just a few weeks ago the highest number of doctors licensed in any year other than 1986, and—get this—the largest single group of those getting licensed were foreign-trained doctors: international medical graduates making up 39% of the entire total.

We believe fundamentally that Ontario can be a healthier place. That's why I'm so proud that the Premier in June at the cabinet shuffle introduced not just a new minister but a new ministry, new leadership, energy and resources to dedicate to the task that we must all be dedicated to: keeping Ontarians healthier in the first place. These are the commitments that we've worked on: no delusions, more honesty and no pretending. No panacea game here, just the simple recognition that in an environment where there will always be fewer resources than we would all prefer, it just makes good common sense to ask people from local communities who are closer to the action to exercise crucial judgments like which health care priority in our area must be supported first. This is the principle that is at play.

I listened to Mr. Tory the other day malign those people who have come to serve on the boards of local health integration networks. I felt bad about it, because I know that John Tory really didn't want to criticize Tony Fell. Tony Fell is a man who shares a different political ideology than mine, but he's also someone who has a demonstrated track record of commitment to community. If you look across the breadth of all of those who I have had the privilege of bringing forward for nomination to roles in local health integration networks, they don't all share a common lineage, they're not all from the same socioeconomic group and they most certainly are not all from the same political party, but they have one thing in common: They are people who have a demonstrated track record of commitment to their communities.

Something I have been very saddened to see is the Leader of the Opposition seeking to be partisan and to dispense with any content to, in one single swipe of a sentence, diminish all of these people as the hand-picked toadies of the Minister of Health. This tells you a lot about the dynamic that they want in health care. They're just like the union stakeholders. They want to set up a dynamic whereby it's all about the fight, or, in the case of the New Democratic Party, it's all about the process. But where does the rubber hit the road? At what point is it the responsibility of the province of Ontario to fulfill its fundamental accountability to the people of the province who, like our government, are restless for change and for improvement? We are not a government that enjoys the privilege of governing because we went to the people and offered them the status quo. We are a government that is fulfilling the commitments we made to the people of Ontario because, like them, we fundamentally believe that our system of public health care is good and can be better, and that's what we're motivated by.

As various provinces adopt or discuss private delivery options, unions pretend that this bill is the real threat to medicare. They dedicate themselves, they bring an energy that is rather remarkable and they spend time and energy convincing a sector that has seen nothing except increased employment. They see their role and responsibility as frightening those people, to make them angry, to tell them that they will be laid off. These circumstances are frustrating to a health care system that has had just enough of those brinkmanship games.

Local health integration networks are operating on a simpler premise. It's a realistic premise. It's no more pretending. It's a recognition that fundamentally the things we seek together, those values that we have in common, can be delivered on with a fundamental commitment and belief in community. John Tory makes up scary stories, and then on the weekend he endorses Copeman-style private medical clinics. Here's what I know about a Copeman-style private medical clinic. That's where the publicly trained doctors leave the public system and the patients behind. They go in search of patients who can afford to pay them thousands and thousands of dollars. Well, I can't afford that and most of the people I know can't afford that. In fact, most people can't afford that, and we work for most people. That is our responsibility.

I used the word "values" before. This is a bill that in the very preamble is founded on the principles of the Canada Health Act. I am a Liberal. I have the privilege of being a Liberal and being associated with the party that introduced the Canada Health Act. It's a privilege to know Monique Bégin and to find in her the confidence that she has to offer about the agenda that we're advancing, an agenda that is proud of the public health care system and seeks to make it even better. We build on that with our Commitment to the Future of Medicare Act, which has strict limitations, strict prohibitions, with serious penalties for any of those who would seek to offer two-tier medicine in our province, two-tier medicine of the kind supported around the Copeman clinics and by John Tory.

1910

We believe fundamentally in community. I had a chance to speak about that before, the common denominator among those we have asked to exercise important responsibilities on our behalf, keeping in mind our fundamental accountability, which we would never, and have never, sought to duck at all.

We know that on election day, October 4, 2007, as we go to the polls in our various ridings, the people of Ontario will be offering their view about how the provincial government has performed on important issues, including health care. No one whatsoever has pretended that there is an alteration in that fundamental accountability, yet those who call for that accountability on the one hand also seek to advance the idea that having these individuals elected is somehow consistent. This is where they miss the point.

Having elected people in local areas providing these roles disconnected from a funding relationship is not a responsible way to go forward. It's only exciting for those who have become intoxicated with the game of health care: the discussions and the fights and the constant mashing. But those of us who believe that the only way we can move forward is with the recognition that we are all in it together, no differently, are proud to accept our responsibilities and the accountability associated with delivering health care in our province.

There are communities we have sought, through the changes that we supported at committee, to enhance the mechanisms by which they are engaged in helping to coordinate and deliver health care. We have obligations to our francophone communities associated with the French Language Services Act, and accordingly I'm very pleased with the changes that have been made in the bill to solidify those relationships.

Even more forcefully, we are proud to create in legislation a mechanism whereby our government can work with First Nations government at the highest level to do something, for once, about the circumstances that affect our First Nations communities. But on this point we cannot pretend either. The government-to-government relationships and mechanisms that we seek out are not robust, not well developed, and the challenges around that should not be misunderstood. Nor should our dedication to working with First Nations and aboriginal communities to create the capacity at the highest level, where they influence the Ministry of Health on a government-to-government basis; not just one voice, not just those on reserve, not just those off reserve, not just those who identify with one band or nation or another, but rather creating a mechanism whereby the 200,000 or so First Nations people, founding people, in our province enjoy a voice in helping to determine how health care decision-making moves forward, working alongside the ministry at the highest level; and guarantee in legislation, with resources from the Ministry of Health, a new capacity to be engaged in the development of the integrated health services plans which will be the important detail work taking place right at community levels in each of 14 local health integration networks.

These are the commitments I made in meeting after meeting with First Nations leaders and these are the commitments that I'm proud our government has delivered on.

Mr. John O'Toole (Durham): This is all scripted.

Hon. Mr. Smitherman: It's all scripted, eh?

The committee sat for 10 days: seven for hearings, three for clause-by-clause. They heard hundreds of presentations and reviewed 171 tabled amendments. Many of those amendments offered, frankly, similar language from more than one party. The committee accepted 56 amendments, 56 improvements.

The Conservative government: Every bill they introduced, they passed as introduced. They jammed it. There was no commitment on the part of that party to the important public hearings process, where you open your-

self up to all of the examination and all of the investigation on the part of the citizens. But we did that.

We reaffirm our commitment to publicly funded, non-profit health care right in the preamble. We seek to enhance transparency. We got advice from the NDP and accepted this proposal to determine, to enumerate the requirements for in camera board meetings, to make sure that the circumstances are clear and minor when any decision can be taken out of the public eye and into an in camera circumstance. We sought to enhance due process, which means that any intention for a change in health care must be signalled, it must be transparent, it must be open for the citizenry to respond. I'm proud of the changes that are made there to engage the citizen and to give the citizen voice back, appropriate and consistent with their role as owners of our public health care system.

I spoke about the unprecedented role for aboriginal and francophone communities at the provincial and LHIN level and with respect to ensuring continuous quality improvement, because we believe that this is a good bill, but we recognize, of course, that we seek to have a mechanism to enhance the principle of system, to have a better coordination of services, a more seamless transition across the continuum of care for our patients. Three or four years from now, the Legislature or a committee should review this bill, should see how it's working, should consider amendments if that's necessary, because we fundamentally believe that this delivery, this change, this mechanism that creates new opportunity for the citizen to be involved is one that will engage them and will provide further opportunities on the theme of continuous quality improvement to be enhanced.

We address concerns that the bill could apply unequally to non-profit and for-profit, and so powers in section 28 now apply equally to each of these: again, evidence that the committee process does assist in providing opportunities to clarify the bills.

Let me talk about some of what you're likely to hear about: some of the opposition amendments that we rejected. I had the privilege today in question period of telling Howard Hampton exactly why we voted down their amendment. The NDP likes to tell you that this is about some competitive bidding model, and the reality is that the NDP opposes even this. Firstly, we cannot, in our circumstances, simply sit back and abide the highest-cost provider. No one who has had the privilege of governing and does not suffer from amnesia should forget the lessons that they were supposed to have learned during those five years that they had the privilege of governing, but this critic and this leader for that party have forgotten it.

I told you today the circumstance that we must face down. When we surveyed them on the issue of the provision of cataract surgery, the same Ontario health care system had a price range per eye from \$450 to more than \$2,000. Quite simply put, the amendments that the New Democratic Party brought forward asked the taxpayer, the patient of the province of Ontario, from here until the end of time, to pay the highest possible cost for

every service. The reality is that they decided to make competitive bidding something about a mechanism to engage more of the private sector, but what they forgot is that this bill applies to service providers that are in the public domain, and they are not all providing these services in an equal fashion.

We must create excellence, and accordingly we must challenge our hospitals, we must challenge our health care providers to find the capacity to provide more services in a timely way, to enhance their efficiencies and to be able to produce a better benefit for the people of the province of Ontario. We see small hospitals like the one in Bowmanville that provides a tremendous capacity to be able to move forward and to become more excellent in the provision of care like that of cataracts.

Mr. O'Toole: They need more money for operating.

Hon. Mr. Smitherman: They need more money; yes, indeed.

There was a motion for elected boards, and this is one of those motions that titillates the NDP. They get excited at the idea that they could put the cat amongst the pigeons. But I ask you: Are they not the same people who argue that local health integration networks are at heart some attempt to diffuse our fundamental accountability to the people of the province of Ontario? I'm proud to stand before you and tell you that on October 4, 2007, we will be held accountable. At the very same time, it's appropriate that we ask people whom we express confidence in, who come from the community, to exercise important judgments and the delegation of important powers that heretofore I have had the privilege of exercising on behalf of our government. We take a whole whack of the powers that are mine and transfer those to people who have been selected from the local community on the basis of their commitment and service to those communities. That is a fundamentally sound principle.

1920

We heard that the PCs brought forward the recommendation that the city of Toronto should become a LHIN. They offer for that I'm not sure what, but let me tell you why this doesn't make any sense at all. Firstly, it would be so large as to be unmanageable. With the responsibility for 2.5 million people, this has its own series of challenges, but the reality is that the boundaries we have chosen weren't chosen on the basis of what worked for this municipality or that; we worked on the basis of scientific analysis, of data analysis, on the issue simply.

Interjections.

Hon. Mr. Smitherman: John Tory's hecklers are at it, and they say, "Well, what science?"—the Tory party doesn't allow heckling, of course—but the circumstances are clear. It's a thing called patient referral data. It's as simple as that. We took a look at where the patients of Ontario were currently getting their care and we drew the boundaries consistent with it. I am happy to release the data. It was provided by ICES, and it demonstrates a very

high degree of the provision of service within those very boundaries.

Interjections.

Hon. Mr. Smitherman: Mr. Speaker, I don't need any help with them, but if you could quiet these ones down, that would help me quite a bit.

The Acting Speaker: I would ask the House to come to order. The Minister of Health.

Hon. Mr. Smitherman: I want to talk about a very specific story. It's the central LHIN. The central LHIN enjoys the responsibility for providing service to most of York region and to the northern part of the city of Toronto, particularly North York. Enclosed in that, or as part of that, are North York General Hospital and a former full-service hospital called Branson, which was reduced to a more modest role under the previous government using—and I won't quote Duncan Sinclair on this one.

I do say that the kind of blind obedience to the idea that a municipal boundary should dictate a health service boundary, even though they bear no resemblance to the service patterns, would have resulted in a circumstance like this for the residents of Toronto. We have tremendous capacity at Branson in the form of some very modern operating rooms, which we're now looking to utilize from a proposal for central region, which includes York region, to provide greater access to operating rooms, because we know that the desire for service growth can be accommodated using an existing infrastructure and recognizing that the people who live in York region have strong relationships with North York General Hospital. That's why we have moved forward in that fashion.

The aboriginal non-derogation clause: The member from Timmins-James Bay provoked a response from me on this point because he alleged that I had made a commitment to do this. In point of fact, in one of a very regular series of meetings with First Nations leadership, I said, "I will run this up the flagpole. I will attempt to determine whether this is plausible." Legislative counsel in the hearings themselves indicated that to put a non-derogation clause in one piece of legislation is to draw attention to the fact that it wasn't in dozens of others and, accordingly, created a very significant legal malaise. It was advice that we sought, and that's why that's not in there.

The last thing I want to talk about is section 28. The government, I should say—

Interjections.

Hon. Mr. Smitherman: I don't know why they're heckling me, Mr. Speaker.

The circumstances with respect to section 28 are clear, and the attempts to amend it at committee were clear as well. They were shenanigans. They were shenanigans brought forward by two now tired opposition parties who are trying to forget the responsibilities they had when they were in government. The Conservative government employed a test that included no transparency and no accountability. They moved about the province of Ontario

and slashed and burned and closed almost 30 of our beloved hospitals, and then they took the opportunity at committee to pretend they hadn't. They are pretending their way through this discussion.

The point here is clear. We've taken powers that have traditionally been in the Public Hospitals Act, that have been powers that the Minister of Health has had the privilege of the potential to exercise, but we've created a very, very significant dynamic around the exercising of those powers. People like to talk about hospitals, alteration of services or closure. The reality is that through the changes we've made in this legislation, we have altered the circumstances under which any such act could occur, and we have made it clear that the minister can act only upon the instigation of, only at the request of, the local health integration network.

There is no nefarious power here. In point of fact, we have moved considerably to give power back to the people over the health care system that they themselves enjoy. It's time, on behalf of the patients of Ontario, to get on with it, to bring Ontario into the modern age of health care service, coordination and delivery; to reject the past, which has resulted in inequitable access to services across the province of Ontario.

I am a Liberal. I believe fundamentally in the principles of equity. I am a Liberal, and I believe fundamentally in our public health care system. Our party believes it is the best expression of Canadian values, and we will not, as a government, do as other governments chose to do: stand on the sidelines, cross their arms and pretend that the current circumstances, the status quo, must live on.

In fact, we believe differently. We have an ambition for our health care system. It's an ambition of a system that is there in the future because it's sustainable, that takes care of people when they're ill and helps them to stay well in the first place by working together with health care providers and with mechanisms that, for once, put the patient where they belong: back at the centre of care and back in charge. When we give more power to communities, when we ask the debate to be an open one, that is transparent, where hard decisions are made in the full public eye, we will have created more of a system and we will have fundamentally done what is most important of all; that is, to take this cherished gift, this thing called medicare, this best expression of Canadian values and make it better because we will have returned it where it came from: to the people who empowered it in the very first place. This is a bill that is about the power of the citizen to help shape the future delivery of health care in our province.

The Acting Speaker: Questions and comments?

Mrs. Elizabeth Witmer (Kitchener-Waterloo): Certainly much of what the honourable minister has just said does challenge the word "honesty," which he repeated over and over again. First of all, I would say that to use the word "honesty" and say that it gives power to the people, this bill actually gives more power to the

minister. If you take a look at legal interpretations, it says there is a significant extension of government power.

Also, this minister talks about not liking private health care and that people are going to have access regardless of the size of their wallet. Why did this government delist optometry services, eye tests, chiropractic services and physiotherapy? I'll tell you, there are people today who, because of the small size of their wallet, can no longer access those services. We all get the letters.

I would also say that for the minister to say that our leader, John Tory, denigrated the individuals appointed to the LHINs is incorrect and it is totally inappropriate. I would just challenge him to stand up and acknowledge that that's not so.

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Also, this is a government that stood before the people of Ontario before the last election and said, "I will not raise your taxes and I will not lower them," over and over again on TV. And what happened when this government came into office? The first thing you did was to introduce a health tax, about \$2.5 billion, \$900 per family. You are hurting families in this province. You have increased health care costs for people, and yet this health tax is going into the general coffers and you can't even account for it. So for you to say that you're helping people—you have created financial hardship for people in this province.

Ms. Shelley Martel (Nickel Belt): Given that the minister had so much to say about unions and workers tonight, I want to welcome the union members and the workers who are in the gallery tonight. I specifically want to recognize Leah Casselman, president of OPSEU, and I want to say that the concerns they raised before and during the hearings were absolutely legitimate, absolutely correct, and nothing that the government has done during the amendment process has alleviated those concerns at all.

Let me give you some examples. The bill, of course, will allow for privatization of health care services through section 33, which gives the minister, and then the LHINs, the power to outsource any number of non-clinical services from hospitals, even if they don't have the approval of the board of the hospital to do that. Nothing changed in that section.

Secondly, the bill permits the privatization of health care services because competitive bidding will be used as the mechanism for LHINs to acquire services. I challenged the Liberal members, who said again and again, "Nothing in the bill says that we're going to use competitive bidding," to put it in the bill. I moved the amendment that would prohibit competitive bidding from being used as a source to acquire health care services, and the Liberal members, except for one, voted that down despite everything that we heard at the public hearings about how destructive competitive bidding has been in home care.

It's a fallacy for this government to pretend that the LHINs are all about the community and more local control. The LHIN members are appointed by the government; they serve at a time directed by the government; they are defined as agents of the government in the bill;

they are accountable back to the minister. There is no method of accountability for them back to the community that this minister purports to say they serve. The power that the minister has to integrate services, which includes transfer, merge, cease operations etc., is a power that the ministry staff told the committee is above and beyond the powers a Minister of Health has already had. That's what we heard during the clause-by-clause.

Mr. Mario G. Racco (Thornhill): I am pleased to support and speak in favour of Bill 36. As you know, Speaker, as the Chairman of the social policy committee, I had the pleasure, with you and other people, to travel the province of Ontario. We visited London, Thunder Bay and Ottawa, and we spent four days in Toronto, to hear deputations from all over the province. We also heard their comments through teleconferencing. Therefore, we were able to listen to almost any corner of the province of Ontario.

A number of issues were raised in those presentations, but I must say that the minister was able to allow 56 amendments to the bill. Of course, of those 56 amendments that were approved in the bill, eight of them came from the PCs and two came from the NDP. So there was change made to the bill to reflect some of the arguments that were presented by the people. And we spent three days on clause-by-clause to be able to satisfy and allow everyone to speak their mind on this very important topic.

I certainly believe that LHINs are the right way to go. They certainly, in my opinion, will allow the local people to have more input into how we manage our hospitals, our health care in the province of Ontario. I understand there are some issues that people have raised, but at the end of the day, we must not only deliver a good service but also be able to deliver an affordable and good service for all Ontario. Certainly, LHINs are the solution to this very important point.

I also know, and I feel good knowing, that the local hospital boards will be able to not only make decisions for the local hospitals but also assist the LHIN bill to be a better bill.

Mr. Joseph N. Tascona (Barrie-Simcoe-Bradford): I'm pleased to comment on the minister's comments on Bill 36. I think the minister is frustrated with the process, because Bill 36 has taken a long time. It really has taken a long time in terms of getting this before the House. In the agencies committee, we're still dealing with the appointments. This process is still a work in process.

The fact of the matter is that on the local decision-making that's supposed to come through the LHINs, you know when you read the bill—and to be up front—that the real power rests with the Minister of Health. That's strictly an interpretation right out of the bill. You can look at it either way, but the fact of the matter is that the final say with respect to health care in this province lies with the Minister of Health. He can't push it away by what he's saying in the debate, because it's in the bill.

The Liberal legacy certainly is paying more for health and getting less. Everybody knows the McGuinty health

tax led to a \$2,000-a-year tax on families in this province. We're not getting eye care, we're not getting physiotherapy care and we're not getting chiropractic care. Those things have all been removed.

What's going to happen with respect to dismantling? That's what's going on here: the dismantling of the health care system under Bill 36. What we're going to end up with is the three Rs: reduced hospitals, reduced health services and reduced health care workers. That's the agenda, and that's what's going to happen out of the LHINs.

You can't sit around here tonight and just do union-bashing and say, "This is the way it's going to go." People in this province have a right to have some input into this bill. This Legislature has to be relevant in terms of hearing the other side, because if it's not, then it doesn't work.

I'd like to hear what the Minister of Health has to say about our comments and whether we're going to have some relevant debate here tonight.

The Acting Speaker: The Minister of Health.

Hon. Mr. Smitherman: Here's what I'll say to the member from Barrie-Simcoe-Bradford about his comments when he talks about the Liberal legacy: I'll come to Barrie, where you put me in your householder because I did such good job on family health teams. How about the fact that MRI wait times in your community have already gone from 50 weeks, which we inherited from you, to something in the teens? How about the circumstance that we're moving forward with the regional cancer centre in Barrie? That will be our legacy there.

The member from Nickel Belt is on the same points, and she's wrong on both of them. We understand that fundamental accountability is ours. That's why we don't pretend to have given all of the responsibility to somebody else. We're sharing it. On election day, October 4, 2007, we will stand before the people and say, "Judge us on what we've done." The member from Nickel Belt speaks again about competitive bidding, but she doesn't address the fundamental reality, which is that the mechanism that she offered as a resolution is designed to make sure that every hospital in Ontario provides services at the highest cost possible. There is no incentive associated with it to provide services in an efficient way. That is the land of the dreamer, but it's not the land of reality and it's certainly not appropriate for a political party that was the government in our province for five years. They learned these lessons. They know you can't pretend that there aren't hard trade-offs, and yet they are pretending their way through this.

To the member from Kitchener-Waterloo, I would simply say this: Most people who are somewhat dispassionate and well-informed about the nature of the evolution of health care systems in our country would look to your time in office—not just yours as the longest-serving health minister in the Harris government, but to your time in office as a government, a time when you didn't make the right decisions and you certainly didn't take decisions for the future of health care.

On the issue of hospital closures, I will close with this: You certainly did good work there, closing almost 30 of them.

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The Acting Speaker: Further debate?

Mrs. Witmer: It's always interesting to listen to a minister who—I guess father knows best and cannot recognize perhaps that there are other political parties in the House who have made contributions to the evolution of health care in the province of Ontario.

Our government introduced initiatives in order to ensure that there were more doctors in the province. I'm pleased today that we're seeing more doctors, and that's a result of the initiatives that we introduced in order to make the process more accessible for international medical graduates, the expansions that we made to the medical schools. We were the ones who introduced 12,000 additional nurses in the province of Ontario. We were the ones who introduced primary care. All this minister has been able to do is take our family health networks, convert them and call them family health teams.

This government, despite what they say, is building on the very strong foundation that we put in place. In fact, if you take a look at the expansion of the cardiac centres, the cancer centres, the MRIs and the CAT scans in the province of Ontario—I take a look at my colleagues across the way—the reason that those new cancer centres are there and the reason those new cardiac centres are there is because of the initiatives and the funding that we introduced.

I know the minister likes to stand in his place and pretend that nothing happened before he got here, but the simple truth is that sometimes you have to be honest. You have to acknowledge that there were governments before you that actually did do good things, just as I would stand in my place and say to you that when the government under Bob Rae was here, they certainly moved the agenda forward in different ways.

What I feel very uncomfortable with today is that despite the fact that you might disagree with other people and their opinions, I do believe that this evening and throughout the course of the day there have been comments made that have been less than respectful to union members. The reality is that I think we in this House we need to respect the opinions of everybody, we need to listen to them, and when we're introducing motions in this House, we need to carefully consider those views that have been expressed.

No one party—not the Liberals, not the Conservatives, not the NDP—has the answers to all the problems, but I would certainly hope that by working together we can make this province and our health care system the best it can be. Nobody has a monopoly on all of the good ideas.

Now, let me get back to the bill that was introduced on November 24, 2005: Bill 36, the Local Health System Integration Act. This bill passed second reading on December 7, 2005, and at that time it was referred to the standing committee on social policy for consideration.

The committee did hold public hearings. The committee did participate in clause-by-clause. Regrettably, when we did clause-by-clause and even now, all of the Hansards are not yet available for us to review, and we didn't have in our possession a summary of all the recommendations for amendments. It is regrettable that that information was not there to help us in our deliberations.

I would also like to add that any and all of the amendments that we brought forward during the clause-by-clause were not amendments that we had created; they were all based on recommendations that we had heard from people in this province. We adopted union recommendations. We adopted recommendations from individuals, the health coalition in the province, hospitals and long-term care. If people had a good idea, and we thought that it was going to make the bill better for the people in Ontario, we were prepared to bring those amendments forward. Regrettably, the government did not accept many of them.

This is a huge, huge bill, and it is going to have an impact on 14 other acts. This bill, despite what the minister says and despite what the government says, gives more power, not to people in local communities, but exclusively and absolutely to the Minister of Health. In fact, I am sure that any Minister of Health anywhere in Canada would be happy to have that absolute power.

But there are 14 acts that are going to be amended: the Charitable Institutions Act, the Commitment to the Future of Medicare Act, the Community Care Access Corporations Act, the Health Facilities Special Orders Act, the Homes for the Aged and Rest Homes Act, the Long-Term Care Act, the Ministry of Health and Long-Term Care Act, the Nursing Homes Act, the Pay Equity Act, the Personal Health Information Protection Act, the Public Hospitals Act, the Public Sector Labour Relations Transition Act, the Social Contract Act and the Tobacco Control Act. I mention this to indicate the scope and the power contained within this legislation in that it is really going to have a totally huge impact on the face of health care, the institutions and the providers within the system.

I also want to make note of the fact that two of the acts I talked about, the Commitment to the Future of Medicare Act and the Personal Health Information Protection Act, were introduced by this government. The reason I mention that is because it just demonstrates the fact that this government does not have a plan for health care. When they brought forward those two acts in 2004, I think we can now see that they didn't recognize that they were going to have to make some further amendments to these acts.

I'm going to start by addressing some of the concerns we have heard ever since talk of LHINs started to surface. In fact, originally much of the conversation was about this secret health care agenda that was out there, because the government was planning this bill long before there was any opportunity for public, open, transparent consultation. Any discussions that took place, took place secretly. Then I want to go on and chronologically highlight some of the concerns with the bill.

I want to emphasize that the fact that they've already had to amend two of the acts they introduced, and that, as you go forward and take a look at the concerns around this bill, it really deals more with process than improving patient outcomes, underscores the fact that the government does not have a plan for health care.

What this does, and they need to be honest, is create a new level of bureaucracy. But they also need to be honest and recognize that, in essence, this new layer of bureaucracy doesn't have any real power. The power, as I said at the outset, remains with the minister. In fact, if you take a look at some of the legal opinions that some of the law firms have put forward, they talk about the fact that this expands the power of the minister.

We can also speak about the fact that they have no plan because most of the timelines for the creation of the LHINs have been missed, just as the timeline for the creation of the wait times website was missed. We still haven't seen a complete timeline for the implementation of this legislation. This government is very fond of making many announcements, some of them going to 2008, 2009 or 2010, but there is oftentimes no detail in the announcements. For example, recently they talked about new doctors. However, there's no timeline. There's no money going to communities. My community was supposedly going to be a satellite, and now we learn that there's no money for the physical structure. Again, our community is probably going to have to do fundraising. It's the same with the school of pharmacy and some of the other promises they made. It's great to come and make your announcement, but do you know what? The government's not providing any money and they're leaving it up to the local communities. We're not seeing any plans for implementation. We're not seeing some of the financial dollars following the commitments.

Also, these LHINs, I think we have to remember, are not much more than an advisory board to the minister. Again, they make recommendations to the minister and it is the minister who really is going to be continuing to make the real decisions. In fact, some people told us in the presentations that they believe decision-making is being further removed from local communities. That is a concern, and I think that is very, very important.

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We also know that there are huge costs involved with the actions of this government in that they are closing the CCACs. We understand that this may cost up to \$100 million. When we saw the leaked Management Board document, it speculated that the CCAC closures might cost \$50 million for severance, \$14 million in legal costs and \$25 million in wage harmonization. Of course, this doesn't take into account some of the costs that are associated with the delays in moving forward with these decisions. We also know that to close the district health councils cost about \$16 million, with \$11 million dollars in severance costs and \$5 million in physical plant costs. We know that costs have already been incurred as a result of reducing the size of the CCACs and closing the district health councils, but we are also now learning that

in order to replace what has been taken away with these LHINs, this is even more expensive for people in the province of Ontario. Estimates show that \$39 million was allocated for the LHINs in 2005 and 2006. Even though the ministry had requested \$52 million, at least Management Board sought to control the costs of the Ministry of Health and only gave them part of their request.

We also know that LHINs are going to have many more employees than the DHCs ever did, and unfortunately there's not a lot of difference. The minister still has a tremendous amount of power.

We have also learned, as a result of an FOI request, that as of October 31, 2005, LHINs at that time had spent more than \$3.8 million even before the legislation to create them had been introduced. Over \$2 million of this was spent on office furniture and design. We need to keep in mind the spending of taxpayers' dollars even before the legislation has ever been passed.

I also will tell you that we did ask to see copies of the contracts that had been entered into by the Ministry of Health and its agents with respect to the creation of the LHINs. Now, we were told that 98 contracts were signed with 44 companies. However, so much for what the minister calls transparency and openness: We were denied access to those contracts, those 98 with 44 companies. I just want to let the government know that we want to hold you to your word to be open and transparent, and we will be appealing that denial to see those contracts.

We also asked for a copy of the tender documents related to the contracts that had been entered into, and again the response from the ministry was, "For your information, the tendering process is under way. The deadline is not yet closed. The selection process has not yet started." I ask the government, if you have signed 98 contracts, how can you still be involved and say the process is still under way? What kind of process is being used? We asked for a copy of all correspondence relating to the contracts that had been signed. The response from the ministry was absolutely unbelievable: "Please note there is no correspondence."

I mean, talk about transparency, talk about openness; this is a government that does not want to keep any paper trail whatsoever. Are we to believe that there were no letters, no e-mails, no telephone calls that took place as these contracts were negotiated? I am sure that members of the government who are here this evening and are listening to this must be as appalled as we are. I have to underscore the fact that this certainly demonstrates the incompetence of this government in managing the health file. There is no accountability to the taxpayers of the province of Ontario.

During second reading debate I outlined some of the concerns that we had heard from health care providers and patients, including the fact that this legislation speaks about process, process, process. We don't hear about the focus on patients. In fact, when I tried to introduce amendments based on input that we got from those who appeared before the committee regarding patient out-

comes, I was told point blank, “This isn’t about patient outcomes. It’s about process.”

We’ve heard from many people about the geographical size of the LHINs and the fact that this is not something that gives power to local communities. We heard about the lack of community involvement. We heard about the new bureaucracies that were being created. But I want to identify some of the specific concerns about the extensive powers that this bill gives to the Minister of Health and the ministry, because this has been a topic of concern over and over and over again. The government can stand here day after day after day and pretend that this gives power to local communities. In fact, the minister went so far as to say in the North Bay Nugget on February 7, “There is a whole new point of access for local communities. Where before they used to have to hope that their local MPP could get them a meeting with the Minister of Health to press their case, they can now press their case locally, including in the lineup at the grocery....”

I’m sure that the constituent in Mr. Murdoch’s riding up in Owen Sound is going to find the chair of the LHIN, who maybe lives down on Lake Erie, in the lineup at the grocery store. I mean, folks, this is absolutely ridiculous. That South West LHIN has almost one million people. The chances of you seeing the chair of the LHIN in your local grocery store is absolutely absurd. Then take a look at the size of the Toronto Central LHIN: 1.1 million. Take a look at the Central LHIN: 1.5 million. For the minister to suggest that you’re going to see the chair of the LHIN in your local grocery store is beyond absurd.

Let’s go back to the extensive powers of the minister and the ministry. I’m quoting here from Fasken Martineau lawyers, their health bulletin of December 2005:

“A LHIN may integrate the local health system by: providing or changing funding to a health service provider ... facilitating/negotiating the integration of persons or entities or the integration of services between health service providers or between a health service provider and a person or entity that is not a health service provider ... requiring a health service provider to provide all or part of a service or to cease to provide all or part of a service ... requiring a health service provider to provide a service to a certain level, quantity or extent”

It talks about transferring services from one location to the other. So, you know, you might lose that local service. It might go to another community and it requires “a health service provider to carry out another type of integration of services that is prescribed ... requiring a health service provider to do anything or refrain from doing anything necessary to achieve any of the requirements set out above....” It goes on and on.

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It speaks about the fact that “A health service provider that receives an integration decision may, within 30 days of receiving a decision, make submissions requesting that the LHIN reconsider the decision.” Then it goes on to state, and here’s where the power of the minister comes into play, “The minister may similarly ‘integrate’ a local

health system by ordering a health service provider that receives funding from a LHIN to cease operating, dissolve or wind up its operations, to amalgamate or to transfer its operations and any property related to the operations affected by the order.” You can see the tremendous powers that are given to the minister in this instance as far as the integration of local health service providers is concerned.

“It is important to note that LHINs are prohibited from integrating a local health system by requiring a health service provider to cease to operate, dissolve, wind-up or amalgamate.” However, “Only the minister has the authority to render such an order.” This is all and absolute power being given to the Minister of Health.

“The legislation further stipulates that a person or entity that is a party to an integration decision or a minister’s order shall comply with it.... In the event that a LHIN has issued an integration decision or the minister has made an order and the person or entity that is a party to the decision or the minister’s order fails to comply within the time specified in the proposed legislation, then the LHIN or the minister may apply to the Superior Court of Justice for an order directing the person or entity to comply. Under the act, while both the LHIN and the minister have recourse to the Superior Court of Justice for the purpose of enforcement, no such privilege is granted to a health service provider. The only option available to a health service provider that does not wish to comply with an integration decision or a minister’s order is to request that it be reconsidered by the LHIN or by the minister, as the case may be.”

Tremendous power, absolute power is being given to the minister under Bill 36. That certainly has tremendous implications for people in the province of Ontario. I think it’s important that we remember the tremendous power of this bill.

There are some questions that are raised as we go through this transformation of our health care sector. For example, have LHINs been provided with the commensurate authority to exercise their responsibilities and satisfy their objectives? Has there been a true devolution of authority such that decisions about health care services should be structured and delivered within a particular community can be made locally? Has one of the public’s most precious assets been returned to them, or has the minister effectively retained his ability to impose limitations on a LHIN’s authority when a community’s priorities do not fall within the spectrum of the minister’s overarching plan?

I would suggest to you that despite some of these quotes that I have taken from the minister’s speech at the Empire Club on November 25, 2005, regarding this devolution and returning these assets to the community—and we heard some of them this evening—I think any preliminary review of the legislation suggests that many and most of the minister’s powers will remain with the minister. Indeed, he has more absolute power than ever before. While the LHINs are going to have the authority to implement changes to the health care sector, the scope

of their powers is limited, and any substantive systemic changes remain within the jurisdiction of any Minister of Health.

I want to move forward and also take a look here regarding Cassels Brock. They say: "The Ministry of Health and Long-Term Care proposes to give itself and local health integration networks (LHINs) far greater powers under Bill 36 than were previously granted by the ministry under (either Bill 26)—which this government ranted and raved about and were so upset about—"Savings and Restructuring Act) the Commitment to the Future of Medicare Act, 2004." It gives them more power "to restructure the publicly funded"—precious—"health care system without"—and I stress "without"—"cabinet approval." They go on to say it "also provides far greater powers under Bill 36 than were previously granted to the ministry under either the Savings and Restructuring Act"

So we see here proposed powers, they go on to say, which "would allow LHINs and the Minister of Health and Long-Term Care to restructure the publicly funded health care system." And it talks about the minister being able to exercise his authority by issuing integration orders.

It goes on to say: "If necessary, court orders could be sought to enforce LHIN integration decisions or minister's orders. LHINs and the minister could require health service providers to integrate services horizontally, vertically or by outsourcing the delivery of these services to the private sector."

You know, we hear all this talk about, "They don't support private, private, private, and John Tory does." Well, folks, you're not being very honest, because this legislation does speak to your ability to outsource the delivery of these services to the private sector. We at least acknowledge the fact that there should be one health system that is publicly funded that could be provided by both the public and the private sectors. You continue to hide behind the cloak that you don't support private, but certainly your actions demonstrate something else.

I spoke earlier about the fact that it was this government, despite the rhetoric, that decided to delist eye tests, optometry services, physiotherapy services and chiropractic services. In essence, you delisted, you created two-tier, and now, for some people, I can tell you, based on the letters I received, that change is creating hardship in Ontario.

I can also tell you, for some of these people who do not have the financial wherewithal to go and get an eye exam, it can mean that there are going to be eye diseases that develop that may cause them loss of sight in the future. So for a government that talks about health promotion and even creates a ministry and a minister devoted to health promotion, your actions demonstrate something totally different.

Also, you need to know, according to this legal opinion from Cassels Brock lawyers, that the minister can "unilaterally expedite the integration of a hospital's non-clinical services by transferring these non-clinical services to a prescribed person or entity on a prescribed date." There's the outsourcing.

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Let's now go through some of the issues that we heard. I would have to say that many people appeared before us. We received many, many submissions. People who knew about the bill—I guess that's the other issue of concern. Most members of the public are totally unaware of Bill 36. They really are not going to realize the tremendous power that is being given to the ministry, the government and the minister, and the implications of this power, until suddenly there is an integration of services and programs, there is the closure of a hospital.

I'll tell you, it is going to have very devastating consequences for people in some parts of this province. People could well be forced to travel miles and miles if services are removed from local hospitals. That could well be the impact, and that's when people are going to realize that there was a bill, Bill 36, that was passed by the Liberal government that is now, in their instance, decreasing their access to publicly funded health care. It's going to cause hardship for people in this province.

What were some of the top issues? People told us again and again that despite the rhetoric coming from the government side and the fact that this was going to improve and create access for communities, people did not see this bill as providing any vehicle for community engagement. This bill talks about the fact that it's going to move toward enabling communities to determine local priorities, and we certainly asked for some amendments to the bill. In fact we had many, many people say to us, "We want to see the process that they're going to use for engaging the local community." But there wasn't any process whatsoever.

The city of Toronto was one of the groups that came forward, and again, there is no formal process. People want to know what the process is. We need to have a process that will, as the minister is so fond of saying, allow local input to the decision-making. Certainly, I think the creation of a community advisory board was one of the ways we heard that the government could demonstrate its commitment to ensuring that LHINs would hear from and respond to local needs. However, that amendment for the creation of a community advisory committee, which some people had asked us to put forward, was rejected by the government, regrettably.

We also asked that a local health professional advisory committee be appointed and that there would be at least one member from each regulated health profession on that committee. That type of amendment was requested by the Ontario Hospital Association, the Cardiac Care Network, the Ontario Long-Term Care Association, Bloorview MacMillan and also the city of Toronto; again, the same response. There was certainly a lot of effort made to somehow move and involve the community and develop a process for input which would move us toward at least having a vehicle that would allow for this access.

There were people who spoke to a need that there be an ability to appeal decisions of the LHINs. We moved that there be a section added to the bill whereby a party to an integration decision or a member of a community

affected by an integration decision may appeal the decision by following the prescribed process. The Registered Nurses Association of Ontario wanted this. They said that while the flexibility to meet a community's different requirements is desirable, explicit parameters for community engagement should be set out in the legislation, and also there should be the ability to appeal decisions of LHINs.

Unfortunately, this bill does not allow for any appeal process on the part of the communities. So whatever hammer the minister or the LHINs bring down, there is simply no opportunity for an appeal process. Again, I think it speaks to the tremendous power of the minister and of the LHINs.

Mr. Richard Patten (Ottawa Centre): Like the restructuring commission.

Mrs. Witmer: Actually, when we had the restructuring commission, if you remember, we were very open. It was a very open process. We appointed a committee. We had Dr. Duncan Sinclair chair the committee. They travelled throughout Ontario. They made decisions and, if you remember, announced their decisions. There was an opportunity for community input and oftentimes there were changes made to the recommendations of the restructuring commission before a decision was made to move forward. In many instances the original recommendations or orders were substantially changed.

Obviously, that was an attempt to ensure that we provided health services efficiently and effectively. That's what allowed us to build the new cardiac centres and the new cancer centres. That was the restructuring commission that recommended new emergency rooms for almost every hospital in Ontario. In fact, I know the member from Ottawa or from Hamilton or from Brantford or from Kitchener–Waterloo—we have brand new expanded emergency rooms in hospitals throughout the province. That is very much the legacy of the Health Services Restructuring Commission. It was to make sure that the population of today had the services that were needed to meet the needs. That's why we built so many new cancer centres, cardiac centres and dialysis centres—we recognized that the incidence of diabetes was increasing.

That process, I would say to you, was a very open process. This process has been much more secretive. In fact, we don't really know what the process for community engagement is going to look like.

We asked the question, what will community engagement look like? Cassels Brock says, "The actual extent to which communities will be involved and consulted"—although it's referenced in Bill 36—"... the details of that engagement are left to be addressed by regulation at a later date." They go on to say, "Given that the ministry's stated purpose for introducing Bill 36 is to move towards community-based care and to enable communities to determine local priorities, this matter"—meaning community engagement—"should be dealt with in the legislation and not left to the less scrutinized regulation-making process." For example, they say who makes up

the community and what community engagement should look like should be front and centre in Bill 36, and it is not.

When we took a look at what was being said, there was a lot of concern about the issue of reconsidering decisions made by the minister or the LHINs. Again, we introduced a number of amendments. All these amendments came from those people who appeared in front of the committee or sent us submissions. They suggested that the 30-day period was too short, and we did introduce several amendments that would have extended the timeline for reconsideration to either 60 days or 90 days, as was the case. That amendment was requested by the Cardiac Care Network. It was requested by the Association of Ontario Health Centres as well. The Ontario Hospital Association and the Bloorview McMillan Centre also spoke to that. The Canadian Hearing Society also wanted us to make some changes to the legislation.

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So there was a lot of concern about the short timeline of 30 days for reconsideration of decisions, which at the end of the day could mean the closure of local health services, which would have a tremendous impact on people in that community. Not only would it have an impact on those who received the services, but it would have an impact on the people who are delivering the services, who would either be transferred to another place or might lose their jobs altogether. But any attempt that we made to extend the reconsideration period was voted down by the government. They stated that 30 days was a sufficient time period for health service providers to secure community reaction to the decisions of the LHINs and the minister, and certainly that was considered too short a period of time by most people.

Now I want to take a look at section 28. We had a lot of input, a lot of concern expressed about the integration powers of the minister under section 28. That is an important section. People came forward and expressed concern about section 28. They expressed concern about the ability of the minister to shut down not-for-profit providers. They said it's unfair, that it treats not-for-profit and for-profit providers differently. They said the minister shouldn't have this arbitrary power. Again, the government was not totally responsive.

Granted, the government has put in some protections for municipalities and long-term-care homes, but I remain concerned about the implications of this bill for those operators that are not currently defined as providers under subsection 2(2) and that might some day be prescribed as such through the minister's regulatory powers. Again, I guess that's what is the overriding concern in this piece of legislation: Anything can happen through regulation, and so the powers of the minister could be expanded. The minister does have the power to shut down health service providers, both for-profit and not-for-profit, and the minister voted down our amendment to remove the power to close both not-for-profit and for-profit health service providers. Certainly we were disappointed, as I know were many of the stakeholders.

People who wrote to us about this particular section and expressing concern included the regional municipality of Waterloo and St. Joseph Health Care in Sudbury. CHEO expressed concern, and the Cardiac Care Network. There were just a lot of people who expressed concern about the power of the minister.

Other people who appeared before us and had a lot of concerns were organizations such as the Canadian Mental Health Association. Again, they wanted changes made to the legislation which were not always accepted. What the Canadian Mental Health Association, the Centre for Addiction and Mental Health and the Ontario Federation of Community Health and Addiction Programs wanted was for the provincial strategic plans to include provisions on mental health and addiction services to ensure that they are included at all times. They have a CAMH study from March 2005 which shows that mental health and addictions is a particularly vulnerable service sector, so they wanted, specifically, a provision that recognized mental health and addiction services to be included in the provincial strategic plan. Unfortunately, that was rejected by this government.

We know that all too often when people in this province talk about health, they are only focused on physical health. We support the arguments that were put forward by the Canadian Mental Health Association, the Centre for Addiction and Mental Health, and the Ontario Federation of Community Health and Addiction Programs. We believe very strongly, and support their request, that provincial strategic plans must include provisions on mental health and addiction services to ensure that they are included at all times. Most of us know that the incidence of mental health problems continues to increase. It's creating a tremendous amount of pressure on the health care system and certainly is contributing to a lot of absenteeism in the workplace. It is important.

Now, the long-term-care group wanted the inclusion that this provincial plan would deal with the whole issue of long-term-care programs. They wanted some amendments made that said the provincial strategic plan shall provide that the minister is accountable for the delivery of core long-term-care programs and shall ensure that the centralized means by which concerns related to long-term care may be brought to the attention of the ministry is continued and that each local health integration network take all appropriate steps to ensure that concerns related to long-term care are referred to the ministry. Again, these amendments were requested by the Ontario Long-Term Care Association, Yee Hong, Hospital for Sick Kids, OHA, the GTA/905 Health Care Alliance, certainly the Noojimawin Health Authority, and the Cardiac Care Network. Again, people were looking for some more specifics. They really didn't want everything left to regulation. There's a lot of concern about the powers of the minister, the ministry and the LHINs, and they want to make sure that their programs, their services are protected and recognized.

In fact, it was brought to our attention that in other provinces where they have attempted to devolve the

accountability, it has resulted in variations to the basic programs and there are different levels of financing. They have now learned that when you devolve accountability, in some of your programs it will mean that some people in some parts of the province are not served as well as others. In fact, the provincial auditor in Alberta, last year, in 2005, questioned these variations in the basic long-term-care programs in the province that were offered through their local health authorities. As a result of that questioning, the Alberta Ministry of Health and Wellness today has restated its role in setting province-wide standards. We also know that Monique Smith, the PA to the Minister of Health and Long-Term Care, in her 2004 report on long-term care, recommended a central direction for a renewed compliance program.

We were disappointed that the government did not learn from either Monique Smith's report or from the experience of our neighbours in Alberta and not do the same thing. There was a request, as I say, to continue with the existing centralized complaints process for the LTC, and they wanted it to be maintained.

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Again, on the whole issue of savings, some individuals wanted recommendations, which we did put forward, that LHINs would not be required to give back their savings to the minister. However, the minister currently can take the savings from the LHINs. So, again, a comment was made that maybe this is a way to reduce costs in the health care system, and you know, there were some who suggested that perhaps the reason for the introduction of the LHINs was to decrease the level of funding for health care in the province. If that's the case, the government should have indicated that that was one of their objectives, rather than continuing to tell us this was all about giving control to local communities.

Some of the people who wanted some changes made here, again, were the GTA/905 Health Care Alliance. They were concerned that the minister was able to remove any financial savings achieved by a LHIN, and they wanted the LHIN to be able to keep those efficiencies and better serve patients in that community.

So what else did people bring forward to us? They were looking for a definition of "public interest." Again, we had the Ontario Hospital Association, the Canadian Hearing Society, GTA/905 Health Care Alliance—a lot of people—looking for some sort of definition of "public interest." I You might be interested to know that there is absolutely no definition of "public interest" in this bill as it's currently written, and the interpretation of "public interest," regrettably, is going to be left up to the LHINs and the minister. The definition that our stakeholders, those presenting before the committee, recommended would be one that would have been similar to that which appears in both the Public Hospitals Act and the Commitment to the Future of Medicare Act. However, again, it was not accepted.

I could go on and on about powers and the minister. There's so much in here about the powers of the minister; it's unbelievable. If you take a look at what is written

here—I've made the point that, despite the comments that have been made by the government about this being a bill that devolves decision-making, dissolves authority to the members of local communities, I think we do know that that is not the case. In fact, that was again something that was raised during the discussion on the bill, and that is the size of the LHINs.

If you take a look at the geographic size, the population size, they talk about these LHINs having some sort of community of interest being based on hospital referral patterns, but we heard from many presenters that, really, in their instance, in their community, they would be moving into a different area compared to where they had been going before. So they certainly could not support the government in what they said about the whole issue of moving into networks where you could be served based on referral patterns.

There was an interesting amendment that came forward from the city of Toronto. I will tell you, the city of Toronto probably had as many concerns about the LHIN legislation as any other municipality within this province. Again, they were concerned about the unprecedented power, but they were also concerned about the fact that the city of Toronto was divided into five LHINs and that only one of them, the Toronto Central LHIN, is fully within the boundaries of the city. The other four LHINs that serve people in Toronto, as you may or may not know—as I said at the outset, not many people really even know that this bill is being debated in the House—reach far out beyond the borders of Toronto. In fact, you might be interested to know that the central east LHIN reaches from Victoria Park Avenue in Toronto to Algonquin Park. So for the government to suggest that it's based on referral patterns or that you're going to see the chair of the local LHIN in the grocery store is absolutely absurd. It's also absurd to think that the health care concerns of the people of Scarborough are going to be the same as the health care concerns of some of the people living on Oxtongue Lake.

The city of Toronto wanted the government to reconsider. First they asked if the government would consider creating one LHIN. That was rejected. Then they wanted the government to set up a collaborative board for all five Toronto area LHINs to ensure that they at least worked together in concert and that city-wide issues could be properly brought to the attention of this collaborative board and addressed in response to the needs of the people in the city of Toronto. Again, those requests from the city of Toronto were totally defeated.

There were other amendments that spoke to providing guidelines for the LHIN boards regarding composition. There were requests made that the LHIN boards should have municipal representation, that children's issues were addressed, that the diversity of the community was accounted for, that people who were selected had the appropriate qualifications. Again, these were amendments that we were asked to bring forward on behalf of the presenters, and the government voted those down.

Mr. Patten: Is there anything you like, Liz?

Mrs. Witmer: We were trying to be responsive to the requests of the people who appeared before the committee, and when people take the time to make a presentation, our role as an opposition party is to make sure that we do respect it.

I think you can see that this has been a process that has not been open; it's been quite secretive. Certainly it demonstrates that the government doesn't have a plan. They have missed timelines. The legislation is flawed. I think we could see that in the committee as well. Despite the efforts of many, many individuals, there was little in the way of changes that were made.

However, I want to express my appreciation to the committee clerk, Anne Stokes, and to the clerk's office. There were many, many amendments that were introduced, as I say, in response to those who made presentations. I know they had a hard time keeping up with the volume of depositions and amendments. They worked very hard; they worked in a very professional manner. I believe that in this House we are very well served by individuals such as Anne Stokes and the clerk's office. I also want to congratulate the Chair, Mr. Racco. I think he handled himself in a very professional way as well.

I would just conclude my remarks by saying that certainly this bill is far removed from what the government claims it to be; that is, a vehicle to devolve health care decision-making to the local community. There is absolutely no process for engaging the community. There is no avenue of appeal for the community when a decision is made by the minister or the LHIN. This is all about giving absolute power to the minister, the ministry and the government.

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The Acting Speaker: Questions and comments?

Mr. Michael Prue (Beaches–East York): It is indeed an honour and a privilege to give a couple of minutes here. But before I do, I would like to commend those who are in the gallery this late at night. I'd like to commend all of you for coming out here tonight. I know that most of you are employed in the hospital sector and care very much for all of the people who are going to be impacted here. That's what brings you out on a night when you could be watching the Olympics or when you could be at home with your loved ones, your family and friends. You're out here to see what this government is going to do to you and about you and your workplace. I have to tell you, you're probably very disappointed people, to be out here tonight knowing what this government has planned, knowing that the minister can force integration, knowing what the minister can do in terms of this bill that is going to affect your everyday working lives.

This bill will facilitate privatization, and that's why we New Democrats are going to be voting against it. That's why we're in disagreement. I'd like to commend the member from Kitchener–Waterloo, even though we're from a different party and even though our philosophies might oftentimes be at loggerheads and distant from each other. She has hit many of these same points.

This bill will allow and will force a hospital—even a hospital and a board of directors that doesn't want to do it—to outsource. That is why we oppose this. That is why, I'm sure, many of you are here tonight. I commend you, and I want you to keep the pressure up. We need to change some of what is contained in this bill.

Last but not least, I'd like to commend the member from Kitchener–Waterloo for talking about the central east. The size of that LHIN is absolutely beyond bizarre. As I've said in this Legislature before, my parents live near Bancroft, which is a number of miles south of Algonquin Park, and they are in the LHIN immediately adjacent to me. It's just too bizarre; beyond words.

Ms. Jennifer F. Mossop (Stoney Creek): The LHIN just referred to is considerably smaller than the one LHIN we now have, which is the entire province of Ontario, the chair of which is the minister. The member from Kitchener mentioned that she is worried she won't run into her chair at the grocery store, but I doubt you see the chair of the present LHIN in your grocery store very often.

These are disturbing arguments, but what disturbs me the most are the conversations I have been having with my constituents recently, who have been fearmongered, who have been told that they are going to lose their jobs. They've had phone calls at their homes, told they must get out to rallies because they are going to lose their jobs. They are worried. They're lying awake at night. They have been filled with horrible thoughts. It is fearmongering of the most reprehensible type.

We are trying to create a system that breaks it down and has more responsive community decision-making. The woman who is in charge of our LHIN, the person who was appointed the chair, is one Juanita Gledhill, who is a passionate advocate of home care, a passionate opponent of the CCAC-RFP model, and that's the reason we chose her. She understands the need for responsive community public health care.

Interjection.

Ms. Mossop: Competitive bidding happened at St. Joseph's Health Care Centre in Stoney Creek. They were able to compete within the public system because they had a better price for cataract surgery. We have excellent cataract surgery happening at St. Joseph's, where there were two state-of-the-art rooms that were not being used and weren't being funded. Now they're both operating, because they bid and they got that contract. It's in the public health care system.

Collective bargaining has never been more respected by a government than by ours. The teachers, public service sector, the doctors—

The Acting Speaker: Thank you very much. Further questions and comments? The member for Durham.

Mr. O'Toole: I'm surprised by the member from Stoney Creek, but I won't digress. There's time to learn many things, and I think she should refer to an article in the Sudbury Star dated February 18. I'll quote this article, which says, "This model is currently used for home care in Ontario. Community care access centres ... are given budgets by the ministry, and they tender contracts...." So,

in fact, the model you're introducing with Bill 36 is clear. Read that article. This article is worth referring to.

It says here, "LHIN boards have also been given the directive to transfer, merge or amalgamate services and operations, as well as start or cease services. In section 33 of the act, for example, the LHINs under ministry orders will have to transfer non-clinical services (i.e. food, cleaning, housekeeping, laundry) out of hospitals and to other persons or entities (i.e. private companies)."

Clearly, that's what the bill says in section 33, and there are several sections.

I want to compliment our member from Kitchener–Waterloo, who knows this file and speaks with sincerity and genuineness.

Many people here tonight would know that there are 14 district health councils in the Ministry of Health that were empowered already to do the planning for health. The Ministry of Health also had district offices that dealt with the planning and interface with government and public boards in the hospital sector today.

In fact, this is a very long discussion that Elizabeth Witmer knows very well, and I'm surprised some of the debate here tonight doesn't transfer much of the history of this debate from the NDP study, which was called the Acute Care Study, which started to look at capacity in Ontario. That study ended up being the formation of the Health Services Restructuring Commission, which ended up in this bill here. We did not do what you're doing, for the very reason that it shouldn't be done.

Ms. Martel: In response to the concerns raised by the member for Kitchener–Waterloo, I want to pick up on her comment about how silly it was for the minister to suggest that you can run into your LHIN chair in the grocery store—silly from the perspective that my LHIN board chair lives about seven hours away from where I live, but silly from the perspective to suggest to the public that your LHIN board chair might actually be able to do something about your health care concern. The fact of the matter is all of the health policy—health legislation, health regulations that are now in place that affect people's ability to get services—is not going to change. The LHIN has no responsibility, no control and no authority to change any health policy, regulation or legislation now that impacts on people's access to gain health care services.

Let me give you two examples in my riding this week. We have a woman who comes in because she can't afford to pay for her eye exam. Should she run into the LHIN chair, who lives in Kapuskasing, in the grocery store and tell about this, the poor LHIN chair is going to have to say, "Sorry, there isn't anything I can do about your health care problem, because it was the Liberal government of the day that delisted eye exams."

Secondly, a constituent came into our office this week who needs a pain pump to manage the after-effects of his cancer. It's not covered by the assistive devices program. It's not covered by the CCAC, unless he is in a palliative state, which he is not. So if he had the opportunity to run into the board chair, who lives in Kapuskasing, seven

hours away, and talk to her about this, you know what she'd have to tell him? "Sorry, there isn't anything I can do about your health care problem, because our LHIN has no ability to change the policies of the assistive devices program and no ability to change the regulation policy at the community care access centre."

That's what's so dishonest about the minister trying to tell people that these decisions are now going to be made close to home. The minister continues to make all of the legislative policies and regulations that affect people's health care every day, not the LHINs.

The Acting Speaker: That concludes the time for questions and comments. I'll return to the member for Kitchener–Waterloo. You have two minutes to reply.

Mrs. Witmer: I want to thank the member from Stoney Creek for her passionate two minutes—

Mr. John Wilkinson (Perth–Middlesex): Soon, Liz.

Mrs. Witmer: Soon?

Mr. Wilkinson: Soon.

Mrs. Witmer: Okay.

Interjection.

Mrs. Witmer: You too?

Interjection.

Mrs. Witmer: Not you?

Interjection.

Mrs. Witmer: Thanks.

—the member from Beaches–East York, the member from Durham and the member from Nickel Belt.

It's obvious that for many people in Ontario, Bill 36 is certainly a piece of legislation that does not do what it is purported to do; that is, give any real control or any real authority to improve patient access to services, to improve patient outcomes. What this bill is all about is setting up another hierarchy. A tremendous amount of money is being spent. There's a lot of rhetoric about this devolving power to the LHINs, but at the end of the day, when we take a look at the legal opinions, when we take a look at the concerns that have been expressed by people throughout this province, we learn that the real power is going to remain with the minister, is going to remain with the ministry and is going to remain with the government.

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The other thing we have to fear is the fact that so little is contained within Bill 36 in terms of any process for community involvement, any process of appeal, any definition of the public interest. Much of it is going to be left to regulation, and regulations are sometimes developed in a very secretive manner. There's absolutely nothing that we in the opposition can do. I hope this government has heard the concerns of people throughout the province, whether it's hospitals, the coalition, the different unions or individuals. Listen, please, and if there's a chance to make more changes, do so.

The Acting Speaker: Further debate?

Ms. Martel: I want to begin my remarks tonight by thanking those in the gallery this evening for being here to hear the comments being made. I recognize that a number of you were at the public hearings, and I want to thank you for participating in those. For those other

people who aren't here tonight but did participate in the public hearings, either for or against the bill, I appreciate that too: those who were in Toronto, Thunder Bay, London and Ottawa as well.

The NDP voted against this bill on second reading, and what we heard during the public hearing process reinforced for me even more why we were right to do that. We, as a result of listening to what people had to say during the course of the public hearings, introduced some 50 amendments. The government accepted one. I'm going to talk about that later on, or maybe tomorrow afternoon, but people should know that the amendment they accepted was an amendment that was in a Liberal private member's bill regarding the criteria around which you have a closed public meeting of a LHIN. It would have surprised me greatly if the Liberals had not accepted that particular amendment since it was directly taken from Ms. Caroline Di Cocco's private member's bill, the Transparency in Public Matters Act, 2005. That was the only amendment they accepted from the NDP. It's good to have a little context around what it was and why I think the government accepted it in the first place.

Nothing in the clause-by-clause altered the government direction, so I'm going to use the time on third reading to reinforce the concerns we heard during the public hearings.

Before I do that, I want to thank David Halporn from legislative counsel, who made tremendous efforts to get our amendments done. He worked overtime to do that, and I just want to take a moment to thank him for doing that.

Tonight and tomorrow I'm going to focus on the following six areas:

First, the power of the LHINs, minister and cabinet: I want to point out that the power of the LHINs that I'm referring to is not a power to change government policy, regulation or legislation, because they can't do that. It's the power to amalgamate services, shut down services and/or transfer services, which is a very dangerous power for them to have.

Secondly, I want to talk about section 28 of the bill regarding the powers the minister has to integrate services, powers that we heard directly from counsel of the Ministry of Health—you yourself asked the question at committee, Mr. Speaker—are more significant than the Minister of Health in the province of Ontario has ever had before.

Thirdly, section 33 is the section that allows outsourcing—privatization—of non-clinical hospital services. That's very clear in the bill. A number of Liberal members should actually read section 33, and then they'd understand what we're saying.

I want to talk about competitive bidding and how the government, when the rubber hit the road, refused to support my amendment that would have prohibited competitive bidding. I'm going to put into the record what the minister had to say during the course of the public hearings about competitive bidding, what many other people had to say about how destructive this has been in

home care, and then point out the absolute refusal of all but one Liberal member to vote in favour of an amendment that would have prohibited competitive bidding in all those other health care sectors that are now going to be the responsibility of the LHINs.

I'm also going to take a little bit of a look at the concerns of First Nations and francophones.

Finally, I'll go through some of the amendments that were turned down by the government.

Let me deal first with the power of the LHINs, the minister and cabinet. Mrs. Witmer talked about a legal opinion. I've seen four different ones. The one I'm going to quote from tonight, though, is from Sack Goldblatt Mitchell. It's rather long, but I really want to give people some third-party validation of some of the concerns we raised and that were raised during the course of the public hearings. So bear with me as I read into the record a number of the points that have been made by this legal firm about this bill.

"The bill purports to acknowledge that 'the community's health needs and priorities are best developed by the community health care providers and the people they serve' and purports to localize the provision of health services by 'enabl[ing] local communities to make decisions about their local health systems.'

"However, in fact, the act grants very little if any real power to health care providers and consumers to make decisions about the health care system. Rather, it transfers control over local community-based health service providers to the minister and cabinet, and to their agents (LHINs), thereby centralizing, rather than localizing, control over health services in Ontario. In this respect, the bill grants unprecedented authority to the Minister of Health and cabinet to effectively control virtually all facets of the services provided by health service providers (other than physicians and certain other professionals) and to completely restructure the way health services are presently provided.

"Moreover, the LHINs established by the legislation are local in name only, and are effectively controlled by the provincial government. By granting government, and the LHINs they appoint and control, extensive restructuring powers, the proposed legislation would, if enacted, enable the government and their agents the power to fundamentally restructure the health care system, including privatization of significant components of the health care system.

"In this respect, there are no provisions in the bill which ensure, require or even encourage LHINs, the minister or cabinet to preserve the public, not-for-profit character of our health care system. Indeed, it appears that these bodies would now be armed with the legal authority to privatize large swaths of our historically publicly delivered health care system."

The first point: "LHINs are controlled by the government

"Section 1 of the act describes LHINs as being charged with the 'management of the health system at the local level.' In fact, LHINs are nothing more than

creatures of the provincial government, effectively controlled by it, established for the purpose of implementing government policy at a local level. For example,

"(1) Cabinet may create, amalgamate, dissolve or divide a LHIN.

"(2) LHINs are governed by a board of directors appointed by cabinet and remunerated at a level determined by cabinet. The government and not the" LHIN "board of directors determines who will be the chair and vice-chair of the LHIN.

"(3) Even after their appointment, the board ... has no independence from government. Every member continues on the board at the 'pleasure' of cabinet and, as such, may be removed at any time without cause. Further, their reappointment is entirely dependent upon cabinet. As a result, it can be expected that the government will be able to exercise significant control over the LHINs. Cabinet is also given the power to create additional LHINs or to amalgamate or to dissolve existing LHINs.

"(4) The only members of the LHIN non-profit corporations are government-selected directors. This distinguishes LHINs from other community-based non-profit corporations (including, for example, public hospitals) which are comprised of, and accountable to, a broadly based membership.

"(5) A LHIN is explicitly defined as an 'agent of the crown,' i.e., it acts on behalf of the government.

"(6) Each LHIN must enter into an 'accountability agreement' with the ministry that covers, among other things, its performance goals and measures and a plan for spending the ministerial funding that it receives. If a LHIN and the ministry is unable to successfully negotiate an accountability agreement, 'the minister may set the terms of the agreement.'

"(7) LHINs are funded by the ministry 'on the terms and conditions that the minister considers appropriate.'

"(8) While LHINs may fund health services providers, the funding must be 'in accordance with government requirements, including the terms of the funding that the LHIN receives from the ministry, terms of the accountability agreement by which it is bound to the ministry, and any other requirements which cabinet may prescribe.'

"(9) While each LHIN is to develop 'an integrated health service plan' for the locality over which it presides, this plan must be made 'within the time and in the form specified by the minister' and be 'consistent with a provincial strategic plan' that is developed by the minister."

These folks aren't accountable to the local community at all. They are beholden to the government of the day, which appoints them.

The second item to deal with: "LHIN powers and control over health service providers

"The bill vests LHINs, as agents of the ministry, with an unprecedented degree of control over the structure of health service delivery in Ontario, which is in many respects even more far-reaching and intrusive on local decision-making than was the case with the Health

Services Restructuring Commission established by the previous Conservative government.

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“The 14 LHINs previously created by the Liberal government are continued, but now established under statute, for the purpose of planning, funding and integrating the local health system. The term ‘integrate,’ as defined in the act, covers a very broad ambit of activities and includes coordinating services; creating partnerships with other persons or entities, whether public or private, not-for-profit or for-profit; transferring, merging or amalgamating services, operations, persons or entities; starting or ceasing to provide services; and ceasing, dissolving or winding up operations.”

These are the broad new powers that we are giving these folks, not any power to change a regulation that might actually help someone get through the assistive devices program. No, let’s give them the power so that they can cease, dissolve, wind up or transfer operations of one provider to another.

“LHINs are charged with the ‘integration’ of health services in Ontario. The legislation envisages that integration under the auspices of the LHINs may occur either through voluntary integration agreements among service providers, which may or may not be service providers” under the act, “or through compulsory integration decisions made by the LHINs. Since the LHINs are authorized to integrate health systems by providing or changing funding, it can be anticipated that many voluntary agreements will be facilitated by either promising or withholding funding from health care providers in order obtain ‘voluntary’ integrations.

“LHINs are given the power to facilitate voluntary integration agreements and the power to veto voluntary integrations. Thus, while a health service provider may ‘integrate its services with those of another person or entity’ without the involvement of its LHIN, the LHIN may order a health service provider not to proceed with an integration. LHINs may also ‘facilitate and negotiate’ certain integrations.

“In addition, the LHINs are given the power to issue compulsory integration decisions requiring health care providers to whom it provides funding to: ‘to provide all or part of a service or to cease to provide all or part of a service; to provide a service to a certain level, quantity or extent; to transfer all or part of a service from one location to another; to transfer all or part of a service to or to receive all or part of a service from another person or entity.’ The bill also allows cabinet to promulgate regulations defining other types of integrations that may be carried out by the LHINs.” That is, if we didn’t cover the waterfront already for any other possible example that there may be out there, then you can do it by regulation.

“In addition, whatever professed limitations there may be on the power of the LHINs, section 36(1)(c) of the bill empowers cabinet to make regulations exempting a LHIN (or, for that matter, a health service provider) from any provisions of the legislation, which effectively means that whatever specific statutory limits are placed on LHIN

authority can be eliminated by regulation enacted without any public debate. Thus, for example, while the legislation precludes LHINs from ordering a hospital to shut down, this limitation on LHIN authority can be removed by cabinet.”

Finally, “Furthermore, it is apparent from the bill’s consequential amendments to the Commitment to the Future of Medicare Act, 2004, that LHINs may enter into ‘accountability’ agreements with a health service provider that govern virtually all of the terms of the health service provider’s operations, including its overall goals, ‘value for money,’ accessibility of services, human resources matters and ‘any other matter’ that cabinet prescribes by regulation. LHINs have broad powers to enforce compliance with accessibility agreements through various methods, including the withholding of funding from the health service providers.”

I wanted to read that into record. I know it was long, but it is important to put a legal perspective on what the bill really does. As I said, that’s one of four legal interpretations of the bill that I’ve seen. None have been complimentary to the government, and all have focused on new powers of the minister to force integration, the power that the minister has to outsource privatized services under section 33, and the new powers that the LHINs have to facilitate operations shutting down, ceasing, being forced to amalgamate and being forced to transfer as well. So none have been very complimentary, and all have been very concerned about the very significant new power that the minister, the cabinet and the LHINs now have under this legislation.

Let me deal with section 28, which is the section that deals with integration by the minister. We heard from a number of presenters that this section enables new powers for the Minister of Health. Frankly, we had that confirmed for us by Ministry of Health staff during the course of clause-by-clause consideration. When a very specific question was raised by the Speaker, who is in the chair tonight, about whether or not this bill provided new powers, they were forced to say yes. They tried to clarify that by saying, “We’re putting it in some kind of framework so we can have a way to maybe massage or manage what those new powers are,” but the fact of the matter is that they were forced to admit very clearly that there are new powers given to the minister under this bill.

Let me go through what the minister can do again:

“28(1) After receiving advice from the local health integration networks involved, the minister may, if the minister considers it in the public interest to do so and subject to subsection (2), order a health service provider that receives funding from a local health integration network under subsection 19(1) and that carries on its operations on a not-for-profit basis to do any of the following on or before the date set out in the order:

“1. To cease operating, to dissolve or to wind up its operations.

“2. To amalgamate with one or more health service providers that receive funding from a local health integration network under subsection 19(1)....

“3. To transfer all or substantially all of its operations to one or more persons or entities....”

What did some of the people who came before us have to say about this section?

This is from the Registered Practical Nurses Association of Ontario. In their brief, they said the following: “The RPNAO believes that if the government wants to live up to its commitment of preserving a truly publicly funded health care system that is both transparent and accountable, section 28 should be deleted.”

This is from the physiotherapy association, which made a presentation to us: “Quite frankly, we prefer to have section 28 deleted. The powers are far-reaching and we are not convinced they are required. Section 26, in our view, is quite enough. The existence of section 28 will hang over the not-for-profit health care sector as a sword of Damocles and will be tremendously destabilizing.”

This from SEIU, Local 1.0n: “If hospitals are not to close under Bill 36, why does paragraph 28(1)1 state that the minister may order a health services provider ‘to cease operating, to dissolve or to wind up its operations?’” That’s a very good question. I don’t think the government has an answer for that.

This came from a joint presentation by the Canadian Mental Health Association, CAMH and the Ontario Federation of Community Mental Health and Addiction Programs: “Under section 28, on advice from a LHIN, the Minister of Health and Long-Term Care can order certain health service providers that receive funding from a LHIN and are not-for profit entities to cease operations. This power is extraordinary, given that most health service providers do not rely solely on public funding. We object to the power of government to order an organization to close.... We recommend that the power of the minister to order an organization to close be deleted.”

We also heard, in the same presentation, the woman who made the presentation for CAMH, one Gail Czukur, who we found out, during the course of questions, used to write policy for the Ministry of Health in a former life. In questioning about this particular section—about the bill in general—she made it very clear that as a person who formerly wrote policy at the Ministry of Health, this bill contained excessive powers, more than we have ever seen vested in a minister or in cabinet before. This was someone who, on the public record, admitted she used to work for the ministry, used to be developing policy for the ministry in a former life and could say with great confidence to the committee that this bill contained excessive powers, powers to the minister that we have never seen before in the province of Ontario.

The minister said that the opposition—I’m not sure if he was talking about both opposition parties—moved some amendments. I can tell you we didn’t. We didn’t move any amendments because this whole section should be deleted, and that’s what we suggested should be done. When it came to the debate on this particular section, I talked about what I had read in Sack Goldblatt, I talked about the concerns that had been raised by CAMH,

talked about some of the other presentations that had been made, and said, “That section can’t be fixed. That section should be deleted in its entirety. We should not be giving this Minister of Health or indeed any future Minister of Health the kinds of excessive powers to force integrations, to force organizations to cease and desist, to force the transfer of organizations that appear in this bill. Nobody should have that kind of power, and we shouldn’t be supporting it.” I encouraged all members of the commit to vote against section 28 in its entirety.

Needless to say, the government didn’t do that. The government tried to amend what is already a very bad section. Regrettably, most of the powers of the minister that were referred to as concerns during the course of the public hearings remain in place.

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Let me deal now with section 33, which deals with integration by regulation. This is the section that clearly provides cabinet with the opportunity to contract out non-clinical hospital services or to increase privatization of health care services. That was confirmed by a number of presentations made to the committee. I’m also going to tell you what Sack Goldblatt had to say specifically about this particular section in their legal opinion:

“As set out more fully below, the bill also allows cabinet to order any public hospital (or the Ottawa Heart Institute) to ‘cease performing any prescribed non-clinical service and to integrate the service by transferring it to the prescribed person or entity on the prescribed date.’ In other words, cabinet may, by the stroke of a pen, transfer any non-clinical hospital service to any person or entity. This means that government can centrally dictate how all non-clinical services are to be provided by hospitals to the citizens of Ontario, including through privatization and transfer to for-profit providers.”

You see, the section is very clear. Let me just read it into the record again:

“33(1) The Lieutenant Governor in Council may, by regulation, order one or more persons or entities that operate a public hospital within the meaning of the Public Hospitals Act and the University of Ottawa Heart Institute ... to cease performing any prescribed non-clinical service and to integrate the service by transferring it to the prescribed person or entity on the prescribed date.”

The government made one minor change in this section, and I’m going to get to that. But I’m going to talk to you about the concerns I raised.

First, the minister himself, even if the local hospital board is in opposition, can order a non-clinical service to be transferred out of the hospital. Against their wishes, he can do that.

Second, there is no definition of “non-clinical service” in the bill, so none of us are quite sure what services the minister can order to be outsourced or contracted out. A number of people came forward and talked about hospital cleaning services, cafeteria services etc. But the lack of a definition of “non-clinical,” as we were told by presenters, is going to lead to a lot of controversy and chaos

in the system about what that means and what the minister can contract out.

Third, he can contract that out to a “prescribed person or entity,” so that can be anybody, probably a for-profit cleaning service—as we heard during the course of the bill, there were many examples where that, regrettably, had already happened—or a for-profit cafeteria service, maybe Sodhexo, for example. But of course the bill doesn't say what that entity is going to be, so that's where you can drive the Mack truck through in terms of privatization of whatever those non-clinical services are.

Finally, it says “by a prescribed date.” We raised this a couple of times. The member for Don Valley West tried to say a couple of times during the course of the public hearings that this section was only for some specific transfer of services that was happening now, and those specific transfers of those specific services were going to be finished by a certain date and then this whole part of the bill was going to be removed, was going to be repealed. That was the reference to a prescribed date, in her opinion.

What was interesting is that when the government moved an amendment, it became very clear that this has nothing to do with shutting down the minister's power to order the contracting out of these kinds of services. All that happens after a prescribed date is that it goes from the minister making those decision and the power is transferred to the LHINs. That's the only change that was made. Those things can still continue. The only difference is who is going to be ordering the outsourcing of some of these non-clinical services.

Let me tell what you some people had to say about these particular sections. This was from OPSEU, Local 260, and I quote: “Why does the bill target non-clinical services? Dietary and building maintenance are inherent parts of the health care system. Others have made these services the focus of privatization and restraint, creating more hospital-borne infections and increasing the likelihood of the transmission of viruses in the health care environment.”

Here's a presentation from the CAW, which told us how this was already happening, even though the bill hadn't been introduced. One of the hospitals where they are the bargaining agent is already moving to divide up or change the positions of its employees in order to contract out some of these services. Here is what they said: “In an Ontario hospital represented by the CAW, management recently proposed that the patient services associate position, a multi-skilled generic classification providing a single point of contact, responsibility and care to patients, be disassembled into the former positions of nursing aide and housekeeping aide of previous decades. The hospital has asserted that Bill 36 is the motive for this regressive proposal and particularly the ‘non-clinical services’ distinction. It is our belief that the hospital had intended to position the housekeeping functions for contracting out, to the potential detriment of quality patient-focused care and effective public delivery of services.”

So it's very clear that hospitals see the signal here. What they are doing is changing job descriptions, job classifications, to try and make sure that some of those employees will come under housekeeping now, so that those services are the ones that are going to be contracted out.

SEIU said that this provision opens the door to “greater privatization” of health care services. It will allow the government “to cease performing any prescribed non-clinical service and to integrate the service by transferring it to the prescribed person or entity on the prescribed date.” This gives the government the right to privatize more health services, particularly the non-clinical ones: “Non-clinical service transfers will be subject to the provisions of successor employer and sale-of-business provisions under the Ontario Labour Relations Act.”

“Displaced non-clinical service workers will have no right to transfer their union contracts to the for-profit private providers of non-clinical services.”

Here's what the ONA, Anne Clarke, had to say in Ottawa: “I'd like now to move on to our concerns related to contracting out of non-clinical services.... In section 33, cabinet may, by regulation, order public hospitals to cease performing any non-clinical service and to integrate the service by transferring it to another ‘person or entity.’ We are concerned that non-clinical services are separately targeted and being treated differently than all other health care services.

“Our particular concern is the consequence of contracting out certain non-clinical services—for example, housekeeping and dietary—which are critical to patient care. Nurses are unable to provide quality care if we can't rely on the quality of non-clinical services. In addition, these non-clinical services are essential to a healthy workplace and for protecting the health and safety of employees.

“Furthermore, the contracting out of non-clinical services such as human resources runs contrary to the whole purpose of maintaining good employee-employer relationships. Contracting out this relationship will only serve to erode morale further and to increase retention and recruitment problems. All of this will be happening at the same time as the shortage of nurses and other health professionals is growing worse as a result of upcoming retirements.”

Let me give you one final example in terms of what people had to say on this section. This comes from the Registered Nurses Association of Ontario, which made a presentation on February 6, 2006. It reads as follows:

“We are more immediately concerned about the impact on patient safety of contracting out non-clinical services in hospitals and other residential care facilities. We have repeatedly discussed with Minister Smitherman and Premier McGuinty the negative impact of two such services: cleaning services and food delivery. Nurses, who are with patients 24 hours a day, know that outsourcing cleaning services has a negative impact on

infection control and on the health and safety of patients and employees.

“The conventional argument for contracting out—‘it will be more cost-effective’—is flawed. Cost savings are achieved by moving to providers that pay minimum wage and no benefits. This was the argument that drove the casualization of the nursing workforce in the mid- to late 1990s, and we are still suffering from its disastrous results on patients, nurses and the health care system.

“To outsource housekeeping and other services with direct patient contact will be disastrous for our patients and facilities....

“Contracting out housekeeping services will result in two potential outcomes. Either nurses will be taken away from central clinical work to pick up the slack, or patients will receive treatment in an unsanitary environment. Either choice has high costs associated with it....

“The second choice is even less palatable. It seems incredible that we should have to remind any government in Ontario about the importance of infection control in hospitals, given our experience with SARS and the more common antibiotic-resistant infections that have spread in recent years. A vital way to prevent infections and their spread in a hospital setting is to adhere to stringent standards which can only be met if people are trained to meet them and if workers know their workplace....

“RNAO has a clear position on outsourcing. Any service provider that is directly linked to patient care—including nurses, doctors, other health professionals, unit clerks, cleaners, and food services staff—must be part of the permanent staffing so that they can communicate effectively and collaborate to deliver safe, quality patient care.”

I agree with all of those organizations, which is why we recommended to the committee to vote against section 33 in its entirety. We should not be giving the Minister of Health the ability to outsource non-clinical services, however they might be defined—and we don’t know that—to a provider that will probably be in the for-profit sector.

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It’s clear, again, that the only change the government made in this regard was to move away from language that actually set a prescribed date that was open-ended, to putting into the legislation a date: April 1, 2007. The new clause says, “The Lieutenant Governor in Council shall not make a regulation under subsection (1) on or after April 1, 2007.” What’s important to note is that on that day, the transfer of the power to outsource gets transferred to the LHINs. So despite what Ms. Wynne had to say during the course of the debate, that this was only reflective of a certain number of amalgamations that were occurring in the hospital system now, and once those were over, this whole section would be removed and nobody would have the power to use it anymore, that was not true. That was false. What is very clear is that after April 1, the minister, who used to have the power to order these outsourcings, will transfer that power to the LHINs, and they can carry on in the same vein of

privatizing non-clinical hospital services. We reject that entirely.

Let me deal with the section on competitive bidding. I’ve got to tell you that there was some very lively discussion about competitive bidding during the public hearings and the clause-by-clause. The nature of the debate went something like this: The minister and his Liberal backbenchers are trying to assert that there was nothing in the bill that talked about competitive bidding. Nowhere in the bill did it say that LHINs were going to use the competitive bidding model to acquire services. I, from my point of view, said, “Well, if that’s what you mean, then you should mean what you say and should bring forward an amendment that would prohibit the use of competitive bidding by LHINs. Let’s see if you’re going to be prepared to do that.” That was the nature of the debate that went on during the course of the public hearings.

I think it’s important to put on the record what the minister had to say about this, because he was at the public hearings. He made the opening presentation. In a section where he told committee members to watch out for all the myths and the misinformation and untruths that we were going to hear from certain people who came before the committee, we should also take into account that there was nothing true about the fact that competitive bidding would be the model used by the LHINs.

This is what he had to say for the record: “Local health integration networks are going to extend the competitive bidding model to the entire public health care system.” That’s what he describes as a myth. “Well, I don’t want to seem repetitive,” said the minister “but I’m holding the bill right here ... and I have read it many times. Folks, it doesn’t say that anywhere ...

“Local health integration networks are designed to better manage and coordinate health care services in order to ensure better access to those services. That does not mean competitive bidding....”

That’s what the minister had to say: opening remarks, first day of the public hearings. He was followed up by Ms. Wynne on many occasions, telling people who raise concerns about competitive bidding that nowhere in the bill did it say that the LHINs were going to use competitive bidding. She repeated that over and over again, and I repeated the challenge to her that if that was the case, then the government should bring forward an amendment and put it very clearly in the bill.

Probably tomorrow, I’m going to get to the amendment that was moved by me with respect to this, but I want to read into the record right now some of the comments that people had to make about competitive bidding, because they were very clear indeed.

This is from the Elder Health Elder Care Coalition:

“Ontario’s experiment with competitive bidding in home care has been a disaster for seniors. Many have seen unnecessary changes in their caregivers. We are extremely concerned that Bill 36 may give way to expansion of competitive bidding, leading to an inefficient and chaotic system. How care is structured has a direct

impact on equity of access, continuity of care, and quality of services.

“Recommendation 8:

“Amend Bill 36 to prohibit expanding the use of competitive bidding as a method for allocating funding to health service providers. Ensure that any allocation process is fair and transparent.”

These comments are from Ethel Meade, co-chair of the Ontario Coalition of Senior Citizens' Organizations:

“Many of our members are wondering if the whole LHIN project is a backdoor way to bring in two-tier medicine. We trust this is not the government's intention, but there is not much in the legislation to reassure them. Is the ‘purchaser-provider split’ merely a more palatable word for ‘managed competition’? We have not forgotten how ‘public-private partnerships’ were given the more palatable name of ‘alternate financing initiatives.’

“What is missing is a clear prohibition against allowing profit-seeking businesses to invest in any sector of our health care system. Experience in various parts of the world has made it abundantly clear that when the profit motive drives decision-making in a public program, the cost goes higher and the service to the public goes lower in both quantity and quality.

“OCSCO believes that the managed competition model in home care is a case in point. It has resulted in for-profit agencies squeezing out more and more non-profit providers. The quality of care has suffered, and communities have suffered from losing community service agencies that have for many years played a substantial role in promoting caring and coherent communities.”

Let me deal with this one, from a presentation in Ottawa. Just give me a few more minutes here, Speaker. It says: “The government says that there's nothing in the legislation that says the LHINs are going to use competitive bidding to acquire services, but the legislation also

doesn't specifically prohibit the use of competitive bidding.” Ms. McSheffrey made it clear, on the record: “When I met Elinor Caplan, one of the things she said to us was that part of her mandate was to review competitive bidding, because it could be used as a model within the LHINs of procurement for services, which is the British system, which is why my mum ended up going where she did for her surgery.”

The point about her mom going for surgery was really interesting. She said the following: “There are two areas that I consider myself an expert in. One is the disaster that has become the British National Health Service. It boggles my mind that anyone in government would use the NHS as a model for health care. Rationalization resulted in my mum being sent two and a half hours north of her home in Stafford for surgery because they were the cheapest centre to bid on that surgery. This resulted in no visitors and expensive transfer costs, as mum had to pay a driver to get her there.”

I'm going to stop at this point, because I see I'm near to ending my time, but when I start tomorrow, I'm going to be reading into the record some more of the concerns that were raised. Then I'm going to read into the record the amendment that I placed. Then you're going to see that even though the government had so much to say on competitive bidding and how it wasn't in the bill, when I moved an amendment to prohibit it, all but one of the government members voted down my amendment. That should speak volumes about what the government's real intentions are with respect to competitive bidding and the LHIN model.

Speaker, I'll pick it up tomorrow. Thank you very much.

The Acting Speaker: It being 9:30 of the clock, this House stands adjourned until tomorrow at 1:30.

The House adjourned at 2127.

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Sarnia–Lambton	Di Cocco, Caroline (L)	Nepean–Carleton	Vacant
Sault Ste. Marie	Oraziotti, David (L)	Toronto–Danforth	Vacant
Scarborough Centre / Scarborough-Centre	Duguid, Brad (L)	Whitby–Ajax	Vacant
Scarborough East / Scarborough-Est	Chambers, Hon. / L'hon. Mary Anne V. (L) Minister of Children and Youth Services / ministre des Services à l'enfance et à la jeunesse		
Scarborough Southwest / Scarborough-Sud-Ouest	Berardinetti, Lorenzo (L)		
Scarborough–Agincourt	Phillips, Hon. / L'hon. Gerry (L) Minister of Government Services / ministre des Services gouvernementaux		
Scarborough–Rouge River	Balkissoon, Bas (L)		
Simcoe North / Simcoe-Nord	Dunlop, Garfield (PC)		
Simcoe–Grey	Wilson, Jim (PC)		
St. Catharines	Bradley, Hon. / L'hon. James J. (L) Minister of Tourism, minister responsible for seniors, Government House Leader / ministre du Tourisme, ministre délégué aux Affaires des personnes âgées, leader parlementaire du gouvernement		
St. Paul's	Bryant, Hon. / L'hon. Michael (L) Attorney General / procureur général		
Stoney Creek	Mossop, Jennifer F. (L)		

A list arranged by members' surnames and including all responsibilities of each member appears in the first and last issues of each session and on the first Monday of each month.

Une liste alphabétique des noms des députés, comprenant toutes les responsabilités de chaque député, figure dans les premier et dernier numéros de chaque session et le premier lundi de chaque mois.

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