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Tuesday 28 February 2006

Mardi 28 février 2006

Speaker
Honourable Michael A. Brown

Clerk
Claude L. DesRosiers

Président
L'honorable Michael A. Brown

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LEGISLATIVE ASSEMBLY OF ONTARIO

Tuesday 28 February 2006

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

Mardi 28 février 2006

The House met at 1845.

ORDERS OF THE DAY

TIME ALLOCATION

Hon. David Ramsay (Minister of Natural Resources, minister responsible for aboriginal affairs): I move that, pursuant to standing order 46 and notwithstanding any other standing order or special order of the House relating to Bill 36, An Act to provide for the integration of the local system for the delivery of health services, when Bill 36 is next called as a government order the Speaker shall put every question necessary to dispose of the third reading stage of the bill without further debate or amendment; and

That there shall be no deferral of any vote allowed pursuant to standing order 28(h); and

That, in the case of any division relating to any proceedings on the bill, the division bell shall be limited to 10 minutes.

The Acting Speaker (Mr. Ted Arnott): I call for debate on this motion.

Mr. Toby Barrett (Haldimand–Norfolk–Brant): I have some concerns that I'd like to address with respect to the LHINs bill, Bill 36, the Local Health System Integration Act, and I welcome getting some comments in before this government chokes off debate with the time allocation motion.

Some of my concerns: As we now see, there is really nothing local about the local health integration networks. We hear that a system will soon be in place to set up essentially 14 ministries of health, all staffed with very large, unaccountable bureaucracies, unelected of course, and to date there is no viable business model for us to examine.

From our side of the House, this legislation indicates a lack of planning, in particular with respect to the dynamics of rural Ontario. Communities of interest such as Norfolk county have been divided one third/two thirds, placing a number of far-flung communities within the same bureaucratic entities.

In my view, this legislation represents a threat to small local hospitals. They are lumped in with the large bureaucracies and lumped in with hospitals in major centres. The legislation suggests that our health care partners are being "bullied"—this is a word that has been bandied about for a number of months—by this Minister of Health. The Ontario Hospital Association proposed a number of amendments; these were ignored by the minister and his appointed cronies.

This legislation represents a slap in the face to First Nations. I'm concerned about two communities within my riding, Six Nations and New Credit. I'm also concerned with legislation that was debated this afternoon, Bill 210, the Child and Family Services Act, and the impact that that legislation around children's aid services would have on native communities in my riding and whether they will continue to do business with children's aid in the future. I'm concerned about what's going on, in particular at Six Nations.

We don't see a plan. This government has given no indication that it has consulted with the federal government, in particular with respect to native concerns. I would submit that this government lacks the decency to submit this piece of legislation to full debate, deciding instead to choke off further discussion.

1850

I'd like to point out that in LHIN 4—that's the LHIN where I live—there are 12 hospitals, including our local hospitals: Norfolk General, West Haldimand in Hagersville, and Haldimand War Memorial Hospital in Dunnville. Our other local hospital is Tillsonburg District Memorial Hospital, a local hospital that's not in the LHIN; it's in LHIN 2.

A number of years ago we had quite a fight in Haldimand county to keep two of our hospitals open, both War Memorial and West Haldimand. I attended the Dunnville meeting; thousands of people attended that meeting. Obviously, thousands of people could not get into the local Legion. It was the same with the Hagersville hospital. That meeting was also packed. People in Haldimand county do not want to go through that again. The concern is that with the creation of a so-called local health integration network, if you can consider a neighbourhood of 1.3 million people local, it puts the very small hospitals in with the very large institutions in the city of Hamilton and sets the stage for a potential siphoning off of resources from the smaller centres.

We did keep Dunnville Hospital open and we kept Hagersville open. I would ask this government to consider my presentation this evening essentially as a warning shot across the bow. I wish to demonstrate the resolve of the good people in Haldimand county. They do not want to see this restructuring to be used as a Liberal excuse to close their community hospitals. There is a preced-

ent: We have seen what happened with Willett Hospital, just north of Brantford, under this government's watch.

The member from Burlington pointed out in the media a sad situation with the Joseph Brant Memorial Hospital in Burlington. That's certainly a fair distance from people down in the southwest corner of Norfolk county, but it's in the same LHIN. Joseph Brant: 48 hospital beds were closed. That's 25% of all the beds in that hospital. It does raise some concern about what is in store for Norfolk General and what's in store for West Haldimand or War Memorial.

I'd like to quote the member for Burlington: "McGuinty promised transparency and openness, but has threatened hospitals not to talk about these health cuts to the media and the public." We see a trend; we see, obviously, a threat being carried through on this closure motion to terminate debate. We are being silenced with this time allocation.

I can only imagine, when I think of the large bureaucracies we heard about today, something like $2 million being spent on expensive, brand new furniture. These people are not elected. I can only imagine how I would feel facing over 1.3 million people in an election, especially if there is the potential for mismanagement of something as important as our health care services. And 1.3 million people, that's the local LHIN. That's the neighbourhood LHIN that spans the services in my riding.

Time allocation: We're going to hear some concern about that this evening. I can only imagine what a student of political science would have to say about a motion like this to restrict debate on legislation like this. I hope he wouldn't say something like this quote: "Closure motions really are inherently bad for our parliamentary system and prevent members of all political parties—government members, opposition members, third party members—from fully participating in the debates of the day. They're designed to limit discussions."

The reason I would hope not to hear such a response or something like that in an essay from a student of political science is because he would be kicked out of school for plagiarism. These were the words used by the present finance minister, in this government, when he sat on this side of the House.

Mr. John O'Toole (Durham): Dwight Duncan?

Mr. Barrett: Dwight Duncan is the name. He sat on this side of the House and uttered those words, October 26, 1998. Here we are, debating a time allocation motion brought forward by this Liberal government, and one can only assume that the Minister of Finance will be voting against this time allocation motion. Of course, the minister's words would probably be taken with a very large grain of salt. I think I speak for all of us: History has shown how contemptuous this present government can be toward commitments, promises and pledges made before being elected. Obviously, it was a very creative interpretation of promises we heard during the last election.

So the real question we're debating today, what we should be debating today, asks, what is this government afraid of? If the LHINs legislation is sound, then why would this government choke off such an opportunity to promote further discussion in this House? Wouldn't reason state that the government would seek out the opportunity to promote its legislation rather than running and hiding?

As I wrap up, as far as this government running and hiding from this debate is concerned, if they were to come down to my LHIN, LHIN 4, or LHIN 2—they could certainly hide out in LHIN 2. It stretches from Georgian Bay all the way down to Long Point on Lake Erie. That's about a six-and-a-half-hour drive; it's about 400 kilometres from top to bottom. That is a very large local neighbourhood.

Ms. Shelley Martel (Nickel Belt): I'd like to say it's a pleasure to participate in the debate tonight, Mr Speaker, but as you know and people in the gallery know and people who are at home watching know, we're here debating a time allocation motion tonight, which is essentially a motion that shuts down debate on this important bill. It shuts down debate after only two days of debate on third reading of a bill that I think many people have very significant concerns about, if the public hearings process was any indication or thermometer with respect to people's feelings.

I'm very concerned that a bill the government says will have major impacts on health services, and it certainly will by the contents of the bill, is one the government now feels it has to rush through and ram through and get done before we finish here on Thursday.

I'm going to participate in this debate by re-emphasizing and reiterating many of the concern I raised when I spoke about this bill last week on third reading, concerns that were expressed during the course of the second reading debate, concerns that we heard over and over again during the course of the public hearings. I can say that on second reading, New Democrats opposed Bill 36, and what I heard during the course of the public hearings—I attended almost every one of those hearings and every one of those presentations—just reinforced my concerns. I want to reiterate those tonight and give people some flavour of what some of the presenters who came before us had to say.

In that regard, I want to thank the presenters who came to make submissions to the committee, those who were in favour and those who were against the bill, and those who provided written submissions. I'd like to thank the folks who are in the gallery tonight for their participation here this evening.

I want to begin my remarks by saying I'm going to focus on four areas. The areas have to do, first, with the LHINs themselves, that there is nothing local about them, that they are agents of the crown and are not accountable back to the communities they are purported to serve, even though the minister would tell you otherwise. Second is the excessive power of the minister himself to order integration of health care services, which are powers we have not seen before in the province of Ontario, and that was confirmed during the course of the

public hearings. Third is the opportunities for privatization of health care services that are found in this bill, particularly section 33 of the bill, and the further opportunities for privatization of health care services, because the government refused to ensure that cutthroat bidding would not be used as the method by which the LHINs would acquire those health care services they're now going to have some responsibility for.

If I have some time, I'm going to talk about some of our amendments, but my colleague Mr. Bisson is going to speak specifically about the francophone and First Nations concerns we heard during the course of the public hearings as well.

Let me begin by talking about the LHINs. The government would have you believe that somehow these local health integration networks are going to make decisions as close to home as possible with respect to people's health care, that they're going to be responsible to do that and are going to be accountable back to the community they are purported to represent. I've got to tell you that nothing could be further from the truth, because the reality of the matter is that the LHINs are agents of the crown. They are beholden to the government in any number of ways, and their accountability is back to the government of the day, not to the community they are purported to serve.

In that respect, I want to start by reading into the record some of the areas where it is very clear the LHINs are agents of the crown. This comes from a legal analysis that was done by Sack Goldblatt Mitchell. There are a couple of legal analyses that have been done; all are very critical. This is the one I like the best, so I'm going to reference it here again this evening. The "LHINs are controlled by the government," and that is a fact. Here's where it is demonstrated in the legislation: Under sections 3 and 4, "cabinet" or the government "may create, amalgamate, dissolve or divide a LHIN."

1900

"(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 board of directors determines who will be the chair and vice-chair of the LHIN." They serve at the pleasure of the government today. These are political appointments, not appointments from the community and certainly not elections from the community.

"(3) Even after their appointment, the board of directors of the LHINs has no independence from the government. Each member continues on the board at the 'pleasure' of cabinet and, as such, can 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." No doubt about that, since they appoint the LHIN board of directors. "Cabinet is also given the power to create additional LHINs or to amalgamate or dissolve existing LHINs.

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

"(5) A LHIN is explicitly defined as an 'agent of the crown'" in the bill; "i.e. it acts on behalf of" and for "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" that the minister provides. "If a LHIN and the ministry is unable to successfully negotiate an accountability agreement," then the minister will impose that agreement upon the LHINs.

"(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," and I quote again from the legislation, "in accordance with governmental 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." So if the government misses anything, they can pick it up in the regulation and set out some more ways that LHINs are accountable and bound to them and not to the community that they are purported to represent.

"(9) While each LHIN is to develop 'an integrated health service plan' for the locality over which it presides, this plan must be '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"—a plan that, I have to tell you, has not yet been developed by the minister. There were a number of questions raised about this during the course of the public hearings. We have no idea who's involved in the development of this provincial health plan. Nobody who came to the hearings said they were part of it. It seems that it's being done behind closed doors, yet it is the very document that is being developed behind closed doors without any public input that the individual LHINs are supposed to emulate when they develop their own local health plans.

These are the numerous ways that the LHINs are controlled by the government, that they are accountable back to the government, their masters, and that they are not at all accountable to the public they allegedly are supposed to represent. The problem, of course, is that they are agents of the crown, and as agents of the crown they also obtain some specific new, significant powers to act on behalf of the crown. I want to go through some of those powers, those new powers, that the LHINs are going to have to act as agents of the crown on behalf of the crown. They include the LHINs' control over health services providers. Here are some of the things they can do: "The bill vests LHINs, as agents of the" crown, "with an unprecedented degree of control over the structure of health services 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."

The 14 LHINs are continued by the government but are "now established under" this "statute, for the purpose of planning, funding and integrating the local health system. The term 'integrate,' as defined in act, covers a" broad range "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." Those are pretty significant powers that the LHINs now have.

They "are charged with the 'integration' of health services in Ontario.... [u]nder the auspices of the LHINs," this "may occur either through voluntary integration agreements among service providers … or through compulsory integration decisions made by the LHINs. Since the LHINs are authorized to integrate health" services "by providing or changing funding … it can be anticipated that many voluntary agreements will be facilitated" by the LHINs either promising to withhold or to give funding to obtain those voluntary integrations. That's very clear. When you have the power to fund, you have the power to force all kinds of things to happen.

"LIHNs are given the power to facilitate voluntary integration agreements, and the power to veto voluntary integrations. Thus, while a health care 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."

There's one more point that needs to be made in this section:

"In addition the LHINs are given the power to issue compulsory integration decisions requiring health care providers to whom it provides funding 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 set out "regulations defining other types of integrations that may be carried out by LHINs."

So it's very clear that the LHINs have quite excessive powers. As agents of the crown, they will certainly utilize or exercise those powers on behalf of the crown to whom they are beholden, and that certainly has nothing to do with or certainly doesn't represent any form of accountability back to the community that the minister says these folks are designed to serve and service. It's very clear they are agents of the crown, and any notion that this has anything to do with "local," frankly, is just a whimsical notion at best.

Let me deal with section 28 of the bill. That talks about the integration that is permitted by the minister. Again, these are new powers that are quite excessive and that will now be exercised by the Minister of Health, who may do the following.

The minister may tell a not-for-profit or a for-profit health service provider:

"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....

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

We heard significant concerns from a number of groups and organizations about this particular power. Let me first quote the Registered Practical Nurses Association of Ontario, whom we heard from on day one, who said the following with respect to section 28 and these new powers of the minister:

"The RPNAO strongly 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 from the bill." We agree.

This comment is from a joint presentation that was done by the Canadian Mental Health Association and the Federation of Community Addiction and Mental Health Services. In the question and answer after the presentation, we learned that one of the presenters, a woman from CAMH in particular, had a previous role in the government of Ontario in developing legislation for the Ministry of Health. This is what she had to say about section 28 of the bill:

"The last parts of our brief talk about the sections that others have addressed before you about the power of the minister in section 28 to actually close organizations. We would suggest that that be deleted. That's certainly an exceptional power. As counsel in the Ministry of Health for many years, I worked on a lot of legislation. This is an exceptional power of the minister, to actually close the operation of an organization altogether. It's one thing to order programs to merge or cease operations, but to close an organization is quite exceptional," said Ms. Czukar, who made a presentation on behalf of CAMH and who used to work with the ministry and should very clearly know. She reported to the committee that this section does provide new, additional powers to the Minister of Health.

A third presentation I want to read into the record came from the Alzheimer Society of Ontario, and it reads as follows:

"Section 28 gives the minister powers beyond what is required and which strike at the core of our civil society. We resist strongly the provision that the minister would have jurisdiction over the entirety of an organization with which a LHIN has a funding relationship. This ... is unnecessary, unreasonable, counterproductive and, we believe, undemocratic."

They go on to give an example why: "Some of our member chapters receive only a small percentage of their overall budget from government. For example, the Alzheimer Society of Toronto receives only 8% of its $1.3-million operating budget from government. On the other hand, the Alzheimer Society of Elgin-St. Thomas receives 50% of its $200,000 operating budget from the province. In neither case, however, should the minister have authority to interfere with our mission-related services that are not funded by government. Section 28 gives powers to the minister to issue directives on all of the Alzheimer Society activities. These powers need to be restricted to services funded by government, as per subsections 26(2)(b) or 27(3). Our accountability for charitable dollars should remain to our donors for purpose, and to the government for tax status."

1910

They weren't the only group that came to express concerns about the government being able to close a portion or all of their operations even though not all of the funding for that operation actually came from the LHIN or from the Ministry of Health. That is why New Democrats urged the government to vote against section 28 in its entirety. The powers in that section are excessive and they are unreasonable. They do strike at the heart of civil society, just as the Alzheimer Society said. That's the reason we encouraged the government members to vote against it, and of course the government members did not, so these excessive powers of the minister remain in the bill.

Let me deal with section 33 next. Section 33 is a section of the bill that allows very significant opportunities for privatization of health care services, and we heard that again and again during the course of the public hearings. Section 33, as set out in the bill, does the following:

"The Lieutenant Governor in Council"—that's cabinet—"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."

We have a couple of concerns with this section, and so did a number of presenters who came before us.

First, the power in this section allows the minister to tell a hospital and a hospital board to stop providing a particular service even if the hospital board wants to continue to provide that particular service with its own employees. But this section allows the minister to tell the hospital board to cease and desist performing that service.

Secondly, the bill talks about a "prescribed non-clinical service," and that is not defined anywhere in bill. While some people would have you believe that that only refers to maybe housekeeping or maintenance or cafeteria services, the fact is that it's not defined and was never defined during the course of the public hearings or in the clause-by-clause. Who knows what the minister of the day would decide non-clinical services to be that he or she wants that hospital to stop operating?

The third problem is that it doesn't describe what entity that particular service has to be transferred to. There is nothing in the bill that says, for example, that anything that goes out of the hospital into the community has to go to a not-for-profit organization—no, no, no. In fact, it says "prescribed person or entity," so it leaves it wide open. The view of many who came to the hearings, and my own personal view, is that that means the government is going to order the transfer of these services to any number of for-profit organizations out in the community, like Sodexho, for example, to provide cafeteria services, or A.J. Cleaning, for example, to provide cleaning and maintenance services in the hospital.

Finally, the other concern that was raised is that it also said by a "prescribed date." There was an interesting discussion at the committee about this, because the government members tried to say during the course of the public hearings that this particular section only referred to some changes in processes that were being undertaken right now and that once those changes in processes of certain functions moving out of the hospital into the community were over, then the minister wouldn't have the power to do that any more; the power would be gone, and that would be the end of any power to force a hospital to contract out its non-clinical services. So the government brought in a regulation, which I am going to refer to in a few moments. But let me deal first with some of the concerns that were raised around this section that reinforce what I have already had to say. This from OPSEU, Local 260:

"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."

This from SEIU, Local 1.on:

"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. 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 provider of non-clinical services."

This, from Linda Haslam-Stroud, who spoke at a press conference here today about Bill 36. She had this to say about section 33:

"I want to talk about section 33 of the bill, which is related to the contracting out of non-clinical services that

we believe are critical for quality patient care and for the health and safety of health care workers.

"Despite the health minister's protestations to the contrary, section 33 of the bill says the cabinet may, by regulation, order public hospitals to cease operating any non-clinical service and to integrate the service by transferring it to another person or entity. We are very concerned that non-clinical services are separately targeted and being treated differently in the bill than other health care services.

"Of particular concern is the consequence of contracting out non-clinical services, for example, housekeeping and dietary services, which are critical to patient care. Nurses know that we cannot provide quality care if we can't rely on the quality of non-clinical services. They are essential to a healthy workplace and for protecting the health and safety of employees. Housekeeping and dietary services are two such areas that have a profound impact on patient outcomes, including infection control and nutritional support.

"Contracting out these services results in workers who are disengaged and demoralized by lower wages and a lack of job security. High employee turnover rates disrupt care, as does transitory employment, where workers do not understand the values and cultures of patient care in a hospital."

Last but not least, let me read into the record some of the concerns raised by the Registered Nurses Association of Ontario with respect to section 33. They say 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....

"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 a central clinical work area 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 we have experienced 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 care professionals, unit clerks, cleaners and food services staff—must be part of the permanent staffing so they can communicate effectively and collaborate to deliver safe, quality patient care."

That's why they said that section 33 should be gone from the bill, amended, prohibited outright.

It's interesting that the only change the government made in this whole section, despite repeated concerns, was to actually put on a proscribed date with respect to the minister having the powers to order a hospital board to cease performing these particular services in the hospital. The change says now, "The Lieutenant Governor in Council shall not make a regulation under this section after April 1, 2007."

The government members tried to say, during the course of the public hearings, that after a certain time, when some of these transitional things that were happening now were done, then the power would be gone; the power to do these kinds of things would be removed. Well, you know what? We found out that after April 1, 2007, the minister doesn't have the power to order hospitals to cease and desist providing non-clinical services anymore—he loses that power. That power then gets transferred to the LHINs. After April 1, 2007, it's the LHIN boards that are going to have responsibility for ordering a hospital board to cease providing non-clinical services.

Frankly, what some of the presenters were told at the public hearings wasn't altogether correct, as we found out during the clause-by-clause. This power does not disappear after some alleged processes, which are apparently occurring right now, end. They were never named, and who knows if that was true. What is clear is that after April 1, the power that the minister has to order a hospital to cease and desist providing a service then gets transferred to the LHINs. Those opportunities for privatization just keep right on going, with all of the negative consequences that are associated with that.

1920

Let me deal with the whole notion of cutthroat bidding, and cutthroat bidding that allows for increased privatization of health care services as well. On the first day of the public hearings, the minister came to the committee to make a presentation and made it very clear to the committee members that—well, let me just quote what he had to say: "But that does not excuse what we have seen in the two months since our government introduced Bill 36, which is an organized campaign of attacks that are often baseless, poorly researched and appear to be driven simply by the desire to provoke fear."

Then the minister went on to outline some of what he called essentially the myths that were being spread about the bill. Here's the one I want to focus on: "Local health integration networks are going to extend the competitive bidding model to the entire public health ... system. Well, I don't want to seem repetitive, but I'm holding the bill

right here ... and, as I've said, 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 at the start of the hearings.

Any number of presenters came before the hearings and made it very clear that the bill doesn't say that the LHINs are going to use cutthroat bidding, but the bill also doesn't prohibit the LHINs from using cutthroat bidding. Any number of presenters made that clear. Let me just reference some for you in terms of the concerns they had about cutthroat bidding already in home care.

"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 an expansion of competitive bidding, leading to an inefficient and chaotic system. Health care restructuring has a direct impact on equity of service, continuity of care and quality of service. Amend Bill 36 to prohibit expanding the use of competitive bidding as a method for allocating funding to health service providers.'' This from the Elder Health Elder Care Coalition.

Secondly, from 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 really a more palatable word for managed competition? We have not forgotten how the public-private partnerships were given the more palatable name of 'alternative financing initiatives.' What is missing is a clear prohibition against allowing shareholding companies to invest in any sector of the health care system. The 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.''

Here's what the Registered Nurses' Association of Ontario had to say in their submission about cutthroat bidding:

"Ontario's experiment with competitive bidding in home care has been a failure. It has resulted in: a shift to for-profit providers (the share of the total volume of nursing services awarded to for-profit providers increased from 18% in 1995 to an estimated 46% in 2001); a loss of the social infrastructure associated with not-for-profit providers; critical shortages of community nursing staff that are directly linked to system instability and worsened working conditions in this sector compared to others; grave concerns about the quality of care; a misallocation of resources resulting from the high transaction costs associated with the process; and tensions between direct providers and community care access centres.

"Expansion of competitive bidding as a method of allocating funding to health service providers in Ontario would be expensive, inefficient, and lead to deteriorating health outcomes. Government officials have stated that there is no intention to extend competitive bidding beyond the home care sector. However, any legislation passed will continue beyond the current government and minister. As a result, that intention must be enshrined in the proposed legislation.

"Recommendation 3:

"Amend Bill 36 to prohibit LHINs from using competitive bidding as a method of allocating funding to health service providers.''

During the course of the clause-by-clause, I moved a motion with respect to cutthroat bidding. I moved a very specific motion, because I got tired of hearing the minister in his remarks saying that nothing in the bill said that the LHINs were going to use competitive, cutthroat bidding, and I got tired of some of the Liberal members telling presenters that they were wrong and no, there was nothing in the bill that would say that LHINs have to use cutthroat bidding. So I moved a very specific amendment which reads as follows:

"No competitive bidding

"(5.1) A local health integration network shall not use competitive bidding, a managed competition or any other similar process for any purpose under this act.''

I put that motion on the table to challenge the Liberal members, and guess what? All but one of the Liberal members voted down that amendment to prohibit competitive bidding being used by the LHINs. That says volumes about what's really going to happen with respect to this legislation. It says volumes about this government's lack of commitment to shut down cutthroat bidding in those sectors of health care that the LHINs are going to be responsible for.

One only has to look at the track record with respect to health care cuts and health care privatization to say it's no wonder that the Liberal members didn't support this particular amendment that I moved. Don't forget, this is a government that, after being elected, one of the first things they did was to bring in a new health tax, after promising there would be no new taxes. After Dalton McGuinty said there certainly would be no health care premium or health care tax, the single biggest tax increase in the province of Ontario came to the public of Ontario courtesy of this government in the first budget, and of course this is a very regressive tax that hits at modest- and low-income families very specifically.

This is a government that said there would be no cuts to health care, and in that very same first budget delisted chiropractic services, eye examinations for people between 20 and 64 and any number of physiotherapy services. This is a government where the leader, Mr. McGuinty, said before and during the election, "We will not have private financing of hospitals.'' He made that very clear both before and during the election campaign, and then, after they were elected, we now have any number of projects—probably 28 of them—that are going to be privately financed, which is going to cost the taxpayers of this province oh so much more money.

We have a government that took the Conservative's regressive, competitive, cutthroat bidding process in home care and continues that very destructive, chaotic process in home care today.

That is the government's track record with respect to privatization of health care services and health service cuts, and no one should have been surprised that the Liberals, despite what they said to presenters during the course of the public hearings, turned around and voted against my amendment to prohibit cutthroat bidding to be used by the LHINs. Nobody should be surprised, because you only have to look at the track record to know that that's exactly what they were going to do with respect to this issue.

I want to leave some time for my colleague Mr. Bisson, but let me just say a couple of more things. I want to point out some of the other amendments we moved that the government voted down. We voted to recognize the role of Franco-Ontarians in planning and delivery of health services in their communities in the preamble, and the government voted that down. We moved that the preamble be amended to respect health care professionals, confirm that they are fundamental to the delivery of health care, recognize a shortage of health care professionals, confirm that regional disparities in the availability of health care need to be addressed, and recognize that patients who are required to travel as a result of integration should be reimbursed. The government voted that down.

We moved a definition of "public interest" in the bill that related directly to the public interest provisions in the government's Bill 8, because there is no definition of public interest in the bill. The government members voted that down.

We voted to have elections of LHIN board members. If they're truly accountable to the community, they should be elected by the community, just like MPs, MPPs, school board trustees and municipal councillors, and of course the government voted that down as well.

We moved a motion that would have made it very clear that any savings achieved by LHIN boards would be savings that would be added to the global budget that they were going to receive in the next fiscal year, not subtracted from or reduced from that global budget. Guess what? The government members voted that down too.

We also moved an amendment that would have made it clear that any of those workers affected by privatization under section 33 of the bill, where the minister can order some of these non-clinical services to cease and desist being provided—that anybody who got transferred to a for-profit agency that wasn't primarily a health service provider would still have protections with respect to their union, their contracts, their pension, their benefits. The government voted that down as well.

Let me conclude, because my colleague Mr. Bisson is going to talk specifically to francophone and First Nations concerns. I was opposed to this bill on second reading, and I heard so much more about the concerns of people during the course of the public hearings. This bill is horribly flawed. The very legitimate concerns that were raised about privatization have not been addressed. The legitimate concerns about the excessive powers of the minister have not been addressed. This is a bill that is not worth supporting.

Applause.

The Acting Speaker: I have to address the people who are in the public galleries right now. I would ask you to listen to me for a moment. As the Acting Speaker of the Ontario Legislature, it's my role and responsibility to maintain decorum in this place. We cannot permit outbursts from the gallery. This is what I have to tell you at this time, and I would ask you to refrain from any outbursts whatsoever, including clapping.

Further debate?

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Ms. Kathleen O. Wynne (Don Valley West): I want to talk for a minute about our record of consultation on this legislation, but I have to say that I've listened to the member for Nickel Belt for weeks now, it seems. We travelled together with this bill and I've heard much of what she had to say many times. But I was really surprised to hear her talking about the need to take the money out of health care system, because if that $2.4 billion that we raised to put into the health care system were to be removed, I'm just wondering what the member for Nickel Belt would cut from the system. So I was very surprised to hear her say that that wasn't a good idea.

We're talking about the consultation on this legislation tonight, and the member for the opposition party earlier talked about us running and hiding and not being interested in continuing debate and shutting down debate on this legislation. We introduced the idea of LHINs in October 2004. We've had town hall meetings and 4,000 people have come and talked to us about LHINs. The minister has spoken to countless stakeholders on this legislation. We've had nine hours of debate and we are moving forward on this legislation because we need to get this framework of planning into place in this province.

It's notable that in the session under Mr. Eves between—

Mr. Joseph N. Tascona (Barrie–Simcoe–Bradford): There we go: Tory-bashing.

Ms. Wynne: Well, you know that in the session under Mr. Eves, not one bill was debated at third reading—not one bill. Of the 67 of 110 government bills that received royal assent, 61% were time-allocated. We've consulted on this bill and, unlike the social contract, which got zero minutes of hearings, we've had hearings on this bill. We are moving forward in a responsible way.

I want to talk a little bit about what's actually in the legislation, because that will demonstrate why it's so important for us to get this legislation through. The member for Nickel Belt talked about "local" being a whimsical notion. In fact, what we've got now in Ontario is one integration network. We've got the Ministry of Health

here in Toronto that has responsibility for the whole province. What we're trying to do is take people from local communities and allow them to have input into the plan for how health care should be delivered.

I want to read from "Objects" of the LHINs, section 5 in the bill. The reason to have local health integration networks is "to identify and plan for the health service needs of the local health system in accordance with provincial plans and priorities," "to engage the community of persons and entities involved with the local health system in planning and setting priorities for that system, including establishing formal channels for community input and consultation" and "to ensure that there are appropriate processes within the local health system to respond to concerns that people raise about the services that they receive." That's the reason we're putting local health integration networks in place: so that we can have that local input.

Right now, if I have concern about the education system, I can go to a school or a school board and I can voice my concern. If I have concerns about even a community agency that's funded by the government, I can go to the board of directors of that community agency. If I have a concern about a municipal service, I can go to the city council. If I have a concern about the health system, if I have a concern about the planning and the way the system is working in my community, I can come to Toronto. If you live in New Liskeard or Niagara, you can come to Toronto and talk to the people in the ministry, but that is not going to give you a very good sense of how the local decisions are being made. So what we're doing is putting in place boards that will have input from the community.

Part of what the local health integration network boards are mandated to do in section 16 of this legislation is to engage the community. To the comment of the member for Nickel Belt about engaging the francophone community, amendments were put in place that would require the LHIN to deal with, talk to and engage both the francophone community and the First Nations communities, to have bodies in place that they would be required to speak to in the planning that they do. I think the idea that there is no local component this legislation is completely misleading, because the whole reason for these networks to be put in place is so that the decision-making can go down to the local level.

I was talking to a constituent today, actually, who is a technician in the health care system in Toronto, and she was concerned about some of the things that she was being told by her union. For example, she was surprised when I told her that there was nothing in this legislation that explicitly expands the privatization of health care, nothing that expands the competitive bidding process. She was surprised that this legislation does provide for planning. She didn't know that that's what this piece of legislation was being put in place to do. She has been listening to a concerted campaign to talk about things that are beside the point in terms of this legislation.

Our record on privatization is that we have brought MRIs back into the public system. We have said to the Copeman clinic, "No, you're not going to be able to deliver your service in that way in Ontario." We've turned privatization back at the border. We are not interested in further privatizing the system, and the commitment to medicare act, Bill 8, is our written commitment to that. What this legislation does is build on that commitment and says that in order to sustain the publicly funded system in this province, we have to do our planning and we have to have local decision-making.

We used to have district health councils. Those district health councils are being replaced. The district health councils had no capacity to implement their plans. They had the planning function, but they had no teeth, as one of the people who came to speak to us said. They were toothless bodies that could not implement a plan, and we're giving the local health integration networks the ability to do that.

I think that far from shutting down debate on this issue, what we've done is engaged in debate with people in this province. We've made it clear what it is we're trying do and we continue to have mechanisms in place. This legislation puts the mechanisms in place that will allow us to continue having that conversation.

I'm absolutely not surprised that the members of the official opposition do not have a clue what it means to engage the public. I was a citizen in the gallery watching the previous government as it brought bill after bill and did not allow debate on those bills and did not have committee hearings on most of its legislation, so it's not surprising to me that they are not interested in the mechanisms in this legislation that would engage people over time. It's all very well to have committee hearings, which we've done, but what we need in this province are mechanisms to continue the conversation about our health care system.

I think I've made the point here before that in order for this health care system to be sustainable, we have to look at future needs, and as the baby boom ages, we're going to need very good planning. I'm looking at you, Mr. Yakabuski. We're going to need very good planning in order to deal with the knees, the hips, the eyes and the deteriorating physiques of all of the people who are aging in this province. The reality is that if we don't get it right, then we're going to lose the system. We have to make it sustainable. We have to find a way to put those local processes in place.

Not every community is going to have the same solutions. That's why we need the local board, because what's necessary in one part of the province is not going to necessarily be the way to go ahead in another part of the province. Geography in Ontario is a huge driver in terms of how we plan for all of our services: education, health care, you name it. We have to take our geography into account. That's why to continue to make all those decisions in Toronto makes no sense. So $21 billion of a $33-billion budget being taken from the centre, from the Ministry of Health, and being put in the hands of local

health integration networks—those boards, those people who have the expertise and the knowledge of the region—is the way we're going to make the system sustainable. We're the last province in Canada to deal with health care on a regional basis. We have to do this in order to make the system move forward in a way that's rationale.

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I'm very happy to support this legislation. I'm very happy that within this legislation are mechanisms that will allow us to keep engaging citizens in the province on the issues that confront them locally. I'm very happy that, once the LHINs are up and running, when people in this province have a concern about issues in their community, they'll have somewhere to go. The meetings of the LHINs are open to the public. They'll have opportunities to bring their concerns to the people who are making these decisions, unlike now, where they don't have a door to open to have that conversation. There's no one locally who can talk to them about the systemic delivery of health care. That's what we're talking about.

I'll just close, but the issue of SARS was raised by the member for Nickel Belt, and the concern about that kind of systemic issue. It seems me that dealing with those kinds of concerns, those kinds of systemic problems, is exactly why we need to have better coordination of services. Without the coordination of services, we are vulnerable as a province to that kind of epidemic, that kind of lack of communication among the different arms of the health care system. We need those local planning bodies in place so that if there's a crisis, if there's a need for the system to rise and deal with a crisis like that, the system is in place and everybody knows where the services are and how to deal with each other on an ongoing basis.

Thank you, Mr. Speaker. I certainly look forward to getting this legislation through.

Mr. O'Toole: Tonight, for those viewing—and I appreciate the people who are staying here, because I know this affects your lives and the work you do. I want to say publicly that I respect the work you do in our hospitals. Lakeridge Health is in my riding of Durham. I see people here tonight representing that.

This government notice of motion number 75 is anti-democratic. It's shutting down the debate, limiting the debate. This is the last week that the House is in session. When they're in session like this—actually, they want this gone. You have to ask yourself, what's their motive?

Ms. Martel is quite an expert. I have a lot of respect for the work she has done as health critic. I would just say that she raised many similar questions to those the opposition is raising here. So don't take it necessarily from me. I listened to her speech with some compassion.

What's really happening here, quite honestly, is that you wonder what the rush is. What's the secret? Why wouldn't they just continue to try to reach consensus? That is the most suspicious and enlightening part of the debate being time-allocated. I put you on alert that that's why we're quite animated here tonight.

I have participated in this. I was fortunate to be the parliamentary assistant to the Minister of Health for a couple of years and know how difficult and complex it is. It does take a lot of money. But most of that money is spent for front-line services for people, and people who are at risk or vulnerable. They need your services. It's difficult.

Here's what is happening. When I look at a local health integrated network, this is anything but local. There are 14 of these community-based things, and there are about 13 million people, about a million people per LHIN. That's bigger than most provinces.

The Acting Speaker: I would just ask the member for Durham to address his remarks through the Chair.

Mr. O'Toole: I am intrigued by the people who are here. This probably affects their lives and their livelihoods, so out of respect for their attendance, I am trying to make it relevant to them.

The LHINs are quite large. They're anything but local. The best way for me to visualize it for my constituents—the assistant minister of health, the minister of wellness, Mr. Watson, is here tonight. He should know that Central East is from Queen's Park to Algonquin Park. It's a large area and a very diverse population to service.

Local health networks are replacing the current seven Ministry of Health offices that are around to act as regional resource offices for the hospitals, long-term-care and other facilities. On top of that, the 16 district health councils are being disbanded. Those 16 district health councils—I'm going to read the notes that were given to me by the researcher. These aren't political notes. They're prepared by Carrie Hull, research officer, Research and Information Services. Here's what she says:

"Local health integration networks are 14 community-based organizations with a tentative"—these are her words—"mandate to plan, coordinate, integrate, manage and fund health care at the local level within a defined regional area. The LHINs replace and expand upon the functions of the district health councils, often referred to as DHCs, the former province-wide network of 16 advisory health planning boards. It is proposed that they will operate under the terms Bill 36, the local health integration system."

We all appreciate the fact that there needs to be improved coordination, especially on the technology side: integrating patient records, digital imaging, all those kinds of things. But for the most part, the communities own most of these hospitals. In my area, for instance, the community just loves the hospital in Port Perry, and the foundation—they're all volunteers, quite ordinary people for the most part, who give of their time and their lives to make sure the resources are there to provide the services that are required.

Now, I'm going to describe for you, from the research paper I have: The Central East LHIN is headquartered in Ajax, and it serves an area from Scarborough all the way to Algonquin Park—a huge area. According to the Ministry of Health and Long-Term Care's website, the Central East LHIN will have jurisdiction over approximately 16

existing hospitals, 70 long-term-care facilities, four community care access centres, three community health centres, two children's treatment centres, 25 mental health agencies, 50 community support service agencies and five addiction centres. A map of Central East is enclosed, and I could share that with anyone. It's quite frightening. The map is here.

Interjection.

Mr. O'Toole: The member from Renfrew–Nipissing–Pembroke wants to have a look at the map. There are some good notes that you'll be able to use.

The suspicion we have is, what's the rush? This is such a fundamental change structurally. What's the secret here? What have you got to hide?

When I read the bill—and I have. I have read every section of the bill, in fact, and I'm quite familiar with it. I sat in on the bill. I put on the record tonight that there are four sections that I have serious troubles with, and I'm going to go over them just briefly in the very few minutes I have.

Section 18 is a section that has not been mentioned by many speakers. I'm just looking at it: "The minister may set the terms of the agreement which shall include the matters set out in" the following clauses. They basically report to the minister. If you read section 18—it's in part IV—you will find in that section that "The minister and each local health integration network shall enter into an accountability agreement in respect of the local health system." It makes it very clear from the beginning and including the preamble that Minister Smitherman is in charge, period. If you doubt that, look at the terms of reference for the minister's authority in section 36.

I'm going to read section 36 for you. It's very important. This is the powers section. If anybody wants to look it up on the website, I'll send you copies of these sections. "The Lieutenant Governor in Council may make regulations." All of these appointments are by order in council as well, which are—I hate to say it, but we did it when we were there, and the NDP did it. They're political appointments. They're probably good people. I'm not discrediting them, by the way. I wouldn't want that on the record. I've sat in on some of the agency appointments, as has Mr. Tascona. For the most part, they're well-intended citizens, and forget the politics.

But section 36 is important to read. There are about 11 clauses in that section, but I'm going to read one just to illustrate how much power the minister actually has. It says in clause (f) that the minister "may make regulations ... respecting community engagement under section 16, including how and with whom a local health integration network or a health service provider shall engage the community, the matters about which a local health integration network or a health service provider shall engage the community and the frequency" of those communications. All of them will go back to the minister. They just have a rubber stamp—"No," "No," "No." That's what they're doing.

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They're going to say, "We gave the LHIN the money, and now you have to change all these birthing centres to one hospital, because there's not enough volume to have every hospital giving mothers and children the opportunity to have a baby in their own community." Then they'll move the incubators and all the stuff that the foundation and the community donated in a fundraiser to some other hospital 80 kilometres away. They'll say, "What happened to our children's centre here in the hospital?" that the auxiliaries and those other people worked for and gave of their time and their life and their commitment to build their community. It's sad and tragic. When I look at Bowmanville or Port Perry or Uxbridge, it's—

Mr. Lou Rinaldi (Northumberland): What happened?

Mr. O'Toole: Mr. Rinaldi knows Northumberland. He knows himself the anguish between Port Hope and Cobourg. He knows, and he did nothing, and now he's blaming—they're going further; it's going further. It's scary, actually.

I just want to make sure that's on the record. Section 36 is worth a read. It's where the real power is.

But there are two other sections that are absolutely critical to a full understanding of how the centralization and dismantling occurs. Section 33 is a rather obsequious little section. You'll want to have a look at this one here. This is so scary that it needs to be put on the record. Section 33 is integration by regulation.

"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" described by the minister.

If you look at all the legal eagle stuff here:

"Compliance

"(2) The persons and entities mentioned in a regulation made under subsection (1) shall comply with the regulation and subsections ... apply with respect to the persons and entities...." They shall cease performing a prescribed service delivery as prescribed by the minister. It's right in here.

I'm afraid. I have to stop because I get so—health care is the number one issue for each one of us in our ridings. It troubles me so much. This is dismantling what has worked, with imperfections, of course. It's troubling that most of the—

Interjections.

Mr. O'Toole: Mr. Speaker, there's some barracking occurring on the other side. Most of the members of the government have all drank the Kool-Aid. They haven't read the bill; they've haven't got the foggiest. I listened to some of their remarks. It's clear that they have had the briefing from the ministry. I'm not disparaging; I'm just saying that they've believed it all. They said they wouldn't raise taxes, and they did. You can hardly

believe a thing they say. That's the discouraging part of my debate.

But sections 18, 28, 33 and 36—those sections alone put all the power in Mr. Smitherman's hand. When you can't get your grandmother changed from a long-term-care facility, George will say, "Well, we've made it better."

Thanks, Mr. Speaker, for the opportunity to bring some light to an issue that's going to have serious repercussions for the delivery of health care, not just in my riding of Durham but in the province of Ontario.

Mr. Robert W. Runciman (Leeds–Grenville): I'm surprised that the Liberal Party, the governing party, has not chosen to participate further in the debate and defend their actions with respect to this time allocation motion and closing off debate on Bill 36, the local health integration networks legislation.

For those who are tuning in on the legislative channel this evening and wondering about what is occurring here, in effect the McGuinty government has chosen to limit debate, limit time to discuss what is perhaps the most significant change in terms of the health care system in the province of Ontario in a generation, if not more than that. It's regrettable that they're not participating.

The current House leader for the government, Mr. Bradley—I could go through a range of quotes from the past with respect to time allocation, but I felt that I'd just pull one out of his long history of quotes while he was sitting on the opposition benches.

The one quote I'm going to use is that time allocation is "putting the boot to the opposition." The government of the day, the Liberal Party under Dalton McGuinty, is not only putting the boot to the opposition in terms of our opportunities to discuss the legislation and the implications of the legislation, but a great many Ontarians—we have some of them in the galleries here this evening who are extremely concerned about the implications for the health care system, and for their opportunities for employment within the health care system in Ontario as well. The government, again, is shutting off the debate, closing the debate, forcing us to vote on this legislation, and with a majority government, we know what the result will be at the end of the day: This legislation is indeed going to be shoved through.

It's unfortunate—I mentioned this earlier as being a very, very significant piece of legislation, but it has pretty much flown under the radar. Most Ontarians—and I'm gauging this from what I hear from my colleagues and what reaction I'm getting in my own constituency office—the public really have very little, if any, understanding of what's transpiring here, what the implications might be for their communities, for their hospitals. There's very little understanding, very little comprehension, very little awareness. There have been some efforts in the last little while by some organizations to try and draw attention, but perhaps it's been too little, too late, given the government's reaction here: that they're simply moving ahead with it regardless. One of the disappointments for me personally is the Ontario Hospital Association's silence with respect to this issue.

I represent a number of smaller communities with smaller hospitals, and two outstanding health care facilities, in Brockville and Kemptville. One of the implications, one of the serious implications in this legislation, as referenced by my colleague from Durham, is the possibility—and I think this is not just a possibility, it's a reality—that we're going to see the moving of services currently provided, especially in some of these smaller facilities, whether it's hip surgeries or obstetrics, as my friend referenced, cataract surgeries, a whole range of specific services that are currently available in the smaller institutions, that from a centralized perspective—and this is really what this is, centralized by the decision-makers in Belleville, who will be watched very closely by the folks here in their ivory towers in Queen's Park. Even though the minister denies it, if you look at the legislation, this really is a centralization of power in the minister's office. As has been pointed out, we have people at the LHIN level who are political appointments. They are there at the wish, if you will, of the Minister of Health and the government of the day. So to suggest that there's going to be any significant degree of independence is really trying to pull the wool over the eyes of the public of the province of Ontario. It just isn't going to happen.

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When I look at my own riding, as such—the primary consideration when you're elected is to represent the best interests of your riding—I'm very concerned about what's going to happen with respect to some of the services that are available in Brockville. Obstetrics is an example where we have had some significant decline in the number of obstetrical—what's the correct word I'm looking for?—the number of births in that unit. I can see it as being in jeopardy, and some of the others that, to the number crunchers, perhaps don't make financial sense, but in terms of the availability of service at the local level, they make a great deal of sense.

When they talk about number crunching and savings and efficiencies, what they're looking at, I guess, is the system, not the individual. Certainly those cost savings may be achieved by the government and the Ministry of Health; it's the individual who has to pick up the additional cost. To go for a minor surgery that will no longer be available in Brockville, you will have to go to Belleville, for example—that service may be provided in Belleville—which is going to require travel and may well include an overnight stay or more than one overnight stay. It may require a family overnight stay as well because of the concern about the family member. Those are costs that will be assumed by the individual, the families, not by the province. Perhaps that is some justification to the number crunchers in Queen's Park, but I don't think it makes much sense if you get down to the grassroots level and start talking to people who care about accessibility to health care services in their own communities.

I mentioned the Ontario Hospital Association. I don't know what's going on there. Some sort of a backroom deal has been arrived at with respect to the lack of even constructive criticism coming forward, the lack of concern about what might happen to some of these facilities and some of the services that are currently provided. Nothing; total silence from that sector. We've talked about the minister being a bully in the past, and perhaps those intimidation tactics have paved the way for what we're seeing in terms of the lack of involvement by the Ontario Hospital Association with respect to these critical, critical changes in the health care sector and the impacts they could have on hospitals and local communities.

Another area that is perplexing to me is the community care access centres. Again, there's another group that have been mysteriously silent. You know, perhaps I shouldn't speculate, but of course we're hearing views that they're not being public with respect to concerns because they've all been assured by the ministry and the ministry officials, perhaps the minister himself: "No one is going to lose their job. In fact, we may just change the sign on your desk from CCAC to LHIN, and you will be getting a very significant severance payment as a result of the sign change on your desk." I hope that's not the case. I hope that's not really what's happening out there, but it's certainly what we're hearing in terms of the silence in that sector as well.

These are all very significant concerns, very significant issues that, for whatever reasons, are not being engaged in by some very important players in the health care sector of this province. It should be troubling, it should be troubling to average citizens, but, of course, as I said, there hasn't been enough noise out there. There hasn't been enough racket, enough public understanding or awareness of just what the implications are. I know that we, as individuals, have certainly all tried, through press releases, through what we can do in our own communities. But we have to get more people engaged in this.

We're not going to see a lot of the implications flow from this until we get past the next provincial election. This has been designed so that the negative fallout from this will not start to appear until shortly after the next provincial election. This is the cynicism of the current government. We saw it with their flip-flop on taxes, when they promised—Mr. McGuinty was on television saying, "I will not increase your taxes." A few months into government and they bring in the largest tax increase in the history of the province.

The cynicism about that is, "We've got three and a half years." It's a cynicism about the electorate. They believe that this will all be forgotten, that it will be long gone from the memory of voters in the province of Ontario by the time they go to the polls in 2007. I hope they're not correct. That's the same sort of approach they're taking with this legislation: "We're going to do this in a way that the implications will not become apparent to the public until perhaps 2008, and then that dumb, unwashed public out there will forget it by the time the next provincial election rolls around."

That's the cynical attitude of the Liberal Party of Ontario, clearly reflected in so many initiatives they undertook in their first six to eight months in office, and again being clearly indicated in the way they're approaching this legislation, the way they've planned this legislation, the way they've planned the implications not to flow until after the next provincial election.

Mr. Gilles Bisson (Timmins–James Bay): I've got about 16 minutes left in our time here for the NDP caucus—

Interjections.

Mr. Bisson: There's the government: "Whoopee, debate has ended." Wow. Are you guys ever smart and big. Give me a break. We're in a time allocation motion because you guys don't want to have a debate on this, and you're celebrating because a member of a caucus has 16 minutes left. I think that tells us where you guys are at.

Anyway, there are three or four points that I want to make in this debate with regard to the legislation, and I wanted to speak briefly on the time allocation. I want to put some stuff on the record because, as Mr. Runciman and my colleague Shelley Martel said, we're here to represent our core constituents, both the people we represent in our ridings but also within the constituency of our critic portfolios.

I'm the representative for Timmins–James Bay, as everybody here knows. But for people out there, that's up in northeastern Ontario: a large population of francophones, large population of First Nations and everybody else. We're a very large geographical area. This legislation is going to impact very directly on the people I represent in this province.

I want to start, in no particular order, by talking a little bit about what this means to First Nations. First of all, I think all of us agree—certainly people here watching and people back home—that First nations have been dealt a fairly bad hand when it comes to the level of service they get in health services in their communities. You just need to travel to communities across Ontario, any First Nations community, to look directly at what services they have in their communities.

We complain when we can't get Meals on Wheels to deliver a meal on time when it comes to care within the community. They'd be happy if they had somewhere to go if they got sick, because many of them don't have hospitals. Many of them don't have first aid stations. Pretty well none of them has long-term-care facilities; very few do. There is hardly any community care. If there's any community care, it's dispensed through the community health centres. There is really no integrated system of health care in those communities, I think primarily because the federal government has done a bad job, and also the government of Ontario over the years has been disinterested.

The First Nations look at this legislation and say, "We'd like to be part of the health care system, but

you're going to lump us into a system that doesn't recognize our unique position within society. Treaties were signed between the federal and provincial governments that say what the responsibilities arte insofar as what they expect from First Nations and what we expect from them."

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They came before this committee and they were very, very clear. Chief Stan Louttit I know I talked to directly from Mushkegowuk tribal council, and the people from Nishnawbi Aski, John Beaucage from his particular treaty council, Angus Toulouse from the Chiefs of Ontario and others—they were unanimous. They came and they said, "Listen, we want a number of things. We have three specific things that we want the Liberal government to address." They were very clear. They said to the Liberals, to the Conservatives and to the New Democrats, "We need a number of things." The first thing they said was, "We need a non-derogation clause. To explain what that means, in no way, shape or form will this legislation infringe on our inherent right to self-government and the rights we have by virtue of the treaties we've signed."

You would think, Ontario being a signatory to that treaty—Treaty 9, where I come from, was 100 years ago this year—would say, "That's not a problem. That's a no-brainer. We're going to give you a non-derogation clause." But when the motion was brought forward by my colleague Shelley Martel—I will not read into the record the entire motion because I haven't got time—that Ontario recognizes that the First Nations are a nation unto themselves in regards to how they govern themselves and that we will not in any way infringe upon their rights as a people, basically a non-derogation clause, the government voted against it. The First Nations are quite upset over that because they say, "A repetition of the past. We've got a bad deal for the past 100 years in this treaty, and it continues." So much for this new relationship that the government touts as being the relationship they want to establish with First Nations. I'll get into that a little bit later with regard to some of the comments we got from Chief Toulouse and Chief Beaucage and others.

Another amendment that I want to read: "'First Nations programs and services' mean all existing and future health-related programs and services directed primarily at First Nations communities and citizens, including, without limitation, those programs and services funded in whole or in part under the 1965 welfare agreement, those programs and services funded in whole or in part by the federal government of Canada," won't be affected. Again, the government voted against the motion. They're saying there are responsibilities on the part of the federal government, but when it comes to health care, they want to make sure that this legislation in no way gets the federal government or the province off the hook when it comes to providing those services. Again, the government didn't accept that motion as put forward by Shelley Martel, my colleague who is our health critic in the New Democratic Party of Ontario.

The other one was the whole issue of the delivery of aboriginal health services. They're basically getting at that "Nothing contained in this act"—and what they wanted is—"no action taken under this act shall be interpreted to have the effect of removing responsibility for the delivery of health services and programs that are directed primarily to First Nations people from the ministry and transferring it to another person or entity."

They didn't want to get caught up in any kind of a transfer, privatization, shifting of responsibilities. They're saying, "Listen. We made a deal with the crown. We didn't make it with Mattel toys, we didn't make it with Sodexho, we didn't make it with anybody else but the crown. And we want to have in the legislation a guarantee that you're not going to in any way, shape or form by the creation of LHINs do away with that."

Again, the motion, as brought forward by my colleague Shelley Martel, was voted down by the government. I say to the government: Shame on you. You're the guys who said, "We're prepared to have a new relationship with First Nations. We will treat you differently. "Come," say the Liberals. "We love you. We'll hug you." And they find out that basically the hug doesn't mean anything. It's like going out on a date and not being very satisfied at the end of the evening with the one you've been with.

Interjections.

Mr. Bisson: I'm just saying that that's what these guys are like.

I want to read a letter dated February 9 from Bob Goulais, executive assistant to Grand Council Chief Beaucage. He writes the following, and this is important. Members need to understand this. He says—and here's the rationale: "The Union of Ontario Indians are concerned that the province of Ontario has failed to properly consult with the First Nations of Ontario on this sweeping legislation that has a genuine possibility of impacting negatively on the aboriginal inherent and treaty rights in health of every First Nation member in the province of Ontario."

They're saying to you very clearly, "Listen. Whoa. Put the brakes on. We need to be talked to. We need to be consulted. We have to work with you. We need to do the health planning ourselves with you so that it basically is in keeping with our traditions and the geography and the people we represent."

He goes on to say—this is after the government introduced all their amendments and didn't respond to any of their concerns. He says, "In conclusion, in Regional Chief Angus Toulouse's response to Minister Smitherman of February 9, 2006, he echoed the sentiments of the First Nations Task Force that the development of the LHINs is not in keeping with the National Health Blueprint and that the present amendments as received by members of the task force" put forward by the government "are not acceptable."

So I say to you: Shame on you. I would think that after 100 years of Treaty 9 and 100-plus years of colonization of the First Nations people of this province, we would at

least for once give them a fair shake. But we couldn't do that in this legislation. I say to my friends: A sad thing.

The other point I want to make with regard to the governance model and LHINS is that I want people to understand that LHIN 13, where I come from, basically goes from North Bay to Hudson Bay, from the Quebec border all the way east, to the other side of Elliot Lake, at least, past Sault Ste. Marie. It's bigger than my riding, bigger than the Speaker's riding, bigger than Mike Gravelle's riding and a few others put together.

Here's the scenario. First of all, the LHINs are not elected. Nobody went to the First Nations and said, "Would you choose who's going to come and represent your communities at the table when it comes to health planning?" Instead, the government says, "We're going to appoint whoever we want to appoint." Now, they haven't appointed a bad guy in Norm Wesley. I have confidence in him. He's a good appointee, but he's one voice on the LHIN and he's going to be there, trying to advocate for health services on James Bay. You tell me how one person, with no allies as far as where he comes from—people who understand the journey of the First Nations, when it comes to services in their communities, are going to be able to be effective on the LHIN board. There's no makeup on that board, the way they set it up, that says, "We're going to make it so that the First Nations have some control over what happens," all of this in the midst of the integration of the health—the federal hospital, Weeneebayko, in Moose Factory, and James Bay General in Moosonee were in the process of amalgamating the federal and provincial hospitals on James Bay. You would think that the government, in the middle of that exercise, would at least, within the LHINs, make sure there's a fair process for James Bay and other First Nations across the north, and other parts of the province, to be heard in this process. I say to you again, shame.

L'autre point que je veux faire, monsieur le Président, fait affaire avec des services en français et comment cela affecte la communauté francophone dans cette province. Je vais être bien clair. Il y a un couple de points que je veux faire sur ce point-là.

Premièrement, la communauté francophone est venue devant ce comité et elle a été très claire. Elle a dit au comité : « On veut avoir une déclaration très claire dans la législation, au préambule, qui dise que les services en français vont être garantis et qu'on va être respecté dans ce processus. Ma collègue M^{me} Martel a amené des amendements directement à l'Assemblée, et je les ai seulement en anglais : « recognizing the role of Franco-Ontarians in the planning and delivery of health services in our communities. » Il y a une copie en français mais je ne l'ai pas avec moi présentement. Elle a introduit cette motion parce que la communauté francophone a été très claire. Elle a demandé : « On a besoin d'être respecté dans ce processus-là. On est un des peuples fondateurs. On était un des peuples qui ont créé cette nation appelée le Canada, avec nos autochtones et avec les anglophones et autres, et on veut être respecté comme on a le droit d'être respecté sous la Charte canadienne des droits et la constitution canadienne.

Le gouvernement a dit : « Non, on ne le fait pas. Ce qu'on va faire, on va mentionner dans la législation que le ministre doit créer un conseil qui va aller consulter pour se faire dire quoi faire quand ça vient aux services pour les francophones de la province de l'Ontario. Une fois qu'ils consultent, c'est bien simple; ça marche comme ceci : M. Smitherman dit : « Je veux que vous vous penchiez sur la question telle et telle, » ce conseil qu'il va appointer. Le conseil travaille très fort et fait une recommandation au ministre. Le ministre n'a aucune obligation d'accepter ce qui a été dit. À la fin de la journée, il peut faire ce qu'il veut. Les francophones disent que ce n'est pas assez bien. On sait comme communauté qu'on se fait avaler par les institutions unilingues et même par les institutions bilingues, et qu'on a besoin d'avoir une fonction francophone pour être capable de déterminer nos services.

L'autre grosse crainte de la communauté est toute la question d'amalgamation. On a présentement, par exemple, des centres de santé communautaires comme à Sudbury, à Kapuskasing et dans d'autres communautés. On a des services—par exemple, des agences de santé mentale comme à Hearst, à la Soo, à Iroquois Falls et à Kapuskasing. Ce sont des organisations francophones. Ce ne sont pas des organisations bilingues. L'administration est en français, le service est donné en français, c'est pour les francophones, géré par les francophones et entretenu par la communauté francophone. Pourquoi? Pour reconnaître la réalité de la communauté francophone. Une crainte des agences francophones est la possibilité, dans cette législation-là, qu'un gouvernement arrive et dit : « Écoute, vous autres, votre petit groupe francophone dans votre agence à Kapuskasing ou à Hearst, vous êtes un peu trop petits. On va avoir des efficacités et on va vous mettre avec un groupe de Timmins ou avec un groupe de Kirkland Lake. Éventuellement ils deviennent, à la place d'une organisation francophone, une organisation bilingue. Ceci veut dire, à la fin de la journée, qu'on perd notre autonomie comme groupe pour gérer nos services. La communauté a vraiment peur de ça. C'est dans la section 28 du projet de loi.

Un autre point est toute la question des services en français. On sait qu'une fois qu'on délaisse les services du ministère de la Santé à aller à une agence—par exemple le gouvernement dit : « On crée des LHINs, et eux vont aller créer un système de santé dans notre région. Et eux autres disent : « Nous, on va privatiser un service tel et tel dans le système de santé, on va dire des hôpitaux. On va privatiser le service de laboratoire. » Ça veut dire qu'il n'y a aucune responsabilité de la part du gouvernement pour s'assurer que ces services sont donnés en français. Quand c'est dans la province, ça tombe sous la Loi 8. Une fois que c'est transféré dans une autre agence quelque part, privé ou même public, qui n'est pas directement au gouvernement, il n'est plus sous la Loi 8. La communauté dit : « Écoute, on a une grosse crainte quand ça vient à ça parce que, à la fin de la

journée, on peut se trouver avec une réduction de services en français avec l'échéance du temps avec cette nouvelle organisation des LHINs.

L'autre point est toute la question de représentation. On n'a aucune assurance qu'il va y avoir un noyau francophone sur les LHINs, pour s'assurer qu'ils sont là pour travailler pour la communauté francophone—et c'est un peu le même problème des autochtones et autres, où ils vont se trouver minoritaires dans une organisation qui est nommément bilingue, mais vraiment une organisation anglophone—et comment eux autres vont aller retrouver leurs services, et s'assurer des services à la communauté francophone, quand ils n'ont pas une habilité de contrôler ce qui se passe aux LHINs.

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The other point I want to make very quickly is the whole issue of what this means to small-town and rural Ontario. Mr. Runciman raised the point, and I think it's a very good one. My friend Mr. Gravelle will know as well as I that we have worked long and hard to provide health services in communities across this province. We want to make sure that people in Kapuskasing, Smooth Rock Falls, Hearst and Moosonee are able to get service as much as humanly possible in the communities.

One of the problems with the LHINs is they will regionalize the services. It'll centralize them in a larger regional centre. I'm going to tell you what's going to happen over a period of time: We're going to start transferring a lot of the administration of our programs into larger regional centres—Sudbury, North Bay, Timmins or wherever it might be—and the smaller communities are going to lose the ability to have a say about what services are delivered in their own communities, and I will argue that when it comes to front-line services, those will also start to be regionalized. Then the bean counters are going to come in and say, "Well, there are only five patients using this service in Kapuskasing. If we told them to drive down to Timmins, which is only two hours down the road, they can get service at a much more reasonable cost to the taxpayer." Eventually, these LHINs will want to save money, and they're going to try to save money by regionalizing both the administration and front-line services. For small-town Ontario, for rural Ontario, for northern Ontario, that is bad, bad policy. We need to not regionalize and not centralize. We need to make sure that we give actual control to the local communities.

I have 34 seconds. I have a lot to say, but I'll only say this: A Liberal government in opposition that decried, every chance they had, time allocation by the Tories said they would not do it. They promised in the election and put in their platform that they would have a democratic process, that members would have the right to have their say, that they wouldn't use time allocation. Like all promises Dalton McGuinty and his Liberal caucus made in that last election: broken. Here were are, time allocating legislation that clearly, to the people up here, who have come in big numbers from hospitals across Toronto to watch this debate, are saying, like me, "Shame on the Liberal government for bringing forward this legislation without proper consultation and then ramming it through by time allocation."

Mr. Tascona: I'm certainly pleased to follow the comments of my colleague from Timmins−James Bay to deal with this time-allocation motion, which is essentially to shut down debate with respect to Bill 36, An Act to provide for the integration of the local system for the delivery of health services, which is code for—and we talked about this before. "Integration" is downsizing, and probably downsizing the front-line workers with respect to health care services in this province.

One area where I think that rings true is when you go through the bill and the amendments that were brought in. Under "Other employees," which is section 11 of the bill, it says, "A local health integration network may employ the employees, other than a chief executive officer, that the network considers necessary for the proper conduct of the business of the network.... The employees employed under subsection (1) are not civil servants or public servants within the meaning of the Public Service Act." The government is making it very clear that the employees that are employed by these LHINs are not going to be part of the provincial government. They're going to be a separate entity unto themselves.

One area that caught my eye in terms of what we've been dealing with, and I think last week when we were debating this bill, when the minister was here in the House, was his frustration with respect to bringing forth this particular piece of legislation three years into their mandate, bringing forth a system of the CEOs and the boards of directors and the bill isn't even in place. They're going ahead with bringing in a structure to fundamentally change the health care system and they don't even have a bill or authority to do that.

I brought a contempt motion with respect to that to the House. I don't agree with the Speaker's ruling on that day—the former Speaker, Mr. Curling—with respect to saying, "You don't need legislation in place to go ahead and do something." They didn't have any legislation in place, and they went ahead and put together these LHINs operations in terms of the CEOs and the boards of directors. What was frustrating in being a member of the government agencies committee, where they bring forward all these appointments to the different LHINs, whether they're the CEOs or whether they're the board of directors, was that none of them knew anything of what they were required to do. They did not have any knowledge of what they were expected to do, they had no knowledge of what the LHINs were going to do, and they had no knowledge of where they were going with respect to the mandate that they'd been given once they got their appointment. It was a complete blank cheque in terms of what was going on, with no knowledge. One had to question whether they were even qualified for the positions in the first place, because they didn't even know what they were going to be doing. That stands forth to date. When we interviewed someone last week with respect to the

board of directors in the LHINs, they didn't have a clue about what they were going to be doing.

So that's very frustrating. I'm as frustrated as the minister, who has brought forth legislation to justify everything that he has done when in fact he didn't have any legislation to do anything. It's quite interesting that you can go ahead with authority—you're supposed to have statutory authority to bring forth all these changes. The Liberal government didn't even have any, and they have the nerve to come forth and say, "Well, we can do it; we'll bring forth a bill later." So here we are with Bill 36, and they're shutting down debate. They don't want to have any more debate on this, because they're so far behind in terms of their agenda to try to bring this forth that they've got to do it now.

One thing that really frustrates me, though, in terms of this bill is the phoniness, the complete misrepresentation in the bill and in the speaking with respect to transparency. You read the amendments:

"Public meetings

"(4) All meetings of the board of directors of a local health integration network and its committees shall be open to the public."

That sounds well and good, but then you go to subsection 9(5), "Exceptions." There are more exceptions than you possibly could have. I'm going to read a few of them, because it just makes this a joke in terms of transparency, because there isn't any transparency. You could use any one of these sections, and there are about 10 subsections that deal with "Exceptions" under "Public meetings"—you could use every one and you could shut the public out with respect to what's going on with the local health integration networks.

Isn't the purpose of transparency and public meetings to know what's going on with respect to the institution, the agency that you're dealing with, so you know what's going on and so the public knows what actually is going to happen to affect their health care service? We're not talking about anything more fundamental in a person's life than the health care service that they're going to receive.

The exceptions that they've got in there are unbelievable:

"(a) financial, personal or other matters may be disclosed of such a nature that the desirability of avoiding public disclosure of them in the interest of any person affected or in the public interest outweighs the desirability of adhering to the principle that meetings be open to the public"—in other words, "We can't disclose this to the public because it wouldn't be very good for the public to know."

The other part of it is, "(b) matters of public security will be discussed." That's an exception with respect to public meetings.

Another one is, "(c) the security of the members or property of the network will be discussed."

The next one is, "(d) personal health information, as defined in section 4 of the Personal Health Information Protection Act ... will be discussed;

"(e) a person involved in a civil or criminal proceeding may be prejudiced;

"(f) the safety of a person may be jeopardized;

"(g) personnel matters involving an identifiable individual, including an employee of the network, will be discussed;

"(h) negotiations or anticipated negotiations between the network and a person, bargaining agent or party to a proceeding or an anticipated proceeding relating to labour relations or a person's employment by the network will be discussed;

"(i) litigation or contemplated litigation....

"(j) matters prescribed for the purposes of this clause will be discussed"—what the heck that means, I have no idea. Then, finally,

"(k) the network will deliberate whether to exclude the public from a meeting, and the deliberation will consider whether one or more of clauses (a) through (j) are applicable to the meeting."

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So, in other words, if they want to exclude the public, they can exclude the public from the meeting to decide whether they want to exclude the public and decide on which reason they're going the use to exclude the public. That's really fair: "We're going to have a meeting to exclude the public, and then we're going to decide in that meeting whether we want to exclude the public, and then we're going to decide what reason we want to use to exclude the public." That's really a good provision. Why don't they just say, "We don't want the public involved in our meetings"? Why go through this charade of saying, "We want the meetings to be open to the public. This is transparent," when they fully know that it's not transparent.

Everybody here in this Legislature knows what's going on. They're shutting down debate because they want to get this farce moving, because everybody they've appointed to the government agencies doesn't know what they're doing. They've now got legislation that will allow them to start this process and nobody knows where this process is going, other than the fact that we know we're going to have less health care than we have now with respect to this process.

I'm going to be sharing my time with the member from Renfrew–Nipissing–Pembroke with respect to this debate. I look forward to his comments.

The Acting Speaker: Further debate on the time allocation motion?

Mr. John Yakabuski (Renfrew–Nipissing–Pembroke): I was sitting back there waiting for the government to respond, but they have not.

We don't have a whole lot of time here, and we could go on about the time allocation motion itself, which is terrible, and the fact that the member for Don Valley West earlier spoke about the previous government using time allocation. Those folks over there spouted against it. They professed that it was absolutely wrong. But now, in government, they're using it on a more and more frequent basis. In fact, they tabled another time allocation

motion today that will be debated tomorrow. That's quite regrettable, because it removes the elected members of this assembly from proper debate in this House. That is regrettable.

Let's talk about the LHINs for a moment. There's so much confusion out there about the LHINs, and the average person really has not been able to get the kind of information that is necessary to draw the conclusions that they should be able to draw about whether or not this is good for health or not. In fact, people who are stakeholders in the health care system have had a hard time trying to understand what these things are all about.

I spoke to people, for example, in the Alzheimer Society the other day; Kathy Wright, I believe, is her name. I have her letter here somewhere. She's very concerned about the powers that the minister has in this bill under section 28, virtually unfettered powers on the part of the minister. That's not what a working system and a workable system is all about. A bill centralizing all this power in the Minister of Health's office is not healthy—no pun intended. Those are some very serious concerns about section 28. There are equally serious concerns about the size of these LHINs. I'm part of the Champlain LHIN, which stretches from Hawkesbury almost to Algonquin Park and up to Deux Rivières. It's massive, it's huge. Do you think that decisions that are pertinent to Deep River or Barry's Bay are going to get a proper airing in a LHIN of that size? It's going to be dominated by the big Ottawa hospitals.

My gosh, I have so much respect for the Ottawa hospitals. They do such a great job, and it is the place where people in Barry's Bay and Renfrew and Pembroke go for tertiary care. But that does not mean we should be cut out of the system. I'm concerned that if the minister has the power to make a decision that he's going to shut down a particular service at St. Francis Memorial Hospital in Barry's Bay, he can do that, and that service will be just shifted to another hospital.

The problem is that we don't have the transportation network to get them there conveniently. I see the parliamentary assistant to the Minister of Transportation. If they get working on Highway 17, that might help a little bit, but it's the distance. I think that the minister has the ability to deny services to rural people, and what we see from this government every day is more and more denial of the reality of rural Ontario; for example, the gas tax bill that I proposed being ignored by this government.

LHINs, again: very serious concerns about the impact that this may have. I have a letter here from Marianhill, a long-term-care centre in my riding. They are very concerned about the impact this could have on them as a not-for-profit long-term-care centre.

I have an article from the Pembroke Observer, again indicating that these local networks are anything but local. They're not local.

The minister talks on and on ad infinitum about bringing decisions back to the people. This is about putting the decisions into one person's lap, the minister himself. He's going to have all the power. That's a very dangerous circumstance that we're creating.

I don't fault the government for making an attempt, and I accept that it's making an attempt, to get some control on health care spending in this province. I actually applaud them for that. Health care spending is something we do have to get control over, because this system is not sustainable if we don't make those kinds of efforts. But what they're doing here is taking the local people out of the decision-making process. Yes, they've appointed local people on the boards, but they're one voice on a big board representing their area. That's not going to be good enough. I have serious concerns about the ability of local people to get local health care and be part of the decision-making process within that LHIN. I have a copy of the bill here.

Mr. Tascona: You've got a minute. Keep going.

Mr. Yakabuski: I know we're running out of time, Mr. Speaker. Not only is it a time allocation motion, but I've been time allocated with the amount of time I get to speak within the context of this specific debate.

Our public health care system is at risk. Mattawa, Marathon, Marianhill—very upset about it. County of Renfrew—very concerned about the impact of the local health integration networks, Bill 36.

If there were two days to talk about this, we could keep talking about it. The problem is that this government here, this party here, has decided, against their own beliefs, that they're shutting down debate on this issue as they've shut down debate on other issues. They're going to shut down debate on another issue tomorrow. They just keep talking one thing and doing another. They're not respecting the people and they're not respecting the people in this House. This kind of behaviour has got to stop. This kind of bill, this local health integration network bill, is very serious in the repercussions it has for the people in Ontario, and going forward in history. I think a fulsome and complete debate is necessary, not one that is shut off, short-circuited.

Hon. Jim Watson (Minister of Health Promotion): This is really a very basic question, why this legislation is before us: Do we want control of our local health care system by the public servants at Queen's Park and on University Avenue, or do we want local people making local decisions? This is really about decisions made by the community, in the community and for the community. It's a basic principle of democracy where you have a local decision-making process in place, which I think in our Champlain district is going to work very well.

The men and women who have put their names forward to serve on the LHINs are individuals of great distinction. It's regrettable that there have been individuals in this Legislature who have cast aspersions on these folks: Michel Lalonde, for instance, un grand bénévole qui vient de l'est de l'Ontario, est le president du comité; Jo-Anne Poirier, vice-présidente de Centraide, the vice-president of United Way; Dr. Rob Cushman, the CEO, who is extremely well regarded as the former chief medical officer of health for the city of Ottawa.

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Now, Ottawa, in particular, suffered tremendously under the Tory government. Let me just review some of the decisions made at Queen's Park that hurt our community. They closed the Riverside Hospital, which was the most efficiently run hospital in eastern Ontario. They closed the Grace Hospital, run by the Salvation Army. They tried to close the Montfort Hospital, yet a court order turned that decision back. They tried to close the CHEO cardiac unit, leaving only one such cardiac unit in the entire province. In fact, they have a great track record of closing hospitals from Queen's Park—28 hospitals under their reign of terror. That's the legacy of the Tory party, and they gutted health care, quite frankly. Who suffers when those decisions are made at Queen's Park without taking into account the local circumstances? It's the people of Ottawa, eastern Ontario. It's the patients.

Now the leader of the Tory party wants to go back to the future and cut even more health care dollars—$2.4 billion dollars he wants to cut. What does that work out to? Among other things, it would be the closing of about 11 community-based hospitals. If you look at that logically from Ottawa's point of view, they can't close the Montfort Hospital because of the court order telling the Tories they couldn't do that. They can't close the Ottawa Hospital; that's the teaching hospital in the community. They're left with the Queensway Carleton Hospital in the west end of the city, the only hospital left that they could close. I'm going to ask the leader of the Conservative Party to explain in the upcoming by-election in Nepean–Carleton why he wants to close Queensway Carleton Hospital, one of the most efficient, well-run community-based hospitals in our community.

Quite frankly, I'm proud of the McGuinty government's record when it comes to health care. I'm proud of the decisions that we have taken, that we're going to transfer that decision-making authority to the local people. We saved the CHEO cardiac unit; we doubled the Montfort; we put a 21.5% increase to Queensway Carleton Hospital; we secured funding for a community health centre in Nepean, Osgoode and Rideau; we increased funding for the Pinecrest-Queensway community health centre; and we increased funding to the Old Forge, to the CCAC, to Meals on Wheels and to other agencies.

Local health integrated networks are about local decision-making. The decision should be made in the community, by the community and for the community. That's why I am supporting this particular piece of legislation.

Ms. Jennifer F. Mossop (Stoney Creek): I have to talk a little bit about what I find so disturbing about the anti-LHINs campaign. It is disturbing because it's misleading, and it's misleading people who are susceptible because they had to endure eight years of closing hospitals and firing nurses under the Tories. Prior to that, they had to endure the reopening of their collective agreements and the so-called social contract in Rae days. All the more reason not to take advantage of them but to make sure that they are given accurate, complete information in context, the context being that we have demonstrated by our actions that we are committed to a strong, sustainable, responsible public health care system.

We have hired thousands more public servants in the health care field in the last two and a half years. We have bought back MRIs that the Tories sold to the private sector; they're back in public hands where they belong. We are funding hospice care for the first time ever in this province's history, including day programs, visiting nurses and residential hospices. We have uploaded public health costs. We have improved community health care. We are building new hospitals. We are rebuilding our most important public service, and I am so worried about the approach that has been taken in the anti-LHIN ad campaign.

I cannot for the life of me, given our record as a government compared to the previous two governments—the reasons why people on these benches ran, put their names on ballots—understand why this misleading is taking place. We have partnered in good faith with health care workers, as we have done with our teachers, as we have done with other public sector workers and with doctors. We have demonstrated a great respect for collective bargaining. We have demonstrated good faith, and goodwill and investment. There is nothing in this bill that would create any new circumstance whereby the public sector delivery of health care is going to be decimated as portrayed in these ads. I cannot believe that anyone in this province wants to return to the old days of the Tory slash and burn or the NDP social contracts.

Partner with us, just as Juanita Gledhill has partnered with us. She is the chair of my LHIN. She lost her job to competitive bidding put in place by the former government through the CCACs and the RFP process. She is a tireless advocate of public home care delivery and a strong opponent of the RFP put in by the former government. She is chair of my LHIN, appointed by this government. There's a nurse from Thorold and a hospital administrator on my LHIN. These are grassroots health care workers helping us make the best possible decisions about how to spend taxpayers' money responsibly in a health care system that will be the best possible and sustainable.

Mrs. Liz Sandals (Guelph–Wellington): I'd like us to think a little bit about the model that we have right now. The entire $33-billion system is managed from Queen's Park. Queen's Park deals literally not with hundreds, but thousands of individual hospitals and individual health agencies. I find it very strange that the two opposition parties are criticizing us for moving to a different model, because if you look at education and you go back 30 or 40 years, we had the same model in education. We had the Ministry of Education dealing directly with little school boards that had one or two schools, and the Tories said, "Let's have county school boards." Then the NDP came along and said, "You know, that's not as efficient as it might be." The NDP did a study and said, "Let's set up local boards that are one county, two counties, three counties." Do you know what happened? The NDP lost the government, the Tories came back, and

they implemented that model where both opposition parties' definition of "local" is exactly the same thing as we're proposing: a catchment area of one, two or three counties. These people are not telling you the truth about what they did. We are simply imposing an efficient model that is still a local model on our health care system.

Hon. George Smitherman (Minister of Health and Long-Term Care): Mr. Speaker, I want to say thank you very much for the privilege yet one more time. Over the last two years, I've had the privilege so many times on behalf of Ontarians to speak about their health care system in the context of the system that we wish to build alongside them. I want to say to all those viewers at home, however few or many they may be, that Fear Factor has come to an end, and we're now embarking, through this speech and in the work we'll do from here on out, where the rubber hits the road, to address the realities of building a health care system that for once puts the patients and community at the centre of that system.

I want to say hi to Christopher and let him know that I'm going to be home soon, because a new season of Amazing Race kicks off tonight. I rather think that I'm not really into so many reality shows, except I like that one an awful lot because it shows me places I'm unlikely ever to go, unless I become a Speaker or something. But it also shows the power of ambition, and speaking of—I won't go there quite yet.

I suppose some people might think it ironic, on a debate that brings a debate to a deliberate conclusion, that I'm proud to be here and doing that. We will work with the Legislature over the course of the next few days, but the discussion that has gone on in Ontario, cloaked, often in backrooms of health care provider organizations only for decades and decades, and which has evaded leadership, is no longer in search of it.

We came to office as a government in a province that stood out in a nation where every other part of the country had sought to develop a model of health care delivery centred around an understanding of what the population's health was in a distinct area. To draw a line on a map is to create the capacity within it to measure the health of the population and to hold accountable those who have the privilege of delivering medicare. I believe, and our government fundamentally believes, that medicare is the best expression of Canadian values. We believe patients should be at the centre of the system.

If we look at organizations in our province where we celebrate the results they produce—Cancer Care Ontario, the Cardiac Care Network, our stroke strategy—these are all accomplishments that evolved with regional nature at the heart of the success that is achieved for patients. That is in whose name we work and in whose name this bill is brought forward.

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Terry Sullivan is the president and CEO of Cancer Care Ontario. He said, "The local health integration network legislation introduced today demonstrates the government's commitment to improving local health care services. The cancer care community will work with the LHINs and the government to ensure quality care is available to all people as close to home as possible."

Countless hundreds of times in the almost two and a half years that I've had the privilege of this role, I have said to communities, large and many very small, that our government fundamentally believes that the best health care that can be found is that health care which is found as close to home as possible. When I hear the member from Timmins–James Bay stand in this place and evoke the name of Moosonee—when he and I stood alongside one another with a community that celebrated the repatriation of satellite dialysis services that allowed people to move back to that community, to those First Nations communities, from Timmins, Toronto and Kingston—and play the role of a fearmonger, I really worry. I worry about the service that the people of Ontario are getting from those who are so loyal to their role as opposition that they pretend their way through a debate. The opposition parties have pretended their way through this discussion, enabled particularly by some in organized labour, who have decided that the appropriate strategy was to fearmonger, was to rattle people, was to go to them and tell them that their jobs were at stake.

Today, the Premier had the privilege in this House to say many things about health care. One of those that he reported, and that we proudly report on as a Liberal government, is that under our government there are 13,000 more people working in health care than when we came to office in 2003. Our Premier said, in response to the Conservative Party leader, "I really fail to understand the leader of the official opposition's confidence in Ontario communities. What he is effectively saying throughout all of the criticism that he's levelled at our government in connection with local health integration networks is that he doesn't trust local communities to have influence for the first time in a real way when it comes to the delivery of health care in their community"—a say for local communities.

Where have the honourable members been transparent in their critiques of this bill—when they talk, as an example, of the so-called ministerial powers section? They pretend their way through this discussion. They pretend that we have not altered, in a way fundamental to the development of this system, the order and the responsibility for the determination of those ministerial power decisions. What we have in this bill is a circumstance where no minister can exercise discretion in those areas unless and until directed or requested to do so by a local health integration network.

I've heard both of these opposition parties say, "All those people you put on those boards, they're just a bunch of toadies. They're lackeys. They're just spokespeople for the government." I'm saddened by that. My colleague from Stoney Creek talked a minute ago about a woman named Juanita Gledhill, who is well known in the Hamilton area, who is serving as our board chair, and she referenced a nurse from Thorold, Ontario. I can assure

you that the nurse we appointed from Thorold, Ontario to the board of the local health integration network is no lackey of any Liberal government. She' s not a partisan on behalf of our party. In fact, any simple investigation would lead to a conclusion that she's a community activist, strenuously supportive of a public medicare system and that she's a supporter of a political party other than mine. But we determined that she was an appropriate part of the mix, because as a front-line health care worker, who brings with her passion for medicare an understanding of the front-line challenges, she can make a contribution to the debate.

Imagine the powerhouse that is begun to be created when we bring nine people who have one thing in common. There is one element of their resumé that bears recognition: It is their fundamental commitment to their communities. These people have been drawn from the same organizations that the manufactured dissent of the opposition here has told us they will now choose to close. That is the circumstance that prevails here at Queen's Park.

I want to say to honourable members that I believe it's appropriate to consider just for a minute what a government has done as a measure of what it's appropriate to offer in terms of a criticism or a critique. We are, after all, a government that came to office and introduced as our very first piece of legislation as relates to health care a bill called the Commitment to the Future of Medicare Act. We are a party that is proud to embrace the Canada Health Act, that stands in our province with two and a half years under our belt and a significant degree of progress in a lot of ways that matter a whole lot to the public health care system. We repatriated MRIs, we're building 40 new community health care centres, one of the most evolved models of primary care, and we're targeting those very directly to many of those communities in our province that experienced the greatest hardship with respect to access to health care.

We're building 150 family health teams that build on the interdisciplinary model that has been promoted by people like Roy Romanow. We delivered more midwives to Ontario, and we're building, with the hospice movement, a residential hospice capacity and a home hospice capacity that others all around the sophisticated world marvel at. We brought in a vaccination program that's going to provide a whole lot more opportunity to a lot of our most precious gifts, our kids. We worked very, very hard to build a newborn screening capacity to take Ontario from worst to first. We've worked tirelessly alongside hospitals and with nursing unions to enhance the percentage of nurses who are working full-time. We've hired more than 4,000 additional nurses in health care in the province of Ontario, according to Doris Grinspun.

Our values are reflected in our actions. We're not a government that stands by and says that a tide of private delivery is the answer. Today, we have a situation where those who make the boldest claims about how much they love medicare have their gunsights trained on the government of Ontario, the same government that's just done all of those public health care enhancements and more.

Meanwhile, here is what's going on today and in the last number of days in the rest of the country. Today in Alberta, they introduced their new health policy framework. At the heart of it, it proposes two-tier medicine. It says in part that this new direction allows for greater flexibility and choice in how health care services are funded and delivered. That happened today in Alberta. It wasn't very long ago that we heard about the government of Quebec's response, on February 16, to the Chaoulli decision. Quebeckers will now be permitted to purchase private health insurance to access care in private, for-profit clinics. In British Columbia on February 14, the government's throne speech said this: "Why are we so afraid to look at mixed health care delivery models, when other states in Europe and around the world have used them to produce better results for patients at lower costs to taxpayers?" You would think, not the quality but on the quantity of the rhetoric that has been trained upon us by those who make the boldest claims about their love for medicare, that we were in fact a government that was initiating reforms of that nature.

Mr. Tory in this very House, himself, is a proponent for these things. He believes that a Copeman-style medical clinic should be allowed to come to the province of Ontario. Mr. Tory has some reconciling to do. The reality is that he stands in his place and plays the role of opposition leader. I guess he does that well, but he has rejected all of the common sense that he had built his illustrious business career on. He has decided, like the New Democratic Party, that health care services in the province of Ontario should be delivered by high-cost providers. In Mr. Tory's case, this, just two weekend ago, was his commentary on the way health care should go in the province of Ontario. We don't agree.

I want to say that I think the real play is being missed here. What we're involved in is in a certain sense a little bit simple. We're creating a new kind of environment for health care in Ontario, one where, as an example, if there was to be a change that occurred related to the delivery of a health care service, if somebody had in mind to do that, it can't sneak up out of the blue. Someone can't wake up one morning and put it on a press release and make sure that it happens. There is now embedded in legislation an obligation placed on behalf of a local health integration network where they will have to develop an integrated health services plan. They will have a legislative obligation to consult on the development of that plan. They will have a legislative obligation to make that plan transparent by posting it in public places. They will have a legislative obligation to have a meeting, in a local community where they are deciding important decisions, in the full light of the public. I feel strenuously excited—strenuously excited—on behalf of the patients of the province of Ontario when we learn that, for once, the decisions about a health care system that, after all, is their health care system—then that, I think, is a great day.

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I think it's about time that those of us who believe in public health care be asked to put our ambitions forward. We're going to continue to work on our mission, a mission in search of what the patients of the province of Ontario want. We believe fundamentally in the public health care system, as I've said, but we also must recognize, those of us who do believe in it and have the obligation to make sure that it produces results where the rubber hits the road, that it's more than just talk and that it's backed up by action, that we deliver results.

There are a lot of people in the province of Ontario who believe as we do, fundamentally, in the public health care system, but some of them lose faith, some of them have their confidence shaken. It cannot always be only about how many more billions of dollars are required. When health care providers that are doing the same service in the same neighbourhood do not work together, then we have a problem, a failure to communicate.

We're creating a mechanism where health care services can be integrated, which means coordinated together. Everybody has decided instead to dredge up a Fear Factor kind of scenario that works for them in their desire to shake further the confidence in health care in this province and to create for workers in this province, who have, I would suspect, rather little to fear in an environment where each and every year health care spending rises by $1 billion or $2 billion—80% of all the dollars we spend in health care is paid to people who work in health care. Health care spending is rising. Accordingly, the trend line is already established, and it is for employment security in a broad sense, in terms of the broad number of people who are working there. And still, union leadership determines that they should scare union membership by going to them and telling them that if this bill passes, they will be fired. But I ask you this: What is their motivation for having people all riled up? And where have they been negligent? They have been negligent, I believe, in deliberately misunderstanding a bill.

I want to ask a question. I have had scenario after wild scenario presented by a variety of different people: If the Alzheimer Society of Toronto is getting 6% or 8% of its budget from the Ministry of Health, the minister could exercise powers to shut it down or merge it. Hooey. Firstly, you've got to ask, are the honourable members involved in such mischief-making that they would manufacture and concoct a storyline that is so far out of touch with common sense? I ask you this: If you understand the bill, if you even bothered to read the bill, if you bothered to try and understand the alteration that has occurred here, where we put people from local communities at the front of the decision-making train for once, why would they come forward with such a proposal? Well, these are the kinds of stories that have been manufactured, to the delight of those on the other side of the aisle.

I want to take a minute to read into the record, because I'm so proud of them, the names of just a few of the people who represent and reflect community who have come forward to stand and be members of local health integration networks. There is this fantastic guy whom I had the privilege of getting to know, Foster Loucks. He's the chair of the Central East LHIN. He was the CEO of Haliburton Highlands Health Services from 1995 to 2002, a fantastic organization that Laurie Scott is a proud supporter of that does tremendous work in delivering community support services and the like. Before that, he served as the administrator of Lakehead Psychiatric Hospital from 1986 to 1995, before that as executive director of the Thunder Bay district health council, as past trustee of the Ontario Hospital Association and a past member of the Thunder Bay children's aid society.

These are the kind of people who, for their own purposes, the opposition members, knowing it wasn't true, have manufactured—the private conversations are, "Oh, yeah. I know this person or that person; they're fantastic." The public presentation is, "These boards are loaded with a bunch of lackeys of the government." I am fundamentally concerned that people of good conscience in the province of Ontario who are willing to put themselves on what everybody would agree is a real tough assignment have been disparaged by a deliberate manufacturing and misrepresentation of the kind of quality they represent.

Here in the Central East LHIN, from Scarborough, Novina Wong. That name may be familiar: a Chinese Canadian who currently serves as a management consultant. Previously, she served as clerk of the city of Toronto, clerk of the municipality of Metropolitan Toronto, and in various other administrative and executive positions at the municipal level. Community service includes the board of the Scarborough Hospital, the Chinese outreach service of the Scarborough Hospital, the community advisory board of the Scarborough Mirror and the Toronto Board of Trade city governance task force. She sounds to me like a person who has a distinguished history and career in public service and in service to community—disparaged and written off by opposition members in a deliberate attempt to manufacture a storyline that's just not accurate.

I want to talk about one or two more, because I had so many opportunities to meet these fantastic folks. In the Champlain LHIN, the area that stretches from Cornwall and up the Ottawa Valley and includes the great city of Ottawa—I can't believe I said that.

Hon. Mr. Watson: Great hockey players.

Hon. Mr. Smitherman: Yes, this year—owned by Toronto money.

The chair of the local health integration network: Michel Lalonde. He retired as chief executive officer of the Hawkesbury and District General Hospital and the Winchester District Memorial Hospital. He is very active in his community and participates on numerous boards and committees. This guy brings such tremendous capacity, knowledge and passion. He loves public health care. He's got a demonstrated capacity around it, but not good enough for the honourable members opposite.

How about up in northwestern Ontario? We've got John Whitfield. He's the chair of our LHIN. He was the vice-president of research and development at Lakehead

University, the interim president, the dean of arts and science. He served on various boards, including the Thunder Bay Community Foundation, Contact North and the Northern Ontario School of Medicine.

These are examples of the people in the province of Ontario, committed and dedicated to the values of the public health care system, who put their hand up and said, "I am willing to serve. Not only am I willing to serve, but I'm willing to engage myself in a mission related to the importance of preserving and protecting for future generations our treasured health care system." This is a challenging mission. Alongside it, these people agreed that they would make their decisions in the full light of day, in a room with their peers and their neighbours and taxpayers and patients, and exercise their good conscience and understanding of community.

Part of that good conscience needs to be a clinical good conscience. It's time for a little honesty in the discussion about health care. It has been a circumstance where no Minister of Health should dare speak about the clinical circumstances which might dictate that it is in the interest of the patient to have some consolidation of services. No Minister of Health dare say that. "That is an acknowledgment of your secret plan to close this, that and the other thing." This is a message that is perpetuated by those who, once again, make the strongest claims that they are the protectors of medicare.

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In 1981, I had my wisdom teeth taken out in a hospital. There are those among the status quo set who still believe that this is the place to do that kind of thing. We have circumstances where the provision of a service is occurring in such a small quantity that the capacity, the safety, associated with it is no longer appropriate for a health care system that sets and has standards as high as ours. No one who wants to be in a province that has a cutting-edge, first-class health care system wants to set up a circumstance where every service is provided on every street corner and in every hospital.

Imagine a scenario that goes something like this. In the province of Ontario we have hip and knee surgery at almost 60 hospitals. Imagine tomorrow that there was a new piece of technology available and it cost $300,000, a not unreasonable sum for a technological development in health care today. Are we in Ontario in the best position to take advantage of such technology on a platform that is a mile wide or nine tenths of a mile wide?

It seems to me that if we want—and I know we do—if we fundamentally want to deliver on the promise and especially on the expectation of a high-quality, high-performing health care system, then for once and for all in our province we must give real life and meaning to the word "system." The reality is that our government inherited the collective government response to health care, not of one party but of all parties. This is, after all, our health care system, the people's health care system, and the health care "system" that we inherited was not performing like a system at all.

If you believe in public health care as we do, then you believe fundamentally that a health care system should deliver an equitable result to health care. It was not, and I asked hard questions about why. Why were we tolerating a circumstance where the Ontario health care system that our government took over from eight and a half years of Conservatives couldn't even tell us how many cancer surgeries it was performing in a year? Why? Why would we tolerate a circumstance where our health care system was producing a 50-week wait for an MRI in Barrie, Ontario, and a three-week wait at another hospital in the greater Toronto area? Why would we tolerate that? Why did we have a circumstance, when our government came to office, where Ottawa was the forgotten land when it came to access to MRIs? Doesn't it stand as rather ironic that our nation's capital, a place where technology has been one of the engines that made that economy roar, was left behind by successive governments that did not invest in their technological needs like MRI? I'm proud to be part of a government that has given a system response to that. Now we have a wait-time strategy. The MRI machine is running all night long in Barrie and we've announced a new machine for Orillia. But only when you draw a line on a map, only when you start to measure the population health and services being provided there, only when you get to the accountability point where you actually get the answer to the question "How long is the wait?" can you start to address this in a fashion which reflects the fundamental principle that a public health care system belongs to the public.

I want to say that we as Liberals are motivated as a political party by leaders like Laurier, by leaders like Trudeau, who established for our party a sense of ambition, an understanding that in Canada there is the potential to be able to unlock and unravel any mystery. But we believe fundamentally that there's no mystery to it at all. It suits a few people, the establishment, like the establishment opposition party over here. They like the system the way it is because they know the system the way it is. But the disrespect that that member is showing at present is nothing compared to the disrespect that his party shows for the patients of the province of Ontario and it's nothing compared to the disrespect that his party shows for the people of the province of Ontario.

Fundamentally, we believe in health care. We believe in public health care. We recognize, and I do in every speech that I give in every hospital and community-based organization, that health care is this most special service, not just like any other public service, not just about the delivery of care but about the tremendous expression of love that goes alongside that care. We are grateful, and we stand in our place and we say it and we celebrate public service. To those people in the gallery tonight, many of whom are front-line health care providers, we salute you and we celebrate the work you do. That's why we're proud to stand before you as a government and to acknowledge that we have hired more than 13,000 additional health care workers since our government came to light. We're proud of the fact that we work to put

more health care workers on the front line, to bring more nursing.

But we also recognize something else. We recognize that at the end of the day, the medicare system is not something to be treated lightly. It is not something that one can choose to get a little emotionally attached to. It's time in our province to engage all of our capacity, the head and the heart and the goodwill of local community, to make sure that we make decisions in a fashion which makes sense if we want to ensure that for future generations this great gift of Canada is available, this medicare system, this expression of our values.

I am not one of those who is prepared to stand idly by and leave that to chance. There are twin threats to our health care system. They can be found on the one hand by those who have such strenuous economic demands that they would outstrip our capacity to resource the system. But there is another demon that lurks, and it is the demon of loss of confidence. It is here where we have the obligation to recognize that there are many in our province, many patients, many residents that we all know, who grow somewhat impatient with the public health care system and who wish to see, through accountability and through a commitment to results, that this great gift of Canada can be sustained for future generations, that we can build on the work of Tommy Douglas and Roy Romanow and Monique Bégin and that we can do this in the name of public health care and entrusting billions of dollars of this resource to people from local communities on the fundamental principle that they can best establish local priorities. Thank you.

The Acting Speaker: Mr. Ramsay has moved notice of motion number 75. Is it the pleasure of the House that the motion carry?

All those in favour of the motion will please say "aye."

All those opposed will please say "nay."

In my opinion, the ayes have it.

Call in the members. This will be a 10-minute bell.

The division bells rang from 2118 to 2128.

The Acting Speaker: All those in favour of the motion will please rise one at a time and be counted by the Clerk.

Ayes

Berardinetti, Lorenzo	Matthews, Deborah	Qaadri, Shafiq
Brownell, Jim	Mauro, Bill	Ramsay, David
Crozier, Bruce	McNeely, Phil	Rinaldi, Lou
Delaney, Bob	Mitchell, Carol	Ruprecht, Tony
Di Cocco, Caroline	Mossop, Jennifer F.	Sandals, Liz
Dombrowsky, Leona	Orazietti, David	Smith, Monique
Gravelle, Michael	Parsons, Ernie	Smitherman, George
Kular, Kuldip	Patten, Richard	Watson, Jim
Lalonde, Jean-Marc	Peterson, Tim	Wilkinson, John
Levac, Dave	Phillips, Gerry	Wynne, Kathleen O.

The Acting Speaker: All those opposed to the motion will please rise one at a time and be counted by the Clerk.

Nays

Barrett, Toby	Kormos, Peter	Runciman, Robert W.
Bisson, Gilles	Martel, Shelley	Tascona, Joseph N.
Hampton, Howard	Miller, Norm	Yakabuski, John

The Deputy Clerk (Ms. Deborah Deller): The ayes are 30; the nays are 9.

The Acting Speaker: I declare the motion carried.

It being past 9:30 of the clock, this House stands adjourned until tomorrow at 1:30 p.m.

The House adjourned at 2130.

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