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# Official Report of Debates (Hansard)

**Tuesday 14 May 2013**

# Journal des débats (Hansard)

**Mardi 14 mai 2013**

**Standing Committee on Social Policy**

Oversight of pharmaceutical companies

**Comité permanent de la politique sociale**

La surveillance, le contrôle et la réglementation des entreprises pharmaceutiques

Chair: Ernie Hardeman
Clerk: William Short

Président : Ernie Hardeman
Greffier : William Short

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

# STANDING COMMITTEE ON SOCIAL POLICY

# COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Tuesday 14 May 2013

Mardi 14 mai 2013

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*The committee met at 1600 in committee room 1.*

## OVERSIGHT OF PHARMACEUTICAL COMPANIES

**The Chair (Mr. Ernie Hardeman):** I call the meeting of the Standing Committee on Social Policy to order, a study related to the oversight, monitoring and regulation of non-accredited pharmaceutical companies. We have one delegation this afternoon, but prior, before we start, and as they're sitting at the table, I just wanted to clear up a piece of business here.

Yesterday, Ms. Gélinas asked for the electronic records from the—

**The Clerk of the Committee (Mr. William Short):** It was last week.

**The Chair (Mr. Ernie Hardeman):** A couple of days ago—the electronic records from the pharmacists from Peterborough—

**The Clerk of the Committee (Mr. William Short):** The electronic worksheets.

**The Chair (Mr. Ernie Hardeman):** Yes, the electronic worksheets. They are not available from Peterborough; they go directly to the Lakeridge centre. So we need a clarification of the motion, that we ask for them from the Lakeridge centre rather than through the pharmacist to get them from Lakeridge. If you would make that motion that we get them from Lakeridge.

**Mme France Gélinas:** Given the new information that has been shared with me, I would request that the same request be made of Lakeridge, please.

**The Chair (Mr. Ernie Hardeman):** Okay. Thank you very much. That also goes with Ms. Jaczek's request. It would be in that same vein. That information would come along with that from Lakeridge.

## SOUTH WEST LOCAL HEALTH INTEGRATION NETWORK

**The Chair (Mr. Ernie Hardeman):** With that, we have the South West LHIN with us today. Thank you very much for coming out. As with all the others, obviously, we're conducting these committee hearings under oath, so we will ask the Clerk to swear you in and start the process.

**The Clerk of the Committee (Mr. William Short):** Mr. Barrett, I think you had asked to swear an oath?

**Mr. Michael Barrett:** That's right.

**The Clerk of the Committee (Mr. William Short):** The Bible is in front of you there, if you want to just grab it. Thank you.

Mr. Barrett, do you solemnly swear that the evidence you shall give to this committee touching the subject of the present inquiry shall be the truth, the whole truth and nothing but the truth, so help you God?

**Mr. Michael Barrett:** I do.

**The Clerk of the Committee (Mr. William Short):** Thank you.

Mr. Low, did you want to do the same or did you want to be affirmed?

**Mr. Jeffrey Low:** The Bible is fine.

**The Clerk of the Committee (Mr. William Short):** Okay. Mr. Low, do you solemnly swear that the evidence you shall give to this committee touching the subject of the present inquiry shall be the truth, the whole truth and nothing but the truth, so help you God?

**Mr. Jeffrey Low:** I do.

**The Clerk of the Committee (Mr. William Short):** Thank you.

**The Chair (Mr. Ernie Hardeman):** Thank you very much. Just for the committee's benefit, I would point out that the South West LHIN is the LHIN that covers my riding of Oxford county. So I do appreciate them being here and I do know the gentlemen personally. If I give them the benefit of the doubt any time during the meeting, you'll know that it's to encourage their liking me, too.

With that, as we do with all others, you have 20 minutes to make a presentation to the committee. Then, when you're finished with your presentation, we will have 20 minutes for each party to lay any questions they have about your presentation and your involvement. I think we start with the—

**Mr. Jeff Yurek:** The NDP.

**The Chair (Mr. Ernie Hardeman):** —the third party with the questions.

With that, the floor is yours, Mr. Low.

**Mr. Jeffrey Low:** Thank you very much, Mr. Chair, and good afternoon to everyone. My name is Jeff Low and I'm the board chair of the South West Local Health Integration Network.

I'm here today with Michael Barrett, our chief executive officer of the South West LHIN, and we would like to thank the members of the Standing Committee on

Social Policy for inviting us to appear before you as you undertake the study relating to the oversight, monitoring and regulation of non-accredited pharmaceutical companies.

Obviously and firstly, we would like to express our sympathy to the patients and family members who have been impacted by this unfortunate issue. We recognize—I recognize—the significant impact that it has had on these patients and family members, and we regret that they have been subjected to this additional stress and anxiety during an already stressful and anxious period in their lives as they go through chemotherapy treatment.

I myself have been the board chair of the South West LHIN for the past 15 months. When I'm not doing this role, I'm also the director of employer relations at Fanshawe College in London, Ontario. At Fanshawe College I'm responsible for all employee-related issues, including union management relations, recruitment and anything that impacts employee relations per se.

In my past, as well, I've also held a senior human resources position with Citigroup and with Canada Post Corp. across the country. It has been a career of about 40 years, and I'm sorry to say it's getting long in the tooth.

I do know the great strides that our hospitals and our health system undertake to ensure that patients receive high-quality care and how steadfast our health service providers are in working to restore the confidence that Ontarians have in their health care system.

I hope that we're going to be able to address the committee's questions today to assist the committee in fulfilling its mandate with this review.

With this introduction, I'd like to pass it over to Mike Barrett, the chief executive officer of the LHIN, to provide some additional information about our organization and the role that it has played in this situation.

**Mr. Michael Barrett:** Thank you, Jeff. As Jeff indicated, my name is Michael Barrett. I'm the CEO for the South West LHIN. I'd like to thank the standing committee for taking the time to hear from the South West LHIN about our role within the Ontario health care system.

I have spent the last 13 years in health care, previously working as the manager of planning and support with the southwestern regional office of the Ministry of Health and Long-Term Care in London, as the regional perinatal and pediatric coordinator in southwestern Ontario with the two London hospitals—London Health Sciences Centre and St. Joseph's Health Care, London—and as the business manager for women and children's services at London Health Sciences Centre. I was hired by the South West LHIN as a senior director back in 2007 and was then appointed as the CEO in 2008 by the South West LHIN board of directors.

A bit of background about the LHINs: The 14 LHINs were established in 2005 as a fundamental component of the Ontario government's plan to build a stronger health care system in Ontario. Specifically, LHINs are responsible for planning, integrating and funding the local health system and ensuring accountability of local health service providers, including public and private hospitals, community care access centres, community support service organizations, mental health and addiction agencies, community health centres and long-term-care homes. The LHINs work closely with—but are not responsible for—the funding of physicians, public health, ambulance services, laboratories and provincial drug programs.

The South West LHIN is one of the larger LHINs, especially in southern Ontario. It covers an area from Long Point in the south up to the Bruce Peninsula in the north. It is home to almost one million people. Our LHIN has a large rural component and includes the counties of Elgin, Oxford, Middlesex, Huron, Perth, Grey and Bruce, and a portion of Norfolk county. Some of the urban centres in our LHIN include London, St. Thomas, Woodstock, Stratford, Goderich, Walkerton and Owen Sound.

Our staff and board work with over 150 health service providers. When I describe health service providers, that includes hospitals, the CCACs and community providers, so that captures the name for all those. Our board makes decisions on investing over $2.1 billion in health funding each year for our region. Our LHIN includes 20 hospitals on 33 different sites.

As the CEO, I have the responsibility of leading a staff of approximately 40 full-time people, with a small number of contract staff. I provide information, advice and counsel to the South West LHIN board of directors on local health system planning, integration and funding issues. I also provide assurance to the board on the LHIN's compliance with legislative acts, standards and codes, and information about potential risks that may affect operations or viability of the LHIN.

Our annual operational budget—the budget that we have responsibility for for our staff—is $6.2 million, which means that 99.7% of our funding goes to front-line health service providers.

An important note is that the province of Ontario is one of the last provinces to move to a regionalized health care system. One of the major differences between regional health authorities in other provinces and LHINs in Ontario is the fact that LHINs have maintained local boards of directors for all of the health service providers that are funded by the LHIN. This means that the organizations that we fund all have a board of directors and staff which are responsible for the oversight and leadership of that organization.

The South West LHIN board of directors is composed of nine members, of which Jeff is chair. It meets monthly to make decisions on health system planning, integration and funding issues within our area. Our board meetings move around each month to different communities to ensure that our board has a presence across our LHIN. Our board has met everywhere from Port Rowan in the south to Tobermory in the north. As part of our board meetings, we hold community engagement sessions in those communities following the board meetings to engage the public and board members from the health service providers in that area.

All of our board meetings are open to the public. We post all agenda materials on our website in advance of

the meeting so that they can be reviewed by anyone who has an interest. We almost always have members of the public in attendance, and we will often have members of the media, unions or health interest groups in attendance as well.

Our board members are also actively involved in a number of integration initiatives with health service providers in our LHIN, engaging the board members of these organizations to help advance these sometimes challenging discussions.

The LHINs operate within an accountability framework that is comprised of the Local Health System Integration Act, commonly referred to as LHSIA, passed in March 2006; the memorandum of understanding; and the ministry-LHIN performance agreement, the MLPA.

**1610**

LHSIA states that a LHIN is required to enter into a service accountability agreement with each of its health service providers that it funds. So the South West LHIN has service accountability agreements with all of its 150 health service providers. These agreements do not define each and every service or program delivered by the health service provider. Instead, the agreement defines performance expectations related to financial sustainability and key service areas. For hospitals, these areas would include items such as emergency room wait times and joint replacement wait times.

If a hospital identifies that it is not able to meet its levels as outlined in the agreement, notification would be provided to the LHIN, and the LHIN and the hospital would then begin the process of performance improvement.

LHINs do not deliver or provide service to patients, clients or residents. Health service providers have the primary responsibility to deliver services and programs to the people they serve, and the clinical and operational decisions are the responsibility of the health service provider. In keeping with the LHIN mandate to plan, integrate and fund the local health system, LHINs work with health service providers to find ways to strengthen the overall health system to better meet the needs of patients, clients and residents.

LHINs also work to integrate organizations across the health continuum. We work to ensure that hospitals are connecting with long-term-care and community providers, and that community providers are connecting with primary care. Integration means a more efficient and effective system, and that is important when health care costs are increasing and our population is aging.

The LHIN, through our board chair, is accountable to the Ministry of Health and Long-Term Care. Each LHIN has entered into an agreement with the ministry called the ministry-LHIN performance agreement which specifies the LHIN accountabilities on key health system measures. These measures include such items as per cent alternate-level-of-care days, percentage of hospital readmissions and others of those types. LHIN and ministry leadership meet on a monthly basis, and ministry and LHIN staff meet and talk frequently on various initiatives.

The LHIN also employs physician leads. We have a physician lead who works one day a week in primary care, critical care and emergency departments. These physicians do not provide clinical advice to patients, but rather provide advice and leadership about health system improvements which could be implemented across a wider geography within their respective areas of specialty.

LHSIA also requires that LHINs and health service providers engage their partners and the public. The South West LHIN undertakes extensive community engagement and, as stated previously, incorporates community engagement sessions into our board meetings. The purpose of community engagement is to inform, educate, consult, involve and empower stakeholders in health system planning and decision-making processes to improve the health care system.

I would just like to briefly touch on our involvement with the issue around chemotherapy with a chronology of events.

On the morning of Saturday, March 30, I received a phone call from Gary Switzer, CEO of the Erie St. Clair LHIN, informing me of the situation related to chemotherapy at London Health Sciences Centre and Windsor Regional Hospital. At that time, I was informed that it may include other hospitals, possibly hospitals in Hamilton and in New Brunswick. Gary and I discussed the need for coordination amongst the hospitals.

I immediately contacted the regional vice-president, Cancer Care Ontario and the vice-president at London Health Sciences Centre, Neil Johnson, and left a message. Neil returned my call and we discussed the situation which was unfolding. Neil informed me about the circumstances at LHSC and we discussed the action which LHSC was taking to address this situation.

Neil also indicated that he understood that Cancer Care Ontario had connected with the ministry and minister's office communications people. Neil and I also discussed the need to ensure coordination amongst the affected hospitals.

The following Monday, on April 1, a teleconference was organized by Erie St. Clair LHIN CEO Gary Switzer that I attended with Gary, Debbie Hammons—who is CEO of the Central East LHIN, who appeared yesterday—along with representatives from Cancer Care Ontario, London Health Sciences Centre, Windsor Regional and Lakeridge Health. The call was facilitated by Michael Sherar, Cancer Care Ontario president and CEO. During the call, we discussed an outreach plan to communicate with patients and their families, and the hospitals outlined the steps that they had taken and would be taking to communicate with patients, their families and the community.

On this call, London Health Sciences Centre informed the group that their communications would include phone calls, couriered letters and face-to-face meetings with patients, as well as the set-up of a web page and 1-800

number to answer questions, and engagement of media to ensure people were aware and knew who to contact for more information. In the coming days, news releases and updates were sent to patients and media, and posted on the hospitals' websites.

We relied on London Health Sciences Centre to communicate with the affected patients and their families and would like to thank London Health Sciences Centre for their proactive approach. LHSC provided us with updates of their progress over the coming weeks to keep us informed. The hospitals swiftly addressed the issue, alerted provincial colleagues and collaborated in the development of coordinated communications.

So in summary, the health service providers in the South West LHIN have a long history of collaboration and partnership. This strong system of health service providers ensures that we are working together to address the needs of the residents in our region and ensuring that the appropriate steps are taken when the system faces an unfortunate situation like the one we are talking about today.

I hope we have provided the committee with a better understanding of what the South West LHIN does and our role within the health system. Jeff and I would be pleased to answer any questions the committee may have.

**The Chair (Mr. Ernie Hardeman):** Thank you very much. With that, we'll start with the questions. Ms. Gélinas.

**Mme France Gélinas:** I will start with something that has nothing to do with why you came here today and just let the good people in Tobermory know that the Chi-Cheemaun is going to be running as of Friday morning so that they can come and visit us in northern Ontario on Manitoulin Island. I just thought I would pass it on to the north end of your area.

*Interjection.*

**Mme France Gélinas:** No kidding.

**Mr. Michael Barrett:** I was in Owen Sound on Friday, and I saw the Chi-Cheemaun sitting there in the sound, so I'm happy to hear that it's moving.

**Mme France Gélinas:** Yes, it will be moving as of Friday.

All right, back to the issue at hand. You were here yesterday; you heard some of the questions. The questions will be very similar. But just to go through, what do you know about hospital procurement and hospital procurement policies?

**Mr. Michael Barrett:** We ensure that the hospitals are following the broader public sector procurement guidelines. We ask them to issue a certificate of compliance to us indicating that they have complied with those guidelines. Procurement is the responsibility of the hospitals, and they certify that they are following those guidelines in that certification back to us.

**Mme France Gélinas:** Okay. When it comes to the procurement policy, they deal mainly with value for money, making sure that the process is done in a way that is fair and that provides the best service, goods etc. at the best price. Is there any relationship between yourself and hospitals that deals with safety? I'm mainly interested in patient safety issues related to procurement.

**Mr. Michael Barrett:** Again, we rely on the hospitals to ensure that those patient safety issues are contained within the procurement processes they will be implementing. So we would rely on the hospitals to do that.

**Mme France Gélinas:** Okay. And did you know, through one way or another, that there were grey areas of oversight when it came to admixing of drugs?

**Mr. Michael Barrett:** I did not.

**Mme France Gélinas:** When did you find out?

**Mr. Michael Barrett:** It was, in small part, on that Saturday when I first received the call and probably in more detail on the Monday, when we had the teleconference with Cancer Care Ontario and the regional cancer programs.

**Mme France Gélinas:** Who told you what?

**Mr. Michael Barrett:** On the Saturday call with the regional vice-president from London Health Sciences Centre, I heard some of the circumstances surrounding the issue at London Health Sciences Centre. Then on the call on Monday with Cancer Care Ontario and the other hospitals, I heard more detail about how wide the impact of this situation was. I heard a bit about how this situation happened, but I didn't get much more detail at that time. It probably came out over the coming weeks as we started to learn more about it at the LHIN level.

**Mme France Gélinas:** Once you found out that there was a grey area of oversight, was it ever discussed?

**Mr. Michael Barrett:** What part was ever discussed?

**Mme France Gélinas:** That when it comes to oversight of drug admixture—the chemotherapy drugs that are giving us problems were being mixed off-site in an area that was neither a pharmacy nor a drug manufacturer. They were a part of Marchese Health Solutions. That was not a pharmacy and that was not a manufacturer, so it fell into what we describe as a grey area. Have you had any conversations about this grey area of oversight?

**Mr. Michael Barrett:** The majority of our conversation has been about ensuring that patients are getting the information that they need around the situation at hand. I don't believe I've had any conversation around the oversight part of the situation with the London Regional Cancer Program.

**Mme France Gélinas:** Did you have this conversation with anybody else, either in-house, with the ministry or with anybody else?

**1620**

**Mr. Michael Barrett:** We have had this conversation internally at the LHIN office, simply to recognize that we're aware that it is an oversight. But we did not have a conversation about what actions we needed to take because we believe that the responsibility for that rests elsewhere within the system, not with the local health integration network.

**Mme France Gélinas:** Do you ever see that responsibility coming to you?

**Mr. Michael Barrett:** No, because as I said in my opening comments, the responsibilities for clinical ser-

vices and programs rest with the health service providers that we fund. We have a responsibility for system management, and we rely on the staff, leadership and the boards of those local health service providers to deliver on clinical programs.

**Mme France Gélinas:** Okay. Who are the players who should have responsibility for oversight? You've made it clear that it wasn't you, and I agree. Who do you figure the oversight should rest with?

**Mr. Michael Barrett:** Pharmacy is not our responsibility, so it would be inappropriate for me to guess where the appropriate oversight lies. I would wait to see Dr. Thiessen's report. He would provide the expert advice around where that oversight should exist and be put into place.

**Mme France Gélinas:** If we were to tell you that there was other outsourcing that the hospital did, that was done with unregulated providers, would you get involved?

**Mr. Michael Barrett:** If that situation existed for a clinical issue, we would not, because again, we rely on the hospitals and other health service providers to deliver on clinical programs and services. That oversight for the clinical programs would be the responsibility of, in this case, hospitals.

**Mme France Gélinas:** So it's clear in your mind that the responsibility doesn't rest with you and shouldn't.

**Mr. Michael Barrett:** Correct.

**Mme France Gélinas:** Okay. Has your LHIN ever had any discussion internally with the ministry stakeholder partners about outsourcing of health care programs and services? Let's take outpatient physiotherapy being divested from one of your hospitals and going into the community. Have you ever had conversations about divesting of programs and services that used to be provided by one of your partners and are not anymore?

**Mr. Michael Barrett:** Yes, we would. We have the responsibility for managing the accountability agreements for all of our health service providers. If a health service provider is looking at closing a program or shifting a program out to a community, that's where our responsibility comes into play: to ensure that if there is a program that is going to be closed—what is the impact? Is it going to impact the community sector? Is it going to impact another hospital? That's where the LHIN would play a role in that system management.

**Mme France Gélinas:** Could you give me a concrete example of this, where a program was divested from one of your hospitals, and how you managed that?

**Mr. Michael Barrett:** One example that comes out clearly for me happened a couple of years ago, as we were working with hospitals and looking at ensuring that hospitals can get to a balanced position. One of the hospitals was looking at actually closing their obstetrics department—one of our small hospitals. Our board carefully considered that to determine, is it appropriate, for one, because maybe the program would be better delivered elsewhere; but if the program is going to be delivered elsewhere, the resources also have to move with it. If they're no longer going to be providing that service and it would be appropriate, then the resources would have to go to another organization that would be doing those deliveries.

In the end, the hospital never went through with that. It was a discussion with us and, through our conversations, the program is still operating soundly at that hospital. That's one example of the types of conversations that we have about program changes within the system.

**Mme France Gélinas:** Could you give me an example of a program change where the hospital ended up not providing that service anymore?

**Mr. Michael Barrett:** I think when the LHINs first took over responsibility for managing the accountability agreements and ensuring we were getting to a balanced position, several hospitals looked at closing what we call complex continuing care beds. Complex continuing care beds are a type of bed within the hospital; in that case, they were closing the beds to ensure they could get to a balanced position. They felt they could close them, based on the fact that the occupancy was down and they were no longer needed. So in those circumstances, the beds ultimately did close and left that hospital, which received the support of our board because, from a health system perspective, the beds were no longer required. It was appropriate that we'd have a reduction of that nature.

**Mme France Gélinas:** Okay. When it comes to handling those discussions where there will be a change in the programs and services, could you talk to me about your community engagement? I'm interested in seeing what happens when the community has a different opinion as to what program and service change is being proposed.

**Mr. Michael Barrett:** Any changes within the health care system often generate interest from local communities. We have had examples where there have been community groups, or members of the community within a particular community, that have raised concerns. In those circumstances, they've been able to attend our board meetings and to hear the deliberations of our board.

In some circumstances, our board has actually gone to the second extent of meeting with that group to talk about the issue at hand. If they were concerned about a particular change to a hospital or a program, our board has, on several occasions, met with those members of the community to hear their concerns. What we found is that the community wants to be heard. If the decisions are being made in Toronto or being made by a board that's not listening, that's when they get concerned. In these circumstances, the community groups had the opportunity to sit face to face with our board members to make some of those decisions.

**Mme France Gélinas:** You touch, in your presentation, on the issue of trust. I think it was you, Mr. Chair, who congratulated the front-line care workers for rebuilding that trust. Is this something that your LHINs are involved with? Is your LHIN involved in trying to rebuild the trust that was shaken up?

**Mr. Michael Barrett:** Do you want me to answer?

**Mme France Gélinas:** Either one.

**Mr. Michael Barrett:** Yes, because we need to ensure that people have trust in every part of the health care system, whether it's in hospitals, primary care or community care. Situations like this, unfortunately, start to erode that trust.

What we need to do is communicate all the benefits that the health care system provides to them on a day-to-day basis, and some of the positives that all of their health service providers have done over the last number of years; focus on the positive to ensure that we reinforce the good things that happen within the Ontario health care system.

**Mme France Gélinas:** For people who were not directly affected—that is, they wouldn't have gotten a phone call but their trust was shaken nevertheless because they heard about it or they knew someone, but they don't get the one-on-one reassurance that was afforded to the people directly—how are you handling that part?

**Mr. Michael Barrett:** I'm very familiar with that because that has been a question that's been posed of me in my position—people who weren't directly affected by the issue at hand but had a relative who may have been. The hospitals have done a good job of communicating what they've done to address this issue, to explain how it happened, and ensure that steps are being taken to address it.

I think committees like this today ensure that the issue is being taken seriously within the province and that there will be actions to address it, so hopefully it doesn't happen again.

**Mme France Gélinas:** Do you feel that the number of complaints to your agency has increased because of it?

**Mr. Michael Barrett:** I can't say that it has.

**Mme France Gélinas:** No? Have any of the complaints come to you, to the LHINs?

**Mr. Michael Barrett:** No. I'm not aware of any calls coming to us from the public. The majority of the concerns directed to the hospital are being addressed by the hospital through the—they've held, at least in London, a number of public sessions to try and address the concerns that have been raised.

**1630**

**Mme France Gélinas:** For people who have had their trust shaken up toward the hospital, have lost trust with the London Health Sciences Centre and would like an independent voice to investigate, they are asking for Ombudsman oversight. They want an independent third party to give them answers, rather than somebody in whom they don't have a whole lot of trust right now, although I agree with you that they are trying to rebuild. What are your views on that?

**Mr. Michael Barrett:** In the South West LHIN, and I can probably speak on behalf of my 13 colleague LHINs as well, a principle for us is transparency. The more people who know about how decisions were made, how we got to that decision point—transparency ensures that people understand it. They may not agree with the final outcome, but at least they understand how we got there. I would have no concerns about increasing the level of transparency about any component of the work that we do.

LHINs take an extended effort; we make sure that we are as transparent as possible with all of our decisions in our board meetings, as I said in my opening statement. I don't think that transparency is a bad thing within the health care system, so that people understand how the decisions are being made.

**Mme France Gélinas:** Do you think that there will be a role for LHINs to play in preventing that type of situation from happening in the future? Do you see a role for your agency?

**Mr. Michael Barrett:** No. I'd reflect on what I said earlier, that the responsibility for clinical programs and services rests solely with the health services providers. We're not in that business. We have the responsibility for health system management, and if we were to take on those responsibilities, we'd need to be structured in a very different way. We don't even have access to personal health information—legislation prevents us from having that—so we're not the right organization to be having that responsibility.

**Mme France Gélinas:** Of the 150 health service providers in your LHIN, are all of them accredited in one way or another?

**Mr. Michael Barrett:** No. All of our hospitals are. A large majority of our community agencies are, but we also fund on a broad spectrum, from the biggest organizations, like London Health Sciences Centre, down to small organizations that include Meals on Wheels, VON and organizations like that. The smaller organizations typically aren't accredited and haven't gone through that process to complete that.

**Mme France Gélinas:** Is this something that you feel would add value to the system?

**Mr. Michael Barrett:** I think that accreditation is a good thing, to ensure that organizations are looking at themselves and their own processes to ensure compliance with appropriate legislation, best practices and standards. The difficulty is that with small organizations, they have very small budgets, and to take time and resources out of their budget means that those resources are coming out of front-line care. I think there is a balance there in terms of the size of an organization that can actually take on accreditation and get it done.

**Mme France Gélinas:** I realize you're not an accreditation expert or anything; where would you draw the bar? In the 150 agencies that you have accountability agreements with, where do you draw the bar as to how small or how big the ones are that are not accredited?

**Mr. Michael Barrett:** We don't require accreditation through our service accountability agreements. With all the agreements that we have with the 150 health service providers, that is not a requirement. Accreditation is something that those organizations take on themselves to ensure that they're adhering to the proper standards within their own field. I'm not in the best position to say what organizations should or should not. I was explaining earlier about why some do and some don't.

**Mme France Gélinas:** This is rather surprising to me, because when the ministry used to have transfer payment agency agreements, they used to require accreditation, but you don't.

**Mr. Michael Barrett:** That's correct.

**Mme France Gélinas:** Okay. I'll let it go around.

**The Chair (Mr. Ernie Hardeman):** Thank you. Ms. Jaczek?

**Ms. Helena Jaczek:** Thank you, Mr. Barrett and Mr. Low, for coming. As you know, you are the third LHIN that we've heard from, and your presentation obviously contains many similarities to what we heard yesterday from your colleagues in Erie St. Clair and Central East. However, we always learn something, and there's a little bit of additional information here which perhaps I'll pursue.

But in relation to this incident, in terms of the relationship between you, your fellow LHINs, Cancer Care Ontario—I'm thinking of this phone call that actually occurred when you first heard from Mr. Switzer. How would you describe the interaction between all the players? Could you sort of characterize what the discussion was like?

**Mr. Michael Barrett:** I think we all recognized the importance and significance of this issue, because the call did not wait until Monday after the weekend was over. We called each other on Saturday. We realized that all the hospitals were dealing with this, and we wanted to ensure that they were working together in a collaborative fashion.

Gary Switzer described this yesterday in his questioning, to state that our role was to allow the hospitals to focus on patients, to ensure that they were getting that information out to the patients who required the information. Our role was to help ensure that there was coordination across the province. So working with Cancer Care Ontario, we were able to do that on the teleconference on that Monday, where we brought all the organizations together to ensure that we had a provincial response to this issue. As we found out on that same day, it was larger than Ontario, as well with a hospital in New Brunswick affected. But our role was to ensure that there was coordination and collaboration amongst the hospitals and the three LHINs that were affected.

**Ms. Helena Jaczek:** Since then, have you been part of the working group that the ministry has instituted?

**Mr. Michael Barrett:** We have not.

**Ms. Helena Jaczek:** You have not. But you feel some of your fellow LHIN colleagues have, I presume—

**Mr. Michael Barrett:** No, we have not.

**Ms. Helena Jaczek:** So you have not.

**Mr. Michael Barrett:** And it comes back to our role to ensure that we're relying on the hospitals to focus on the clinical programs and services, and we stay at the health system management level. So we have not—no LHIN has been involved in the working group that was established between the ministry and hospitals.

**Ms. Helena Jaczek:** Okay. Now, you, Mr. Barrett, did work originally, or previously, as a manager of planning and support with the southwestern regional office. Obviously, we all know there were regional offices for many, many years, probably decades. Our government did institute the LHIN structure. Would you be able to sort of give us, from your perspective, some of the pros, maybe some cons, of the new structure, as you have a perfect opportunity to compare the two?

**Mr. Michael Barrett:** Sure. There were seven regional offices that were structured by the Ministry of Health and Long-Term Care. They had a responsibility for working with the health service providers in the geography that I'm in now. We worked in partnership with the district health councils as well. So district health councils had the responsibility for planning; the regional offices had the responsibility for the operational components of the health care system around flow of funding and things like that.

The major difference between those two organizations—because right now LHINs do planning, funding and integration, so we do everything that those previous offices did. In our geography, there was actually 90 staff within the two DHCs that existed within our area, plus the regional office. You saw, in my opening statement, that we have 40. So there is a significant reduction in the number of staff that are actually doing the same job, and even more with what we do now by actually having the decisions made.

The regional offices had no decision-making power. Now decisions for local health system funding, planning and accountability come to our board. Our board is there in those local communities, whether it's Walkerton, Chesley or Owen Sound, making those decisions in front of the public and the media. Whereas before, decisions typically were made in Toronto, now those decisions are being made locally.

**1640**

**Ms. Helena Jaczek:** So you would say that local is good in terms of the decision-making, and you've been able to achieve some cost savings in terms of administrative costs because you've integrated the DHC with the regional office.

Furthermore, you have those two functions—the planning and the funding—closely linked, so presumably there's some efficiency in terms of approval of the agreements that you have with hospitals and so on, because it's all in one place. Is that fair to say?

**Mr. Michael Barrett:** That's correct. With district health councils, they did great planning, but they actually couldn't move that planning forward into implementation. They relied on the health service providers that they were involved with—hospitals, community care access centres and community providers—to make those decisions, but they had no power to actually move those planning recommendations forward into change, whereas now we can do the planning, together with our health service provider partners, and our board can make the decisions around changes in the flow of funding and changes in health system services to ensure that those planning recommendations that were sound with the DHCs, those

same recommendations that come to us or that we do now, can be implemented by our board.

**Ms. Helena Jaczek:** In terms of the administrative costs of your budget, how much for these 40 staff and any other accompanying administrative costs? What type of percentage are we looking at?

**Mr. Michael Barrett:** Our annual operational budget is $6.2 million for 40 staff, plus a number of contract staff, and we do receive a number of one-time allocations as well for different items around the physician leads, which I mentioned—the three physicians that we hire. Those come on a one-time funding basis. But our operational budget is $6.2 million, so that means 99.7% of our money that we receive goes to front-line health service providers.

**Ms. Helena Jaczek:** To front-line health care, so a very minor cost for the staffing etc.

In terms of your board meetings—this was a little piece that was a little different from what we heard yesterday, and thank you for including that piece—you do have members of the public attend. Are they able, in any way, at any time, to make some sort of deputation or provide feedback that the board might consider?

**Mr. Jeffrey Low:** We do have many people who attend our board meetings—unions, the general public and the press as well. We don't entertain delegations per se, but as a general rule, if there's someone there who has something they want to say we make room for them to be able to express their opinion.

**Ms. Helena Jaczek:** You allow them to do that?

**Mr. Jeffrey Low:** Oh, absolutely.

**Ms. Helena Jaczek:** Okay, that's very good. In terms of complaints—my colleague from Nickel Belt was talking a little bit about this—does the LHIN receive complaints? As an example, if a patient or family member might have tried to complain to a hospital or one of the agencies for which you are responsible and if they were not satisfied, do they call or can they call? How would you handle it?

**Mr. Michael Barrett:** We have a process within our office that lays out how patient complaints—or consumer complaints, as we call them—would come into our office. We have one person within our office who has that responsibility to address them.

The complaints can come from a number of different areas. They can come from a physician telling their patient to call the LHIN. They can come from MPP offices. We get calls where "I'm not exactly sure how to address a particular question that comes in," so they call the LHIN.

Typically the questions that we get aren't our responsibility, so if they're clinical programs and services, that type of issue, we'd work with whether it's a hospital or the CCAC, because they have patient relations staff that would help deal with that. So we make that connection for that patient calling in.

Sometimes the questions that come in are around OHIP—issues with their OHIP card, how they're dealing with OHIP. We don't have responsibility for OHIP, but we ensure that they're connected with the right people within the OHIP office. We create that link between us and the other part of the health care system to make sure that they're directed to the right location. Our philosophy is that they will get an answer or assistance in getting to the right person to talk to about their concern.

**Ms. Helena Jaczek:** And do you find that that usually resolves the issue, or do you have people phoning back saying, "I'm still not satisfied"?

**Mr. Michael Barrett:** On the odd occasion, we may get patients, clients or residents who have concerns about the delivery of services. We've done our connection with the health service provider. We feel that everything that could be done has been done to get addressed, and we explain that to the patient, client or resident when they call.

Typically, we will take those complaints and, as I said earlier, get them to the right person to get them addressed.

**Ms. Helena Jaczek:** In terms of your accountability agreements with the individual health care provider agencies, if you find that perhaps the provider is not responding to your suggestion, say, around wait times, or there is something that you're concerned about: Could you just go through the process of how you handle that?

**Mr. Michael Barrett:** I think it's a very good indication of how the LHIN system works. When the LHINs first started, we had a number of hospitals with financial challenges. We worked with the hospitals to try to get them to get to a point where they could get to a balanced position. In some cases, we actually appointed a peer reviewer to look at that hospital to determine ways that they could get to that balanced position.

The benefit of the LHIN system is that in some circumstances, the administrations of the two organizations come to a stalemate in terms of how to advance the conversation. This is where board governance and having a board of directors at the health service provider level and at the LHIN level has played a really strong role in advancing some of these conversations that had difficulties to advance. In some circumstances, we've brought in a three-member group of our board to meet with a three-member group of the health service provider board, whether it's a hospital or a community provider. That elevates the conversation above the administrative-type talk that happens with staff. In all those circumstances, having the board governors involved has allowed us to elevate the conversation enough to help to get it over that, as I said, stalemate to advance the conversation. We've had a number of circumstances where we've seen great success in doing that.

**Ms. Helena Jaczek:** When would you need to contact the Ministry of Health and Long-Term Care if a situation was not resolved? You presumably may have to do something like that.

**Mr. Michael Barrett:** Typically, we try to resolve the issues at the LHIN level because the accountability agreement is between the LHIN and the health service

provider. It's not between the ministry and the health service provider.

When the ministry becomes involved, it would be in a situation where the ministry does have some responsibility for an issue. The ministry still continues to fund different components of the health care system, so a provider may receive funding from us as well as from the ministry. Not in many circumstances, but it would be in those circumstances where we'd involve the ministry in the conversation to help address it. But we try to resolve it at the LHIN level.

**Ms. Helena Jaczek:** And as a general rule, you are successful.

**Mr. Michael Barrett:** We're not perfect, but I think we've had a good track record of success.

*Interjection.*

**Ms. Helena Jaczek:** Mr. Low, would you like to fill us in?

**Mr. Jeffrey Low:** I would definitely say, as a general rule—and Mike has made an excellent point: The advantage of having individual boards with all the health service providers is it provides an extra layer of opportunity to have conversation in a meaningful way on how to resolve issues—take it out of the administration, take it out of the operations into the whole governance perspective. We have board-to-board engagement sessions where we bring together board chairs and members of boards from across the South West as well where we have these types of discussions on a high level, if you will, but in the overall sense of how health care is being provided throughout the South West. It does provide us with a second look, if you will, and I'm a firm believer that the opportunity that has been made here in Ontario to keep boards at the actual health service provider level has been integral to our success.

**Ms. Helena Jaczek:** That's very interesting, especially in light of Mr. Barrett's comment that other provinces, in fact, did not maintain a board of directors within their regionalization as it occurred. So you both would be firm believers in maintaining that board of directors.

**Mr. Jeffrey Low:** Yes.

**Mr. Michael Barrett:** Yes.

**Ms. Helena Jaczek:** Because actually, this committee is supposed, at some point, to do a review of the LHINs, as you probably know. Hopefully we're going to get some additional information through this most unfortunate process, but it's very helpful to have your input.

I think we'll reserve our time, Mr. Chair, for whatever may happen.

**1650**

**The Chair (Mr. Ernie Hardeman):** Okay. Thank you. We'll then go to the official opposition. Ms. McKenna.

**Mrs. Jane McKenna:** Thank you so much for being here. You were very attentive yesterday, sitting and listening through the whole process. My first question is just for clarification for myself. When we had the hospitals here they came out to say that they were the ones that set up the communications for the direct lines to the oncologists and actually called all of the patients that were affected by this chemotherapy drug. I'm curious as to what your roles actually were.

**Mr. Michael Barrett:** Our role is very limited in this conversation. What I said earlier is we wanted to ensure that the hospitals were coordinated in their response because the Erie St. Clair LHIN was hearing what Windsor Regional was doing; we were hearing what London Health Sciences Centre was doing, and we wanted to make sure that we had collaboration and coordination across all hospital sites across the province so that there was one approach to move the response forward. That's why we asked the hospitals to come together on that Monday to have the teleconference to talk about how we can ensure that there is coordination.

**Mrs. Jane McKenna:** Okay. I was just confused because when they were here they seemed to say that everything was fine with what they were doing and they didn't need anybody else coming in to interject that. I just wanted to know that myself—that other layer that was there.

I have another question here. On what you said today—sorry, there wasn't a page number on it. You say here, about your performance contracts that you have, that if one of them is not met—I just wonder what is the ramification for the hospitals not meeting the performance contracts that they have in front of them?

**Mr. Michael Barrett:** So in the service accountability agreements that we have, if they're not meeting the indicators or requirements that are outlined in that agreement, we institute what's called a performance improvement process. That performance improvement process is intended to address the deficiency that they may have. It may be financial, it may be something else in terms of wait times, which I mentioned. The performance improvement process around financing: I mentioned earlier that we've had hospitals that have had difficulties getting to a balanced position—this was early on in the LHIN mandate. In three circumstances we appointed a peer reviewer. The peer reviewer went in, compared the cost of that hospital to other comparable hospitals across the province. Ultimately, at the end of that process, we got those three hospitals to a balanced position.

Another circumstance around wait times would be cancer surgery wait times. Our cancer surgery wait times in the South West LHIN have been the worst in the province for the last six years. We've taken significant action to get that number down. We've now dropped it from just under 100 days down to 59 days. We've made significant progress, but it's ensuring that each hospital is addressing that cancer surgery wait time within their own organization—making sure they have the right data, making sure they have the right processes in place to get the cancer surgery wait time down.

In both those circumstances, if there was one area that they were deficient on, we would meet with the hospital to target that area to try to get them to the area that would meet the requirements of the agreement.

**Mrs. Jane McKenna:** What specifically would you do to have such a drastic drop, to get them to those wait times? I'm just curious of what that would be.

**Mr. Michael Barrett:** With the cancer surgery wait times, we implemented a project called the cancer surgery improvement project across the South West LHIN, co-chaired by two of our hospital CEOs, together with a cancer surgeon within our geography. They looked at clinical pathways to ensure that we were addressing the time that it took for the patient to get from the referral to actually getting the surgery completed, and what were the delays in that process.

Pulling that apart, they were able to identify efficiencies within that pathway to reduce the time it would take from the specialist's consultation to the time the surgery took place. That was done in a number of different aspects—in this case, it was urology surgery. That allowed us to get to a lower wait time.

The other piece was around data analysis: If we had people waiting on the wait-list for cancer surgery, how long have they been waiting for? Is it their own choice that they're not going through with the surgery? They may be going to Florida or someplace south, not wanting the surgery right away. So doing a deeper dive on the data to figure out whether the wait times that are showing up on our data analysis are actually clear and concise around what's happening with the patients themselves. There are a number of different components that we took to try to address that.

**Mrs. Jane McKenna:** When you've set up those parameters for what you're achieving, does the Minister of Health and Long-Term Care look over that to make sure that all the checks and balances are in order, or is that from your level? Where does that level come from?

**Mr. Michael Barrett:** The only connection we'd have with the Ministry of Health and Long-Term Care would be—we have a performance agreement with the ministry. The ministry says, "We want the South West LHIN wait time for cancer surgery to be a certain number of days." That's what we call our target. Our target is typically below what our current performance is. Then it's our responsibility to figure out all the different steps that we need to take locally to try to address, to get the number down to the target that was agreed to with the ministry. The ministry sets the target, and then we look to adhere to that through the local processes that I described.

**Mrs. Jane McKenna:** Okay, thank you very much. That's it for me.

**The Chair (Mr. Ernie Hardeman):** Mr. Yurek?

**Mr. Jeff Yurek:** Thanks, guys, for coming up. I have a couple of questions for you. I've been asking everyone—the College of Pharmacists seems to be okay with the suggestion, and the hospital association kind of wasn't in agreement with it yesterday: What are your thoughts on the College of Pharmacists overseeing hospital pharmacies?

**Mr. Michael Barrett:** As I said earlier, that issue is well outside the scope of our responsibility, and I'd be hesitant to give any input or advice around what the appropriate tack would be with their involvement.

**Mr. Jeff Yurek:** With regard to procuring compounded or admixed mixtures, has the Ministry of Health ever discussed with you setting up a procurement guideline for that process outside of the BPS?

**Mr. Michael Barrett:** No.

**Mr. Jeff Yurek:** No? I know that that area has been grey for a number of years, and we've heard testimony that the Ministry of Health has known about this for quite some time now. Wouldn't you think they would have given you guys a call to maybe review the procurement process that hospitals are undertaking, perhaps, in this area, and since it is a grey area and they don't know who's regulating who or overseeing what, that maybe they would have taken the lead and let the LHINs take the lead in the area and direct the hospitals to review their processes?

**Mr. Michael Barrett:** No, because the ministry wouldn't look to us to provide advice to hospitals around clinical services and programs. They rely on the hospitals to undertake that. We do not have the expertise or the skills within the South West LHIN to address those types of issues—

**Mr. Jeff Yurek:** But this isn't really a clinical skill or process. It's a procurement, like the BPS, which I think falls short on—especially when they know there's a grey area present, do you not think that maybe that would have been a direction to maybe lead the LHINs on?

**Mr. Michael Barrett:** I don't disagree with the fact that it needs to be addressed, but we're not the organization to address that.

**Mr. Jeff Yurek:** Okay. That's it.

**The Chair (Mr. Ernie Hardeman):** Okay?

**Mr. Jeff Yurek:** Okay. Thanks.

**The Chair (Mr. Ernie Hardeman):** Ms. Gélinas?

**Mme France Gélinas:** I have 60 seconds left so I'll use them wisely. The RNAO put out this idea that the contracts that the CCAC has with home care providers look very similar to the contracts you have with some of the smaller providers you talked about, such as Meals on Wheels. Has the LHIN ever looked at being the one who has contracts with the home care providers rather than the CCAC?

**Mr. Michael Barrett:** No, and as my colleague indicated yesterday, we don't have responsibilities for front-line service, whereas the providers that we fund, including the CCAC, do. That's why we rely on them, whether it's the CCAC or hospitals, to undertake that process, and it's not something that we would get involved with.

**Mme France Gélinas:** But a contract with Bayshore is no different than a contract with Meals on Wheels.

**The Chair (Mr. Ernie Hardeman):** Go ahead and answer that question.

**Mme France Gélinas:** A contract with Bayshore is no different than a contract with Meals on Wheels. What's the difference?

**Mr. Michael Barrett:** Well, the CCAC has the responsibility for providing that front-line service, whereas

LHINs ensure that the providers that we fund are providing the—we rely on the hospitals, the CCAC and other providers that we fund to deliver front-line service. It's not our organization.

**Mme France Gélinas:** So you see a difference—

**The Chair (Mr. Ernie Hardeman):** Thank you very much. Ms. Jaczek?

**1700**

**Ms. Helena Jaczek:** Since we have you here, I'd like to ask you a little bit more about your LHIN and the role that you play in Ontario's health care system.

First of all, you have a very large number of providers—I think it was 150 or so. Is that a reasonable size for you in terms of the geography of your LHIN, in terms of sort of the span of control, your ability to manage those accountability agreements?

**Mr. Michael Barrett:** It is a large number of providers, but you have to look at how the providers interact with each other. We have a large academic health sciences centre, a teaching hospital in London, and referrals come from the geography that we have responsibilities for, from Owen Sound to the north, and up from St. Thomas and Tillsonburg from the south.

It is a large number—very challenging, with the number of staff that we have—but I think it's certainly a size that's manageable with our responsibility, because we're not providing that front-line care; we're providing health system management, ensuring that those 20 hospitals and the 150 organizations are working together in a comprehensive network of care.

*Interjections.*

**Ms. Helena Jaczek:** Mr. Chair, I'm finding the side conversations really distracting.

**Mrs. Jane McKenna:** Sorry.

**Ms. Helena Jaczek:** I'm sorry, Mr. Barrett. If you could continue.

**The Chair (Mr. Ernie Hardeman):** If we could keep the sound down at the far end—if we could keep the tone down so we can have the discussion here that's going on the record.

**Ms. Helena Jaczek:** Thank you.

**Mr. Michael Barrett:** I pretty much concluded. It's a large geography. From end to end, it takes us about six hours to drive from north to south. The 150 health service providers is large. But as I said, that group, plus—my colleague from Erie St. Clair mentioned this yesterday. The Erie St. Clair LHIN and the South West LHIN function as a very close network because of the referrals into London. There are a lot of referrals that come in from Chatham and Sarnia, which are outside of our LHIN. But I think we ensure that the providers that we have responsibility for are working together in networks.

The one other piece that I'll add is, within our geography, because it's rather long from north to south, we do a lot of work in Grey-Bruce, the collection of providers there, within Huron-Perth—there's a collection there—and then within the Thames Valley area, which was Oxford-Elgin and London-Middlesex, to ensure that those providers are working together in a more comprehensive network across their geographies.

Where it works for a smaller geography, we will pull them together. In a larger geography, we also do a lot of initiatives across the full breadth of the LHIN.

**Ms. Helena Jaczek:** So you've been able to manage the challenges, and you feel you're functioning in an appropriate way that provides for quality care across your LHIN?

**Mr. Michael Barrett:** Yes. You can slice the province a number of different ways in terms of the delivery of health care services and health system management. There are proposals out to have smaller groups of health service providers coming together, which I think again is very helpful within a small community, to have all providers across the sector working together.

Again, I think what we're doing is working. It's not to say that it's perfect, and I'm happy to talk about that in the next—when we talk about the legislation that will be coming before this committee.

**Ms. Helena Jaczek:** And in terms of the responsibilities of the LHIN, as currently constituted: Would you say that you feel they're appropriate? Is there any other function that you would be interested in taking on, or something that you would prefer to divest yourselves of? Could you just flesh that out for me, please?

**Mr. Michael Barrett:** For me, it's very clear that primary care needs to be brought into the fold. Primary care is the foundation of the entire health care system, and right now it's not as well-connected as it could be with our hospital community mental health and addictions partners. We've taken strides to bring them into the mix. With the appointment of a primary care lead, we now have a primary care network. But we need to ensure that primary care is better connected with the rest of the system. I think they'd admit that as well, and we've been trying to do that.

**The Chair (Mr. Ernie Hardeman):** Thank you very much. That concludes your time. Any further questions from the official opposition?

**Mr. Jeff Yurek:** We're good.

**The Chair (Mr. Ernie Hardeman):** No further questions? Then we thank you very much for making your presentation this afternoon and for answering our questions.

As I was sitting here listening, it was very interesting, but I notice that there was not much in the questioning that had to do with the challenges we're facing with the chemotherapy. I guess that's because maybe their connection to the LHIN is not quite as acute as it is to some of the other people we've been meeting with. But we thank you very much for being here to answer the questions that were put to you.

**Mr. Michael Barrett:** Thank you.

**The Chair (Mr. Ernie Hardeman):** Thank you. With that—yes?

**Mr. Jeff Yurek:** Chair, just further to the stability data received today, it raises a new issue. Would we be able to request from Baxter and Marchese their stability

data on gemcitabine and cyclophosphamide? Is that possible?

*Interjection.*

**The Chair (Mr. Ernie Hardeman):** The Clerk says yes. Do you want to make a formal request for that?

**Mr. Jeff Yurek:** I would like a formal request for the stability data that they use.

**Ms. Helena Jaczek:** In relation to refrigeration?

**Mr. Jeff Yurek:** If you read that data, it kind of goes, "Uh-oh, what's going on here?" They'll probably have their own data that they have, but let's just get it on the table.

**The Chair (Mr. Ernie Hardeman):** Okay. Yes, Ms. Gélinas?

**Mme France Gélinas:** I don't think that this is the right time, but I'd like to go through the list of other witnesses that have been called and if any scheduling has been done.

**The Chair (Mr. Ernie Hardeman):** We have two more scheduled presently. We can give those names now, if the Clerk would just tell the committee.

**The Clerk of the Committee (Mr. William Short):** For the Monday following constit week, which is May 27, Jake Thiessen, I believe, is scheduled for that day. We were waiting for confirmation from another group, which we have not received yet, along with the new name of the pharmacy assistant that we just received from Lakeridge DRCC, I believe.

On the Tuesday, it's the Ontario chemical producers, I believe it was—the group that had actually emailed in asking to present before the group. I'm not sure if I have the right name of the association, but it was the chemical producers' association, something along those lines, that are scheduled for the Tuesday. That's where we stand right now.

**The Chair (Mr. Ernie Hardeman):** Have you got any further names that have yet to be scheduled that have been asked by the committee to appear?

**The Clerk of the Committee (Mr. William Short):** The one other pharmacy assistant from Peterborough health, which we haven't scheduled yet, which we're waiting for the Monday, depending on—I think the preference was for the Lakeridge one before the other Peterborough one. If I stand corrected, the subcommittee can meet and change that preference, but that was the information I had so far.

**Mme France Gélinas:** When is our next subcommittee meeting?

**The Clerk of the Committee (Mr. William Short):** Whenever you guys want to call one.

**Mme France Gélinas:** Given the list of names that we have received, I would ask that we sit down and look at them together and see who we want to call next. I think that could be useful.

**The Clerk of the Committee (Mr. William Short):** Yes, that's fine. I'll arrange one through the Chair.

**Mme France Gélinas:** When Medbuy went out on their RFP, they told us that three companies responded to their RFP. We got a graph as to how the three companies scored on their scoresheet, but we never really received the actual proposals that I'm guessing the companies had sent in. I'm sure they didn't send it in already in a graph by their criteria. There has to be a document that led to what we got. It seems like we're missing a part, or maybe I'm missing a part; that happens too.

**The Clerk of the Committee (Mr. William Short):** I believe that Medbuy is planning on tabling something with us as early as tomorrow which may include what you're talking about right now.

**Mme France Gélinas:** Very good.

**The Chair (Mr. Ernie Hardeman):** Okay? Ms. McKenna?

**Mrs. Jane McKenna:** Can we find out who owns Medbuy, what corporation owns it?

**The Clerk of the Committee (Mr. William Short):** Yes.

**The Chair (Mr. Ernie Hardeman):** Yes, that can be done. I think that's very important. I think it might be helpful for the committee, not only who owns Medbuy but what the Medbuy entity actually is. I think we heard some testimony in the committee that the directors were representatives of hospitals, but we also heard in testimony that the contract does include money coming back to the hospital over the purchase. I think it would be interesting to know if some of the money that goes to Medbuy is also part of the activity as to a refund to the hospital in the process of buying through that avenue. I think it would be helpful to the committee if we got the particulars of the structure of Medbuy.

**Mme France Gélinas:** Their website has some of that information, as to who are the member hospitals and that kind of stuff, but there's no harm in asking them to provide it to the committee.

**The Chair (Mr. Ernie Hardeman):** Okay. Anything else? If not, we stand adjourned until Monday, May 27.

*The committee adjourned at 1710.*

## CONTENTS

Tuesday 14 May 2013

Oversight of pharmaceutical companies.................................................................... SP-171
South West Local Health Integration Network ................................................................ SP-171
Mr. Michael Barrett
Mr. Jeffrey Low

### STANDING COMMITTEE ON SOCIAL POLICY

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