ISSN 1710-9477

Legislative Assembly of Ontario

Second Session, 40th Parliament

Assemblée législative de l'Ontario

Deuxième session, 40e législature

Official Report of Debates (Hansard)

Monday 31 March 2014

Journal des débats (Hansard)

Lundi 31 mars 2014

Standing Committee on Social Policy

Local Health System Integration Act review

Comité permanent de la politique sociale

Étude de la Loi sur l'intégration du système de santé local

Chair: Ernie Hardeman
Clerk: Valerie Quioc Lim

Président : Ernie Hardeman
Greffière : Valerie Quioc Lim

Hansard on the Internet

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. The address is:

Le Journal des débats sur Internet

L'adresse pour faire paraître sur votre ordinateur personnel le Journal et d'autres documents de l'Assemblée législative en quelques heures seulement après la séance est :

http://www.ontla.on.ca/

Index inquiries

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-3708.

Renseignements sur l'index

Adressez vos questions portant sur des numéros précédents du Journal des débats au personnel de l'index, qui vous fourniront des références aux pages dans l'index cumulatif, en composant le 416-325-7410 ou le 325-3708.

Hansard Reporting and Interpretation Services
Room 500, West Wing, Legislative Building
111 Wellesley Street West, Queen's Park
Toronto ON M7A 1A2
Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario

Service du Journal des débats et d'interprétation
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Monday 31 March 2014

Lundi 31 mars 2014

The committee met at 1400 in committee room 1.

LOCAL HEALTH SYSTEM INTEGRATION ACT REVIEW

ÉTUDE DE LA LOI SUR L'INTÉGRATION DU SYSTÈME DE SANTÉ LOCAL

The Chair (Mr. Ernie Hardeman): I call to order the meeting of the Standing Committee on Social Policy. We are here today to hear public delegations on the review of the Local Health System Integration Act and the regulations made under it, as provided for in section 39 of that act.

ONTARIO HOSPITAL ASSOCIATION

The Chair (Mr. Ernie Hardeman): Our first delegation is the Ontario Hospital Association, and we welcome them here this afternoon: Anthony Dale, president and chief executive officer; Elizabeth Carlton, interim vice-president, policy and public affairs; and Andrée Robichaud, president and chief executive officer, Thunder Bay Regional Health Sciences Centre and Ontario Hospital Association (OHA) board member. We want to welcome you all here.

For your presentation this afternoon, you will have half an hour. You can use any or all of that. After that, we will have a half an hour opportunity for each caucus to address any questions to you as they relate to your presentation, or to make comments for the committee's purposes. With that, the time will start now, and you'll have half an hour to make your presentation. Any one of you can speak, as you see fit.

Mr. Anthony Dale: Thank you very much, Chair, and good afternoon. Thanks so much for having us here today.

As the Chair mentioned, my name is Anthony Dale, and I am president and CEO of the Ontario Hospital Association. Just for your background, the OHA is a voluntary organization which represents the 149 public hospitals that operate across approximately 225 sites in the province of Ontario.

On behalf of our members, I am very pleased to be presenting today and sharing the experiences and perspectives of Ontario's hospitals as they relate to the strengths and opportunities for our work with Ontario's local health integration networks.

Today I have the good fortune of being joined by one of our member representatives, Andrée Robichaud. Andrée is the president and CEO of Thunder Bay Regional Health Sciences Centre, a member of the OHA board of directors and the chair of a special committee convened by our board to guide the OHA's work in preparing for the review of the LHSIA. Beside me, as the Chair mentioned, is Elizabeth Carlton, our vice-president, policy and public affairs. Behind us, just for your information, are several other members of the OHA staff, who are here to help with some technical questions if you have any.

To begin, I'd like to give you a bit of background on our organization and its members. As the voice of Ontario's hospitals, the OHA strives to achieve a high-performing health system for Ontarians by fostering leadership, supporting innovation and building linkages between hospitals and their communities.

As I'm sure you can appreciate, Ontario's hospitals are as diverse as this province, and so our members represent a broad range of hospital types. They include community, acute care, small hospitals, complex continuing care and rehabilitation facilities, pediatric hospitals, mental health and addictions centres, and internationally ranked academic hospitals with associated research centres.

Together, Ontario's hospitals employ over 200,000 people and serve thousands of Ontarians every day. In 2012-13, Ontario hospitals performed 350,000 in-patient surgeries, over 1.1 million outpatient surgeries, and responded to over 5.9 million emergency room visits. In total, there were 20 million patient visits in Ontario's hospitals last year.

We're extremely proud of our province's hospitals and the work they do every day to ensure that Ontarians have access to high-quality care. We're also proud of our hospitals' impressive track record in demonstrating leadership, innovation and collaboration to bring better care to patients and clients and bring greater efficiencies to people.

For years, Ontario's hospital leaders have recognized the need to collaborate and partner with other care providers in order to continually improve efficiencies, access to care and overall quality. Because of this good work, Ontarians are hospitalized less frequently than anywhere else in Canada, and Ontario has the lowest rate of age-sex standardized acute care hospitalization at just 7,038 hospitalizations per 100,000 people.

All of these successes have worked together to produce an efficiency dividend for the province that in 2013 totalled $3.6 billion. That's $3.6 billion that can be better spent on other pressing health system priority areas.

These successes have not been achieved in isolation; on the contrary, they are a direct reflection of Ontario hospitals' many positive relationships and partnerships with other health leaders in the delivery of care and in its planning.

Since the introduction of LHINs, there has been marked and concentrated effort at the local levels across the province to further improve accountability and health system performance. That focus remains, and we believe that every leader in today's health system has a strong interest in continuing to work together to bring even better care to people and the communities we serve.

It's in that spirit of pursuing ongoing progressive collaboration that the OHA participates in today's discussion. We see the LHSIA review as an opportunity to engage stakeholders and evaluate an important piece of legislation to determine whether there are barriers to effective health care service delivery in Ontario.

For our part, we have undertaken a robust member engagement process to ensure that we have an accurate understanding of our members' experiences with LHINs and to inform our recommendations.

As the chair of our board's special committee that guided the OHA's work related to the LHSIA review, Andrée is ideally suited to describe our approach and our motivation for the recommendations we are presenting to you today, so I'll now turn it over to her for a brief description of how we arrived at our recommendations.

Ms. Andrée Robichaud: Thank you, Anthony, and good afternoon to the committee members. Merci, Anthony, et bonjour aux membres du comité.

Comme présidente et directrice générale d'un hôpital, je peux vous dire que les hôpitaux attendaient une révision de cette loi avec anticipation. As the president and CEO of a hospital, I can speak to the keen anticipation hospitals have had in expecting a review of the LHSIA.

J'aimerais aussi souligner que l'engagement de ses membres est une fonction primaire de notre association. I can also highlight that robust member engagement is a primary function of the OHA.

C'est avec ces deux intérêts que le conseil de l'OHA a convoqué, dans un premier temps, un groupe de travail en 2012 pour commencer une révision préliminaire des relations entre les hôpitaux et les « LHIN » et comment cette loi impacte leur travail collectif. It was in these two interests that the OHA board of directors convened an early working group back in 2012 to begin an initial examination of hospitals' relationships with their LHINs and how the LHSIA impacts their collective work.

Le travail de ce groupe a suscité de très bonnes discussions, mais aucune recommandation ne fut développée, étant donné l'absence d'une révision formelle de cette loi. The work of that group afforded some good discussion, but no formal recommendations were made in the absence of a recognized LHSIA review process.

En novembre dernier, lorsque la révision de la loi fut annoncée, le conseil de l'OHA créa un comité en bonne et due forme dont j'ai eu le privilège de présider. Then this past November, when the LHSIA review process was announced, the OHA board of directors formally convened a special committee of its members, a committee that I had the distinction of chairing.

The OHA special committee for the LHSIA review built on the work of the previous working group but with a more formal mandate. That mandate was to consider options for responding to the activities related to the LHSIA review and to provide direction to the OHA.

I should also add that the committee's membership included hospital CEOs from each of the 14 LHINs.

As a committee, we shared our experience working with LHINs and our other health system partners and began to explore ways that we could be doing even more together. In all of our discussions, a consensus was often found in the common appreciation for the made-in-Ontario model of integration that the government chose to implement nearly a decade ago.

Hospitals see LHINs as a valuable regional body that can facilitate local planning, understand and address local issues, and help enhance health system performance. These are strengths of the LHIN that Ontario hospitals support.

We found consensus in our appreciation of and value for the added accountability that LHINs have helped us achieve. So, in preparing for the OHA's submission to this committee, we started asking ourselves how we could, as a health system, build on the progress that has been made to date. How could we establish even more accountability? How else could we drive change and advance integration? What could we be doing to better serve our communities?

We looked at the legislation also, and there are a few areas where we noted that the legislation itself could be made stronger. We will touch on those a little later in our presentation.

1410

But the bulk of our work focused on the prime opportunity that the LHSIA review presents to put additional measures in place that we believe could really accelerate and enhance our work in supporting local health system improvements. Our committee supported the OHA in putting these ideas to paper. We have presented our ideas and recommendations to all of the OHA's hospital members for their review and feedback, which has been incorporated in the submission before you.

My colleagues and I believe that the citizens of Ontario want and deserve coordinated action to improve their health care system. They want hospitals, LHINs, the Ontario government and everyone in the health system working together toward the common goal of ensuring great patient care. We know that asking questions about

what works well in our health system and what can be improved is always an important discussion to have.

Our committee has done a good job of guiding the OHA work in preparing for the LHSIA review, and we're very pleased to share with you such thorough insight from the province's hospitals. I will now turn it back to the association to share our findings and recommendations.

Mr. Anthony Dale: Thanks, Andrée.

It's true that Ontario's hospitals see great value in the important role LHINs play in planning and supporting accountability and other performance efforts. It's also true that the LHSIA itself is a strong piece of legislation, particularly because it centres on improving the interconnectivity of health services, allowing for local creativity and innovation, enabling equitable access to health services, encouraging and requiring community engagement, and supporting evidence-based practices and programs. It provides LHINs with a clear legislative mandate and a strong foundation of authority.

Since the introduction of LHINs, we have seen health system accountability grow and mature. We recognize how accountability to our LHINs and to our communities has helped enhance overall health system performance. For instance, thanks to LHIN-hospital accountability agreements, there are much clearer two-way expectations respecting hospital-based performance outcomes than there were 10 years ago. And we have seen how a provincial, local and regional focus and integration have helped target our efforts on key health system challenges, particularly alternate level of care, or ALC, patients.

ALC patients are people who have received their full episode of care in a hospital and are waiting for discharge to another, more appropriate setting. Now, it's certainly not uniform across the province, and there is still a lot more work to do. But by working closely together, providers, LHINs and the Ministry of Health have been able to reduce the number of ALC patients in Ontario's hospitals from a provincial high of 20% just a few years ago to less than 14% today.

Today's LHSIA review represents an opportunity to advance the discussion about what else can be done to make the health system work better to serve these patients and clients. From our vantage point, there are two helpful ways we can do this. The first is by strengthening our understanding of roles and responsibilities, and the second is to establish a long-term strategic plan with explicit performance metrics for the system.

Let's start with roles and responsibilities. Let me say that, in our experience, all health system partners share a strong commitment to advancing a high-performing system. Certainly, the OHA and all of Ontario's hospitals enjoy a very strong relationship with the LHINs. Our responsibility today is transforming our shared commitment into a common course of action.

In 2008, when KPMG reviewed and reported on the effectiveness of the LHINs, it was noted that a clearer understanding of the respective roles and responsibilities of the Ministry of Health and Long-Term Care and LHINs was needed in order to advance health system integration. The Ministry-LHIN Effectiveness Review signalled the existence of "authority grey areas," where it was unclear what aspects of authority and decision-making rested with the LHINs and what authority the ministry retained. Additionally, in Don Drummond's 2012 review of public services, a number of similar issues were noted.

Both the KPMG review and the Drummond report allude to the need for clarity over these respective roles. We do believe that more work needs to be done to define and sharpen the roles and responsibilities of the ministry and LHINs in order to strengthen health system planning, funding and organization, ultimately for the objective of improving quality of care for people.

The goal of the act is to enable LHINs to make local decisions about program funding, with the ministry determining broader health system policy and goals, establishing criteria for funding allocation, and engaging in capacity planning. But in practice, this has proven far more complex to do than it might seem on the surface. For instance, some areas of health care funding remain centralized—the pricing of quality-based procedures is a good example. Other decisions, such as determining allocations from the Seniors Strategy, reside at the LHIN level. This intermingled approach to decision-making and the setting of provincial and community-based priorities associated with it needs to be better aligned and integrated.

When it comes to making decisions about the way in which health services are delivered, more work needs to be done to calibrate the parameters of decision-making at the LHIN level. Let us ask: In what areas should LHINs have clear and unambiguous authority to make decisions, and in what areas is there an overarching provincial policy consideration that needs to be taken into account? When thinking about the planning reconfiguration of health services, are there minimum access standards that should be established to guide decisions? In our view, as health system funding reform accelerates, and LHINs and hospitals and then other providers start to make long-term decisions about changes in service delivery, this question will become even more significant.

The LHSIA review presents an ideal opportunity to strengthen the ministry-LHIN and inter-LHIN collaboration frameworks and address these authority grey zones. It's also an opportunity to explore the question of whether or not policy standards and benchmarks are needed in areas where there is an intermingling of ministry and LHIN roles.

Over two years ago, the Ministry of Health and Long-Term Care released its action plan for health care. The action plan spells out the government's three main areas of priority and describes the activities and initiatives under way to make progress in each one. The objective, which is a commendable one, is to transform the system to make it better for patients. Given the extraordinary fiscal challenges facing Ontario, it is essential to change the way health services are delivered.

Ontario's hospitals are playing a leadership role in system transformation. For instance, hospitals are accelerating their efforts to implement health system funding reform in order to further improve quality of care for patients and drive greater value. They have not received a funding increase in two years, and we fully expect that in the upcoming budget, there will again be no increase in spending on hospitals.

Now, while challenging, we understand why this is necessary. It is part of a strategic effort to expand funding and capacity elsewhere in the system, particularly in the community. That's why, as part of the OHA strategic plan, we track expenditures in the community setting as a vitally important metric.

In the lead-up to the balanced-budget target year of 2017-18, at the very time hospitals and other providers are implementing very large-scale change initiatives, the system will also come under intense pressure. Service demands will continue to grow across the board at the very same time that the system will come under very considerable compression as it moves to contain further cost growth. At this pivotal juncture, we believe it is essential to establish a long-term strategic plan for the system.

The government of Ontario should set and communicate specific medium- and long-term goals for the system, with specific, quantifiable performance targets, so that health care providers can effectively contribute to their achievement and the public can understand where our health system is headed and why.

The truth of the matter is that today, hospitals and other health providers are grappling with hundreds of indicators and other performance metrics. Examples include but are not limited to quality improvement plans, accountability agreements, patient safety indicators, Cancer Care Ontario, the Canadian Institute for Health Information reporting project, Accreditation Canada, the Cardiac Care Network of Ontario and Ontario Stroke Network programs, and audits, to name just a few.

Often, these indicators and reporting mechanisms are not in alignment, which is cumbersome from an accountability and compliance perspective. There has been some positive movement to address these concerns in recent months, but what the issue still powerfully demonstrates is that we don't yet have clear our long-term system goals and objectives.

A crucial component of this long-term strategic plan must be health system capacity planning. Capacity planning is a crucial component to guiding the health system's focus. It includes activities such as forecasting and benchmarking the number of different types of beds or services in hospitals or long-term care, and the number of assisted living spaces, home care hours, primary care services and mental health services, to name a few. All this is needed to meet the needs of different populations into the future.

A comprehensive capacity plan would drive sound decision-making regarding where care should be provided, who should provide it and how it should funded. We need to develop a provincial and regional mechanism for forecasting the necessary breadth and mix of services across the different health care sectors.

The health care system, I don't have to tell you, is highly interdependent. In 2006, when an almost-decade-long expansion of long-term care wound down, the number of ALC patients in hospitals suddenly began to increase, and it did so with extraordinary speed. That is how interdependent our health system is, and that's why we need to be making deliberate, informed choices about where to maximize health system capacity outside of hospitals, particularly in the lead-up to the province's balanced budget target.

We cannot afford to lose our grip on the gains that we are making in changing the system to better meet the needs of our patients and clients. Building on the recommendations of other organizations that I know have appeared before you, the OHA and its member hospitals encourage the committee to consider the development of a long-term provincial plan, supported by capacity planning, as one of your recommendations.

These are our core recommendations for the committee to consider. We also have a number of targeted recommendations specific to LHSIA itself that we believe can help strengthen the legislation. I'm going to ask Elizabeth to speak to each of these in a bit more detail.

1420

Ms. Elizabeth Carlton: Thank you, Anthony. Continuing on the theme of supporting Ontario's LHINs and achieving the full extent of their mandate and the needs of Ontario's health care system, we would like to offer a few additional considerations specific to the act itself that we believe would help enhance the legislation and the work that it governs. Our written submission outlines a few recommendations for amendments to LHSIA, but there are just two specific ones which we would like to highlight for you today.

The first relates to strengthening LHIN governance. Ensuring that LHIN boards are representative of the communities they serve is an important feature of LHIN governance. Drawing LHIN board members from local communities not only makes LHINs more accountable to the regions they serve but also fosters creativity and innovation.

There are good governance practices in health care that serve the health system very well, and we believe we could apply those to the strengths of LHINs. For example, delegating board recruitment and selection activities directly to the LHINs would help ensure that their governance structures are best suited to promote long-term board stewardship and stability and that recruitment efforts reflect the best possible skill-competency mixes for individual organizations and communities. Moving in this direction would help keep LHIN governance consistent with widely accepted good governance practices. It would also align LHIN governance with the well-respected tradition of voluntary governance that is present in most other areas of Ontario's health care system.

We also wish to point out that section 27 of the act requires LHINs and health service providers to wait a total of 60 days before proceeding with even voluntary integrations. Now, while we appreciate that this provides the opportunity for LHINs to review and respond to voluntary integration proposals, there is currently no mechanism in the legislation that would allow the LHINs to waive this period, even when they support such a move and see no need to wait the 60 days. We believe that amending LHSIA to provide LHINs with the discretion in limited circumstances to waive the notice period for voluntary integration would help eliminate unnecessary delays and help accelerate positive integrations at appropriate times.

As I have mentioned, we have other suggested amendments to the act outlined in our submission, but it is these two which we believe best complement our core recommendations that Anthony described earlier.

I will look forward to your questions but will turn it back to Anthony for some closing remarks.

Mr. Anthony Dale: Once again, I'd like to thank the committee for your time today. I'll close our presentation by saying that the health system transformation currently under way in Ontario is a significant step forward in changing the system for people for the better.

We have seen through our experiences with the LHINs that collaboration and partnership are key ingredients to building a better, more efficient and more integrated system. Like all Ontarians, we wish to see this momentum for high performance continue to build, so we are pleased that this review of the LHSIA is taking place and that we've had the opportunity to participate.

So thank you, and we look forward to the discussion here today.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We will now have half an hour for each caucus, and we will start with the government side for the half-hour. You do not have to use it all at once if you wish to just rotate, and we'll just keep rotating until everyone's time has been consumed.

With that, Ms. Jaczek.

Ms. Helena Jaczek: Thank you, Chair. And thank you for coming in and for all the consultation that you have undertaken with your members.

I guess I'll start with some of your suggestions, first of all those that do not require legislative change. I must say, I'm a little bit confused. You're calling for a provincial strategic plan for health care. I think, as we all know, the Ministry of Health and Long-Term Care is undertaking a transformation of health care, the action plan for health care, which is clearly to put less reliance on acute care and hospitals and much more of an emphasis on community. And then you've also alluded to a whole lot of benchmarks and indicators that are kind of out there.

I would have thought that the government's intention was fairly clear, but you're pointing to the need for something else. So could you articulate, tell me more about, what you mean by "a provincial strategic plan"?

Mr. Anthony Dale: Sure. As I said in our opening comments, we do strongly support the government's action plan and its various components. There is ample proof that the OHA and the hospitals are fully committed to its implementation.

I guess what we're also saying, though, is that from the point of view of an individual hospital, that has to sometimes juggle literally hundreds of performance indicators that are embedded in everything from a hospital service agreement that it has with its LHIN to a quality improvement plan that it has with its board and is submitted to the provincial government to other indicators of performance that come at it from external bodies, some of them with regulatory authority—if you're an individual hospital, it can be very difficult to deal with such a diffusion of focus, because everybody's indicator is important.

What we're saying is, let's work to create a long-term plan, building on the action plan, that sets apart the most important system performance metrics that all providers should concentrate on, and make sure that we have built the pathway very clearly to achieving it. That's it, in a nutshell.

Ms. Helena Jaczek: You're saying, then, that those particular, most important areas of focus would be reported to the provincial ministry.

Mr. Anthony Dale: They would, in fact, set them. If you note, in the LHSIA review is the requirement that the province establish a provincial plan for health care and that it table it each year in the Legislature. Obviously, the ministry is using the action plan as its way of being held to account for this particular requirement.

All we're saying is to concentrate on the long term, concentrate on articulating those long-term, strategic objectives, and that we should be even more definitive about the pathways we're choosing to use to achieve them.

Ms. Helena Jaczek: In other words, just to make it really clear—because we're all very concrete people here, and buzzwords get a little complicated—what you're basically saying is that there would be indicators that would be reported on, consistently, from every hospital, presumably to the LHIN as well as centrally to the ministry. Am I understanding that?

Mr. Anthony Dale: It's a little bit tighter than that. It means, at a system level, what are the primary system changes that the government wants to achieve over the long term—and articulate the benchmark objectives that you would like the system to achieve.

I have in my hands here, for instance, the indicators that are part of the Health Quality Ontario common quality agenda, the indicators that go into the hospitals' performance agreements with LHINs. In the hospital performance agreements with LHINs alone, there are 33 separate indicators. With the common quality agenda, there are another 23. If we look at the new performance indicators being designed for the clinical handbooks that are associated with quality-based procedures, there are another 125. That's just one package alone. That's a

cumulative number of well over 200 indicators. All of it is important. All of it, at the micro level, is pushing and driving change in those clinical areas and more systematic areas.

From the hospital point of view, we're just talking about helping to sharpen our understanding of where the focus needs to be overall for hospitals, just being a bit more specific over the long term about exactly what you'd like the hospitals to achieve within that wider system.

Ms. Helena Jaczek: Okay. As you know, we've heard from many deputants. We've been all over the province and heard interesting submissions. The LHINs themselves are advocating that they expand their sphere of responsibility to include primary care and public health. Obviously, you have physicians on staff at your hospitals. You liaise with public health. Do you have any opinions on that?

Ms. Andrée Robichaud: I think primary care is—first of all, what is primary care? When you look at the definition of primary care, you look at first contact. It's bigger than your family health teams; it's bigger than the physicians. It does include public health. One size doesn't fit all.

I think the government really needs to look at, in terms of primary care, what a framework is. In a very rural area, as you would know, a lot of the family docs keep the hospital going. In other areas, our family practitioners don't work in the hospital. So there needs to be a really good framework, a robust framework, when you look at primary care before you ever move to where that governance should be. I think, from a primary care position, we really need to look at: How do we want it to work and how should it work? And then add a third question: How do we then organize it, and where, from a government perspective, should it lie?

1430

Ms. Helena Jaczek: Would you, then, as a summary, say it might be premature to—

Ms. Andrée Robichaud: I would think so, yes.

Ms. Helena Jaczek: Okay. Thank you.

In terms of your engagement with the hospital, as an organization, as the Ontario Hospital Association, do you have any liaison centrally with the—I forget what the LHINs call it, but they have a leadership council or something. Do you have a relationship at that level to try and talk about consistency across the 14 LHINs?

Mr. Anthony Dale: Sure. There are certain formal relationships we have with the LHINs. The OHA is a member of the LHINs' System Strategy Council, which meets quarterly. At that venue, which I've just started to attend in the last year, there is discussion about the kinds of issues that we're describing to you, mostly related to the long term.

At the meeting held most recently, capacity planning was absolutely the topic of the day. I understand that at the next meeting, the different provider associations, along with the LHIN leadership there, are going to be discussing very tangibly what information we know about capacity planning that exists today in the health care system and what we can do to bring it all together and partner with the provincial government and move forward with this critical function.

Probably the most important direct relationship the OHA has with the LHINs is through a joint committee that deals with the hospital service accountability agreement and the associated performance metrics, the ones I described here. That template agreement was negotiated jointly several years ago between the OHA and the LHINs, and it's certainly a timeless document. It has stood the test of time rather well.

That committee is very much intended to support both LHINs and hospitals with the annual cycle of accountability. There are a host of resources that we provide to do that. There are joint webcasts and telecasts with joint work projects around working through some of the performance indicator questions. I know you'll be aware, Helena, that it's very, very complex stuff, but that's a very specific example of the kind of direct relationship the OHA has with LHINs.

Ms. Helena Jaczek: Okay. So let's first talk about that template agreement. Obviously, you've brought the issue of this plethora of indicators to that table, and presumably have advocated for some sort of streamlining.

Mr. Anthony Dale: You're right. That's why I said in the comments we made at the beginning that there is progress being made. It's just that if we step back and we think about the challenges ahead of us over the next three to five years, we just can't get that focus quick enough, is all I was trying to say.

Between the ministry and the LHINs and the OHA and—

Interjection.

Mr. Anthony Dale: —HQO; thanks, Elizabeth—there is a lot of work going on right now to try and arrive at what the overarching system indicators should be. And then we need to literally align these legally binding, highly complex compliance documents together so that they're fully integrated. Otherwise, you've got one set of performance requirements driving you in one way and another set driving you in another. So we just want to make sure they're in much greater alignment and integration.

Ms. Helena Jaczek: Okay. Well, that's very helpful when we go back to your comment regarding the provincial strategic plan, because I feel fairly confident that from the point of view of the ministry, they would say, "Well, what are your proposals? You're the guys on the ground who know it, so please come with that streamlined kind of, what you believe"—given the action plan, given the transformation—

Mr. Anthony Dale: We're not the kind of organization to sit back and tell everyone else what to do. We've got our sleeves rolled up and we're working very closely with all the other partners to try and accomplish the very things we've articulated. This committee and this review asked us to speak about the kinds of things that we think are most important, so it was in that spirit that we made that—

Ms. Helena Jaczek: So it's a process of accelerating, perhaps, encouraging, making sure that it actually happens, is where you're coming—

Mr. Anthony Dale: Yes.

Ms. Helena Jaczek: Okay, that's helpful.

Capacity planning: We heard quite a bit from the various LHINs and from the CCACs, as a matter of fact, in that, of course, many of us have ridings with more than one LHIN. One of our members has four LHINs, four CCACs, and they see a difference in the level of service that is provided, particularly when it comes to a community care access centre. It's often explained to this committee that the differences are because of a lack of capacity, either of personnel or resources in some fashion.

Can you just talk to me a little bit more about how you see that capacity plan being developed, or who would be the key players here? How should this be organized, this capacity plan across the board?

Mr. Anthony Dale: Yes. You're asking a very complex question, and we won't pretend to be able to answer it as precisely as perhaps you'd like us to. But in one earlier point in the province's history, when it came to health system planning through the Health Services Restructuring Commission, there was a deep database of information and a methodological approach to thinking about, based on population health needs, exactly what level and amount of service would be required in a specific community into the future—five years, 10 years down the road. I'm not saying the commission was perfect, because it wasn't, but it was that future look that people often forget was actually the other half of its mandate.

All we're saying is, we need to use that same basic approach—looking at data, information about population health need in a local community, in a region and even at the provincial level—and forecast with real precision what the future capacity needs are going to be. From our point of view, the most significant areas requiring that attention are community services and long-term care, because we know from the evidence reported in the government's access-to-care reports that these are some of the most heavily cited kinds of services required by people waiting for discharge from hospital.

We know anecdotally that that is absolutely what the evidence suggests, but we don't yet know exactly what that means next year, the year after that, five years after that, 10 years after that, and that gets back to the heart of our submission. As we move up to that balanced budget target and we keep that compression on hospitals to transform the system, we have to make sure you've got capacity—especially in home care and long-term care, assisted living, palliative care and so on outside of that hospital setting—to catch those patients and give them the care they need with a minimum of wait, if any.

That's a complex challenge, but if the ministry and the provider community apply themselves, I'm confident we can get the right methodological approach. What comes next are the hard decisions to build out that capacity into the future and meet that future need.

Ms. Helena Jaczek: What about the capacity of hospitals? You focused your comments on the community sector. How do you look at your own capacity?

Mr. Anthony Dale: Great question.

Ms. Helena Jaczek: Do you do bed projections, ER, staffing projections, need for ophthalmologists? How do you work—

Mr. Anthony Dale: Well, there is a lot of service capacity planning in hospitals today, and that's done with the ministry. For a lot of the very high-cost, specialized services, there's already a foundation behind them for service planning.

But the question you're asking is a very good one because if you look at the numbers, since 1998, the number of hospital beds in the province has stayed roughly at the same amount: about 31,000 beds. Over the same time, almost two million people have joined the province and so that, combined with some of the other performance metrics I've described to you about the length of stay being very, very low, admission rates being very, very low, per capita spending being the second-lowest now in the country, points to a system that is pretty efficient. But we know, given the sheer size of the hospital budget—it's almost $23 billion, if you include the hospitals' own revenues—there's a lot of room for improvement within the hospital itself. That's why we're so invested in the transformation agenda. Quality-based procedures and other dimensions of funding reform hold a lot of promise at achieving greater quality and value within the hospital setting itself.

Thinking about future capacity within the hospital is a fundamental piece of that transformation, and that's the kind of direct connection of the hospital into that wider process.

Ms. Helena Jaczek: And you're engaged very actively in that in terms of your—

Mr. Anthony Dale: We have a very strong partnership with the ministry, the senior ministry officials. I think we would all agree that we all have a lot of work to do over the next many years to strengthen the health system funding reform, but it is a very strong collaboration and it's getting better every day.

Ms. Helena Jaczek: Just turning to one of my pet peeves in the GTA, which is boundaries, the original ICES report—as our researcher has looked back and seen, in 1996, originally there were seven regions that the province proposed, basically around tertiary care facilities, to ensure that there was that strength in each planning area.

Has it been an issue for any of your member hospitals, in terms of communication? We've heard stories about the electronic health records and everything being wrapped around the patient and everything being seamless. But from the practical point of view of my constituency office, it's not seamless.

1440

Mr. Anthony Dale: No.

Ms. Helena Jaczek: You can hear my bias. But from the point of view of individual hospitals—the sort of

infamous Markham Stouffville Hospital having their satellite in Uxbridge in a different LHIN, etc.—is this an issue, or have you been working around it? Do you see any opportunity for change?

Mr. Anthony Dale: To be honest, we take your guidance on it. It's not something we hear about frequently at the OHA. The few occasions when it has come up have to do with someone within a hospital not really quite knowing precisely what the rules are or the policy framework around LHINs, so they might wrongly say, "Sorry, I can't serve you here because you're from another area." But those are very few and far between.

But we would take your guidance. If there's more there than meets the eye, we would like to hear about it.

Ms. Helena Jaczek: So you're essentially neutral on that subject?

Mr. Anthony Dale: Well, no. We take your guidance on it. If there's something there, then we'd like to hear about it.

Ms. Helena Jaczek: Okay. Thank you. We'll probably reserve our time, whatever is left. What is left?

The Chair (Mr. Ernie Hardeman): Okay, thank you very much. We'll go to the official opposition. Who has a question? Mr. Holyday?

Mr. Douglas C. Holyday: I could start. I noticed you referred us to an efficiency dividend of $3.6 billion in 2013. Can you explain that, please?

Mr. Anthony Dale: Sure. It's illustrative, but what it is, is that if you look at per capita spending in hospitals in each province across the country, if Ontario's hospitals were funded at the national average, you'd have to spend $3.6 billion more just to move up to that level.

To us, it's an important way of demonstrating just how efficient the system is. So, if you just compare that to other provinces, it says we're spending a heck of a lot less per capita in Ontario, and that allows more resources to be freed up for other priorities. In our view, that's a critical thing to do—in particular, community and long-term care and assisted living.

Mr. Douglas C. Holyday: What provinces would be in the higher end of the scale?

Mr. Anthony Dale: Alberta. Alberta spends the most per capita in the entire country, by a vast, vast amount.

Mr. Douglas C. Holyday: What would the reason for that be?

Mr. Anthony Dale: I don't know.

Mr. Douglas C. Holyday: Would they be inefficient?

Mr. Anthony Dale: We're talking about per capita expenditures, and from our point of view it suggests that Ontario is relatively more efficient than Alberta. If you look at some of the political debate that has occurred in Alberta over the past couple of years, that theme has been prevalent in that province: "If other provinces spend less per capita than we do, why can't we lower our expenditures and become more efficient?" Again, the whole purpose of this is to free up resources for other priorities.

Mr. Douglas C. Holyday: Okay. I have to think about that one.

Mr. Anthony Dale: Sure.

Mr. Douglas C. Holyday: I notice here that you're making a recommendation to get away from government-appointed LHIN boards. I just wonder what your reason was for that and how you arrived at it.

Ms. Elizabeth Carlton: When the legislation was first introduced, it was something we addressed in our submissions at that time, and our position has remained unchanged since then. The reason is that, traditionally, best practice in good governance is to have voluntary, community-appointed boards. Traditionally, it has been found that they're selected on a competency, skills-based model, they represent the community and there's no kind of financial incentive. That's really how you get the best people.

I think we've done a lot at the OHA, in terms of our work on good governance—the Governance Centre of Excellence—and I can tell you that we have over 2,000 volunteer board members within the system. The selection process that we have promoted through our Guide to Good Governance and other materials has been sort of a competency model selected through the community in a very transparent manner. Of course, the hospital sector is a voluntary, sort of, non-remunerative model, and there has been no shortage of applicants, so it tends to yield the best candidate as opposed to just having people appointed.

Mr. Anthony Dale: I think another dimension to that is that the board itself becomes responsible for its long-term stewardship, not someone else. That, as I'm sure you're aware, is a key dimension to good governance, that the board itself takes responsibility for recruitment and retention of board members and builds up the resources and supports around them. That's what we're saying: Let's make sure that that happens at the local level into the future.

Mr. Douglas C. Holyday: So instead of the government appointing people to sit on these boards, the board itself would run the competition—

Ms. Elizabeth Carlton: Yes.

Mr. Douglas C. Holyday: —and seek people who have the qualifications, and the interest, I guess, in the local areas themselves, perhaps even through the hospital communities, to strengthen the boards.

Mr. Anthony Dale: Well, it certainly wouldn't have to be through the hospitals. It should be through the LHINs themselves. We know that there is the ability of people to apply for OIC appointments as a LHIN board member, and there are absolutely processes in place. What we're saying is, place it in the hands of the LHIN or give the LHINs a body to accept full responsibility for that recruitment and retention function—I think there's precedence in the college sector for that kind of role—and then make recommendations to the province for that appointment. There's different ways to look at it, but the key is to patriate that responsibility at the LHIN level.

Ms. Elizabeth Carlton: But just to add to that, I think what we've found in the hospital sector is that ownership that the board has over their processes, the strength of community representation, is a fundamental component

of the governance practice. It's a great strength that the hospital can point to, and the community feels that they generally have a voice.

Mr. Douglas C. Holyday: Well, I notice also that you're recommending that these people not be paid. That's probably fine with me, too, but I just wonder: How much are they getting paid now?

Ms. Elizabeth Carlton: Currently, the board chair is paid $350 per diem, and individual board members $200 per diem.

Mr. Douglas C. Holyday: I'm sorry, that was $250—

Ms. Lisa M. Thompson: It's $350.

Mr. Douglas C. Holyday: It's $350 for the chair. And how much for the members?

Ms. Elizabeth Carlton: It's $200 for board members, per diem.

Mr. Douglas C. Holyday: How many times would they meet?

Ms. Elizabeth Carlton: I don't have those facts at my fingertips, but you can expect that they may—

Mr. Douglas C. Holyday: Well, would it be monthly or weekly, or would some of these people be out every day?

Mr. Anthony Dale: I'm sure it would depend on the LHIN and it would depend on the organization. But I think what we're really trying to say to you is that there's a long tradition of volunteerism in health care governance. We're saying: Let's make it consistent.

Mr. Douglas C. Holyday: I'm just wondering—I've had people from the LHINs call on me over the years, explaining what they were doing and so on, and three or four of them would come. Would they be on the per diem for doing a thing like that?

Ms. Elizabeth Carlton: I think that's something you would probably have to ask them. I know that there's probably some guidance around when they can charge the per diem, but we're probably not best suited to answer that.

Mr. Anthony Dale: Again, it's the tradition of volunteerism in health care governance that we're driving at here, not how much they made or may not—

Mr. Douglas C. Holyday: Like the hospital boards themselves.

Mr. Anthony Dale: Pardon?

Mr. Douglas C. Holyday: The hospital boards themselves. The people who are on the hospital boards for the most part are volunteers, are they not?

Mr. Anthony Dale: No, they're all volunteers.

Mr. Douglas C. Holyday: They're volunteers, and they're not paid?

Ms. Elizabeth Carlton: They're not paid.

Mr. Anthony Dale: Most if not all of all of their health provider organization boards are unpaid.

Mr. Douglas C. Holyday: Okay, thank you very much. That's all for me.

The Chair (Mr. Ernie Hardeman): Ms. Thompson.

Ms. Lisa M. Thompson: I'm noticing in your package that you prepared for us today that a lot of your recommendations point to the fact that there has been strife, if you will, because the relationship between the ministry and the LHINs had not been clarified. And I can appreciate that. You specifically point to the Drummond report. If I can quote your package here:

"The Drummond report recommended clarity of roles and responsibilities at the strategic, local and provider levels to stabilize the health policy-making and funding environments in order to help all parties manage routine and new initiatives more smoothly, create a better patient experience and increase public confidence in Ontario's health care system." Then you go on to say, "We fully support this recommendation."

My questions are around that, okay?

Mr. Anthony Dale: Sure.

Ms. Lisa M. Thompson: When you say you support this particular recommendation coming from the Drummond report, in your ideal world, what kind of timeline would be involved with this?

Mr. Anthony Dale: We don't want to leave you with the impression that things have stood still since KPMG and Drummond—

Ms. Lisa M. Thompson: That's fair.

1450

Mr. Anthony Dale: There are absolutely improvements being made in the way the ministry and the LHINs manage decision-making in this complex system.

Where I think we need to apply ourselves more directly is in thinking about health system funding reform. This is a good example where we're designing an entirely new way of funding hospitals and other providers. Much of that data and analytical work occurs at the provincial level, because that's where the capacity is for that type of analysis. But the LHINs are also given, as they should be, the authority and autonomy to make other funding decisions, and award allocations and so on. We just have to do a better job of working together—and that includes the provider community—and of lining everything up to maximize our impact.

If you think about funding reform into the future—let's get tangible for a second—hospitals are soon going to be making decisions, working with LHINs, about the future location of health services. They'll want to start thinking about whether or not there's any kind of criteria, specifically around access, that might be needed before we go too far down the road.

A historic example over the past 10 years has been emergency departments in rural communities—and I think part of this can be chalked up to LHINs, at the time, being quite new—examining new and different ways of designing the clinical footprint in a LHIN, saying, "Okay, let's think about the future location of services, including emergency."

What we saw was that there were a few too many isolated regional approaches. That's why it's important, from time to time, that we pull the camera lens back and we say that when it comes to something like emergency departments or other critical services—maybe obstetrics is another example; key tertiary-level services are also good candidates—are there minimum access standards

that we should all be using, from a policy point of view, before making a decision? Is it one hour by land ambulance or by car between the incident being reported and arriving in an emergency department for triage? Is that the right distance? How many members of the population should expect that? Those kinds of standards exist in places like British Columbia.

All we're saying is that there's probably a need to examine the need for some kind of policy parameters or framework for those kinds of decisions regarding access, especially over the next five to 10 years, as funding reform really starts to dig in.

Ms. Lisa M. Thompson: Okay, very good. When you talk about examining that particular model and whatnot—you referenced BC—and growing on your viewpoint of governance, who would you suggest to participate in taking a look and going forward? Do we just leave it in the hands of the ministry and the LHINs, or do we need to pull in more people to this lens?

Mr. Anthony Dale: No, the more people the better. The ministry actually has a very strong track record of this kind of approach. Several years ago, in response to this emergency room question, they appointed the Rural and Northern Health Care Panel. It was actually chaired by Hal Fjeldsted, who is the former CEO of Kirkland and District Hospital. They constituted a committee with a wide range of stakeholders from all sorts of health provider organizations and funders and regulators. It produced a series of recommendations to get to this very question. From our point of view, the next step in the work process is, "Okay, let's now think about where we need to apply it."

Ms. Lisa M. Thompson: Okay. Good. So there are some models out there.

What else do I have? It's interesting as well, coming back to your package: "The OHA recommends that:

"The LHSIA be amended to clarify relationships between the ministry and the LHINs regarding provincial programs and networks."

Leading up to that, you cite existing provincial programs and networks, such as Cancer Care Ontario, cardiac care etc. Is it possible for you to share real-life examples of what isn't happening because we don't have those clear relationships?

Mr. Anthony Dale: Sure. I would just go back to the example I tried to cite earlier. This document here is just the tip of the iceberg in terms of the indicators.

Ms. Lisa M. Thompson: The tip of the iceberg? Yes.

Mr. Anthony Dale: Cancer Care Ontario has an amazing track record of performance and success. It has very strong relationships with hospitals in the wider community. It also has its own performance indicators, and so do LHINs and so does the Cardiac Care Network and so does Health Quality Ontario, so that's how it presents itself.

Again, you've asked that we come here to talk a bit about things through the eyes of the hospitals. They feel as though they're pulled in many different directions, but again, it's all for an amazing good. There's no value in discussing the value of each of these indicators, because they're going to help someone. But we're talking about just making sure that at a system level we're bringing about the long-term focus on the right system indicators so that hospitals and other providers know the long-term trajectory toward change.

Ms. Lisa M. Thompson: Okay, I appreciate that perspective. I'm good, Chair.

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

Ms. Cindy Forster: Thank you, Chair. Thank you for being here today. I'm going to zone in on patient care and what we hear; Ms. Jaczek actually spoke about what she hears in her MPP office.

The government has been moving services from the hospital to the community for a number of years. I was surprised to hear you say that the total number of beds in the province is almost the same as it was in 1998, because certainly, in my own community, we've lost hundreds of beds over the last four or five years. Although we agree that there are situations where this makes sense, we are concerned about the creep of a lot of services that were offered in the hospital to the private sector in the community. Things like physiotherapy, chiropody, breast screening clinics in some situations are moving to the private sector where somebody is actually making a profit off these services, as opposed to using that money for front-line services.

I'll use an example. I was in the hospital—actually asked to go and visit a friend's mother. The family was from Alberta. I went into the hospital to see her. She'd fractured her hip and she had been transferred to a long-term-care area two days after surgery and was waiting five days for physio. She had not been out of bed in five days, and when somebody heard my name from behind the curtain next door, they said, "Is that you, Cindy?" I said "Yes." "Well, I need to see you."

This was an older, retired nurse, who also had been waiting five days for physiotherapy in a bed that probably could have been used—and this is just recently—for somebody else, had the hospital had the money to have the appropriate physio services there in place.

So I'd ask you to comment. Have we closed the beds perhaps too quickly, at the same time as the community services piece isn't up to speed?

Mr. Anthony Dale: I think you're right to ask the question. I don't know the answer, but it speaks to our primary objective, which is capacity planning, and that includes hospital care. But the OHA does accept and support the need to transform the hospital from being all services for all people. It's just too expensive over the long term to maintain that model. Hospitals get involved in other areas of service delivery that others might be better suited to deliver, frankly. That is what's paramount in the eyes of the hospital community.

Ms. Cindy Forster: At the same time, we know that community-based mental health services are promised when inpatient beds are cut, but they often don't materialize. What do the hospitals do in this case? What's the

hospitals' responsibility to these patients in our community who are actually ending up in our jails, ending up in the slammer at police stations?

Mr. Anthony Dale: I think hospitals are part of the solution, but it's not quite the right question to ask—what are we going to do about it?—as though it's solely up to the hospital community itself. I think history has proven that's not a sustainable approach to things. Other providers have much more precise expertise and ability to deal with patients with those kinds of needs. I think it's a good example of the kind of thing that we need to work on even more closely with LHINs and government, if there is proof that patients are falling through the cracks and not getting the care they deserve.

But again, I'd just go back to the core message that we want to leave you with, which is that it's long-term capacity planning—not just planning, but building out that capacity—that is essential to the future of health services delivery.

As you work up to the province's balanced budget target—and all parties are committed to achieving a balanced budget into the future—all leaders are going to have to work with providers to develop a solution.

1500

If you assume health inflation is about 3.5% a year, and let's say you kept the health budget at its current level for several years—let's say the three or four years in the lead-up to the balanced budget target—we've got to work together to find $6 billion in cost avoidance to achieve that balanced budget target. That's why new and innovative approaches to everything in health care are so absolutely necessary. That's why the hospital sector is in the early days of a massive transformation, using health system funding reform and other change initiatives, to change the way they deliver services.

Again, our goal here is to move resources out of other parts of the system into areas where there is evidence that more capacity is needed and, frankly, patients are going to get the level of care that they actually need. If you are in a hospital, if you are frail elderly and you're in the hospital too long after your hospital care, you're more likely to get an infection, you're more likely to get other health conditions, and it's just not the ideal place for you to be. As a former nurse, I know you know that. That's the theme that's most important to us.

Ms. Cindy Forster: I understand all that, but I think in the meantime, patients are falling through the cracks. I have four or five examples of patients who—it's like they come to the emergency department and they're being pushed back out the door, either to be readmitted later to find out, "Oh, yes, she did have a stroke," or, "Yes, she did have a stroke, but go home and wait by yourself till the stroke clinic opens tomorrow." Or you come in with chest pain: "Yes, you've had a myocardial infarction, but by the way, you had one before. Were you here for chest pain before?" "Well, yes I was, but I was sent home." I hear these stories every single day from people, and my concern is that while it's a great thing to be able to give care to people in the community, there needs to be a transition plan.

Mr. Anthony Dale: Right. Absolutely.

Ms. Cindy Forster: I don't think that that plan is necessarily working. So while we may be reducing health budgets, we're increasing policing budgets, because the police are staying in the emergency departments for three and four hours at a time with mental health patients. The paramedics aren't out being able to do their work because they're remaining, sometimes for a full shift, in the emergency department. So what are your recommendations, from the hospital sector, as to what do we do in the meantime while this shift continues to occur?

Mr. Anthony Dale: We have to get on with the task of knowing precisely how much capacity we're going to need into the future. We know that there are, from the government's action plan, 271,000 people who visit emergency departments when primary care is their more appropriate place for care. We know that there are 140,000 people who are readmitted to hospital each year; after they've left hospital, they come back because they can't access the level of care that they need in the community. That's right out of the ministry's action plan. Those are people who we need to do more to serve and to give them the kind of quality of care that they have paid for all their lives in their tax dollars.

Ms. Cindy Forster: Okay. I want to follow up on the PSLRTA recommendation as well. The OHA is recommending that LHSIA be amended to limit the application of the Public Sector Labour Relations Transition Act only to full-scale transfers, amalgamations and mergers, and that parallel amendments to the PSLRTA would also be required. So when you talk about full-scale, are you talking about a unit? Are you talking about a hospital site? Are you talking about a hospital? Or are you talking about a health system? Because the current arrangement is that if a program moves, PSLRTA kicks in, right?

Ms. Elizabeth Carlton: I appreciate the question. This is a really important area to understand in terms of really being able to fully take advantage of the integration opportunities that are currently within the sector and also within the legislation itself. We had raised this issue because our members are, in good faith, trying to move forward with a number of integrations, and this is something that has been universally raised in terms of our consultation with members as being a bit of a barrier.

Precisely to your question, when you look at—"partially" means anything less than the entire amalgamation. So it could be a unit. It could be a department. It could be any kind of service that supports a department. It has been interpreted very broadly, if that helps.

Ms. Cindy Forster: So you're suggesting that—

Ms. Elizabeth Carlton: I suggested it be to full scale. One of the things that I think hospitals would like to do is moving services that more appropriately should sit in the community or by another agency. I think Andrée could speak to some real-life examples of those. But you would want to ensure that it's a small unit, so even if you're just taking one group of five people, or a back support system out to another agency, that that triggers PSLRTA and the transfer of rights.

Ms. Cindy Forster: For example, you're suggesting if a hospital decided that all dialysis was going to be done in the community, that that program wouldn't fall under PSLRTA because it's only a program. Is that what you're suggesting?

Mr. Anthony Dale: Yes.

Ms. Cindy Forster: Thank you.

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

M^me^ France Gélinas: Did you want to add something?

Ms. Elizabeth Carlton: No.

M^me^ France Gélinas: I'll start by apologizing. I had to do an hour lead. I just finished, so I missed everything—all the good stuff that you have said. If you've already covered it, just say, "Read it later," and I won't waste your time.

Mr. Anthony Dale: Sure.

M^me^ France Gélinas: The first one I want to ask about: I live in northern Ontario. There are lots of smaller hospitals. Except for the five big ones, they're all small. I just wanted to know: What role does the hospital versus the LHINs play in things like moving physiotherapy from a hospital to the community? So if a hospital decides to no longer offer outpatient physio, does the LHIN get involved, or is it solely a hospital decision?

Ms. Andrée Robichaud: I'm from Thunder Bay, so another—

M^me^ France Gélinas: One of the big ones.

Ms. Andrée Robichaud: Where I come from, it's collaborative. If we're thinking of moving—for instance, we had an asthma clinic that was truly primary care and didn't belong in the hospital and had been—

The Chair (Mr. Ernie Hardeman): If you could just move the microphone over a little.

Ms. Andrée Robichaud: Oh, sorry. It had been delivered in the hospital for quite a while. So when we said that this would be better served in the community, we talked to our LHIN and worked collaboratively in how we found a partner who's interested in delivering that service. We're in the process of doing that right now. We have two or three community partners that are interested, and the LHIN is working with us to find the better fit in moving that forward.

M^me^ France Gélinas: Okay. If we speak specifically for physiotherapy, did you keep your outpatient physiotherapy in Thunder Bay?

Ms. Andrée Robichaud: Our outpatient physiotherapy was not delivered by us; it was delivered by St. Joe's, which is the rehab hospital. So I can't speak to that.

M^me^ France Gélinas: Okay. Just association-wise, is it something that your members do always through the LHINs?

Mr. Anthony Dale: There was, I'd say, within the last four to five years—you're talking about physiotherapy?

M^me^ France Gélinas: Outpatient physio.

Mr. Anthony Dale: Outpatient physio was an area where a lot of hospitals looked to see, "Is this something that we should continue to deliver, or are there other alternate places that might be able to do it?" It was learning from the examination of the accountability agreement cycle that year.

The LHINs and the hospitals did agree to the point that Cindy was making, that we need to get better at transition planning for that kind of transfer of services. In the case of physio, that stood out.

M^me^ France Gélinas: On transition, but the end result, who looks at the fact that the service used to be delivered under layers of oversight in a very secure environment where there was no overcharge and where you were covered—to an environment that has no oversight, the risk of extra billing is there, and most of them were for-profit? In my neck of the woods, we had no OHIP coverage, so it was all private.

Mr. Anthony Dale: That would be the role for the funder and the regulator, ultimately.

Ms. Elizabeth Carlton: But if I could just add, there are provisions in the act currently. If health providers want to integrate services and that means stopping a service, moving a service, whatever, they have to give notice to the LHIN, and the LHIN has to review it. So I don't think health service providers in this environment are unilaterally doing things without a conversation, without advance notice to the LHIN, and, ultimately, usually consulting with the public as well.

1510

M^me^ France Gélinas: So help me understand, then—a lot of community support services have come here to say, "LHINs gave us a voice, they are respectful of us, they consider us a partner." For a hospital, what has been this change from—you used to deal either directly with the ministry or through their regional office; you now deal through the LHINs. What is the reality for you?

Mr. Anthony Dale: The reality—and we touched on this at the beginning—is much stronger certainty over the accountability obligations for the hospital, especially for the in-patient activity. If you remember, say, 10 years ago, it was very difficult for the ministry and providers to have a common understanding of, literally, what the service-delivery obligations were in return for monies received.

What we've seen through the LHINs and the creation of accountability agreements is a very clear, very specific, very tangible understanding of the performance outcomes. So that's been, in the main, the primary experience of hospitals.

M^me^ France Gélinas: Why couldn't the regional office or the ministry have given you those? Why does it have to go through a LHIN? Why can't the ministry give you a strong accountability performance appraisal?

Mr. Anthony Dale: The ministry had one year's experience with hospital service accountability agreements, and what they found in their experience was that they were drowning in data and information about individual hospitals, and having a hard time understanding how the data and information about performance fit together on a local and regional level. So that's been, I think, the primary benefit.

M^me^ France Gélinas: Okay. And the benefit for you?

Mr. Anthony Dale: Certainty.

M^me^ France Gélinas: Certainty.

Mr. Anthony Dale: Hospitals have much more certainty in their planning horizon than they did before. That's even today, in a situation where the allocations are only being given one year at time and the long-term horizon isn't there the way it needs to be. There is at least much more planning certainty than there was historically in the past.

M^me^ France Gélinas: Okay. Do you see the need for LHINs to do this? You don't see a regional office of a government or a ministry being able to give you that certainty?

Mr. Anthony Dale: Some kind of regional authority, regional function, with the legislative authority to back up words with action is, I think, a very desirable model to have. I wouldn't want to go back to a centralized ministry approach. I don't think you'd find many people who would.

Ms. Elizabeth Carlton: The accountability builds, also, on the planning. The LHINs' role is to fund, integrate and plan, so the planning is done locally, which intuitively makes sense, and then the accountability flows from that: Who is going to do what? One of the features of the accountability agreements that hospitals sign with LHINs is that they can be far more customized than, say, the ones that used to be executed with the ministry.

M^me^ France Gélinas: Is this also true in northern Ontario, where the regional office in northern Ontario used to be pretty approachable?

Ms. Andrée Robichaud: I have not worked under a regional office. I've only been there three and a half years so I've only worked under the LHIN. I was in another jurisdiction prior to that so I can't compare.

M^me^ France Gélinas: In Ontario or outside of—

Ms. Andrée Robichaud: No, I was in New Brunswick.

M^me^ France Gélinas: In New Brunswick? Okay.

So let's take something that's coming: We all know that hospitals do about 600,000 colonoscopies a year; 200,000 of them are going to be moving to the community. None of this came from local planning. The LHINs never came and said, "I think we should move," so how do you balance that?

Mr. Anthony Dale: How do you—I'm sorry?

M^me^ France Gélinas: How do you balance that? You're saying that the strength of the LHIN is because they integrate planning, funding, and have the accountability agreement with you that brings you the certainty that you like, but then we still have governments that come down and say, "You shall divest yourself of 200,000"—

Mr. Anthony Dale: That's one of our main themes in our presentation, which is dealing with what we call "authority grey zones," using language out of the KPMG report and the Drummond report. There are areas where the province, through the ministry and the LHINs, has an interest mutually, but it's not yet clear how they intersect. There are many examples where there is probably a need for an overarching policy framework or parameters for decision-making to guide individual LHIN decisions. So we would agree with you.

M^me^ France Gélinas: So you see this as a clarification. Would you see that the LHINs will have the final say as to, "Do we do this within our geographical area or don't we"? Is this what you're telling me?

Mr. Anthony Dale: I think it's an excellent question. I don't know the answer to it—if they do today or not.

M^me^ France Gélinas: Okay. No, I'm telling you: Would you want them to, given that, to me, you have all to lose—

Mr. Anthony Dale: All to lose?

M^me^ France Gélinas: Yes. What have you got to gain in moving colonoscopies outside your hospital and into the community?

Mr. Anthony Dale: Do you think the system has any potential benefit from that, if it's going to, say, a not-for-profit or—there's all the independent quality oversight from the CPSO and other regulators.

M^me^ France Gélinas: Are there things to gain in the community? Yes, absolutely. But I'm asking you—you're there representing hospitals. You've identified this as a grey area, so I'm asking you: From the hospital association's point of view, how would you like this grey area clarified?

Mr. Anthony Dale: The government has put out a policy framework document, which is a start, which addresses some of the risks that we had originally identified when the proposal was first put out there.

One of the things the government has done to address that risk is give the hospital the approval over a particular divestment in any given community. So it's embedded within the decision-making framework over any contemplated divestment. Cataracts, I know, are open for discussion today, and it's our understanding that if there's a proposal to move a basket of those services out of the hospital, the hospital has to agree to do it. That's a safeguard that we recommended to the ministry, and they accepted.

M^me^ France Gélinas: Okay, but you haven't clarified the grey area. Where would you like one authority to end and the other one to start?

Mr. Anthony Dale: That's why I don't know the specific answer to the question you're asking today. We'd be happy to work on it and get back to you, but I think we're saying in some ways the same thing. There are multiple examples of areas where we have more work to do to understand and sharpen roles and responsibilities. It's just that we're not expert enough in the specialty clinics divestment proposal to answer the question precisely for you today.

M^me^ France Gélinas: Do you see, then, a role for hospitals to have full authority on certain things that affect their hospital?

Mr. Anthony Dale: Full authority?

M^me^ France Gélinas: Could we end up in a situation like that?

Mr. Anthony Dale: Could you be more precise with your question?

M^me^ France Gélinas: Yes. Once you have a grey area, it's an area where we don't know if it should be ministry, if it should be LHINs or if it should be a coordination where one ends and the other one starts. I'm asking you: Could you see a role where it would become all ministry?

Ms. Elizabeth Carlton: There are some roles now that are purely ministry: policy-setting standards and setting all the rest of it, and there are some roles that are uniquely LHINs. I think what we're hearing from our members is there is a bit of a grey zone, and that's what's been identified by Drummond and others.

It's a bit unclear who's on first: What is the appropriate level of government to go to? I think that's just what we're getting at. When the legislation was introduced we had no experience to go on and so it tried to kind of set boundaries. What we're hearing and you're hearing from us is that maybe it's time to revisit that and say, with sharper focus, "Here are some areas that really should be ministry clearly and here are some areas that are clearly LHIN authority."

M^me^ France Gélinas: And none of that work has been done?

Mr. Anthony Dale: Some, in different policy areas. We cited the future of health system funding reform as a great example of an area where we need to do a lot more work in understanding the policy framework for future decisions, especially regarding access.

M^me^ France Gélinas: Okay. Any other, or—

Mr. Anthony Dale: That should do.

M^me^ France Gélinas: Okay. What is the way to bring those discussions forward? What is the preferred way to clarify the grey area?

Mr. Anthony Dale: In our material, we talk about taking a methodical and deliberate approach to understanding where the opportunities and the risks are in that decision-making space. From our point of view, health system funding reform is an area where we do need to work with the ministry and the LHINs on the policy parameters for decision-making, and the ministry is very open to that. We work with them very closely every day. We've been concentrating in the last three years on strengthening the technical underpinnings of the formula behind funding reform. We have more work to do, but now we're turning our eyes to the policy considerations.

1520

Ms. Elizabeth Carlton: This way, maybe, through what you've heard in these hearings, you may have some ideas to put forward as well. But certainly, as we said, the ministry and the LHINs initially tried to come up with sort of a compact of who's going to do what, and maybe it's time that they revisit it and reach out to stakeholders and see where the areas are where there needs to be a clear delineation. One example we hear is that there's policies that come down, but one LHIN might sort of apply them differently. There's always an opportunity for interpretation of a policy. It's that sort of thing that our members raise as questions, beyond the obvious gaps, perhaps, in roles. But I think there is scope and it's an opportune time to perhaps have a close look at it.

M^me^ France Gélinas: I would say, if you've done any work or invested any brainpower into this area, send it our way.

Ms. Elizabeth Carlton: Yes.

Mr. Anthony Dale: Sure.

M^me^ France Gélinas: This is certainly a huge part of what we're doing here as to: Will the LHINs stay the same, will their power be extended or shrunk, and how will the grey area be clarified? A lot of people that have come from the community support sector have been very consistent in what they want. We've heard very little from hospitals, to the point where it was worrisome.

So my next question is: We did travel to nine different communities. Every single one of those communities, except one, Vankleek something—

Ms. Helena Jaczek: Vankleek Hill.

M^me^ France Gélinas: Vankleek Hill—had a hospital. None of the hospitals participated. Any tidbits as to why that is?

Mr. Anthony Dale: Well, I think this review was supposed to happen in 2010-11. Then there was a legislative change to move it to some out-years, and then that date came and went. I guess about two years passed between that deadline and your first meetings in December. So the sector had assumed, frankly, that this review would never happen. Your hearings have happened very, very quickly, and I know why that's the case—you've got business to conduct—but when hospitals have to prepare for a submission before a legislative hearing, it's time-consuming. They're very conscientious. They want to make sure that they're representing themselves appropriately. The hearings were very quick, so that's probably why you experienced what you did.

Ms. Elizabeth Carlton: And also knowing that we would be making a submission, as we typically do. All of the LHINs were represented in our working group, so everyone had an opportunity to feed into this process.

M^me^ France Gélinas: I can tell you, it was surprising and disappointing that the hospital sector did not participate. It is a huge sector money-wise, people-wise, resource-wise, in every way you want to look at it, and you are it. You are the voice that will talk to us about how regionalization has affected your sector.

Go ahead.

Ms. Cindy Forster: Niagara. Niagara participated.

M^me^ France Gélinas: Oh, yes. True.

Ms. Helena Jaczek: And North Bay Regional Health Centre.

M^me^ France Gélinas: They came to Sudbury?

Interjection: Yes.

M^me^ France Gélinas: I was there.

Mr. Anthony Dale: I'm sorry you feel that way, but all I can do is say that the review was really supposed to take place four years ago. Then there was a legislative change, and then that came and went. Two years passed. If you were us, what would you assume?

M^me^ France Gélinas: Okay. I don't know if you've been following the review at all—

Mr. Anthony Dale: Yes.

M^me^ France Gélinas: —and heard some of what the presenters had to say. Are there scenarios that really would not be acceptable to OHA?

Mr. Anthony Dale: Meaning what?

M^me^ France Gélinas: Meaning some of the ideas that have been put forward by—

Mr. Anthony Dale: You mean structural change?

M^me^ France Gélinas: Yes.

Mr. Anthony Dale: I think on structural change, we'd say this: You'd probably never design the health care system to look the way it does today if you could start from a blank sheet of paper from scratch. But there's two ways to look at things: the theoretical and then the practical. What we are very concerned about is disruption in health system planning and decision-making at a pivotal juncture in the province's health care system transformation and the lead-up to the balanced-budget target.

Our major message, before you got here, was all about health system capacity planning and capacity building. You will know from our discussions one-on-one that our overarching concern is building capacity in the community and long-term care in particular in the lead-up to that balanced-budget target, because as you get close to 2017-18 and the compression on hospitals and even the rest of the system, you know how highly interdependent it is. We know from experience that in 2006, when the long-term-care construction ended, within a 60- to 90-day window, hospitals at the tertiary level in particular started saying to us, "Why are we being inundated with ALC patients? We don't understand what's going on." It was a simple connection to long-term care.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes all the time. I'm sure that the best part was yet to come, but we must move on.

To the government: Mr. Colle.

Mr. Mike Colle: The best is yet to come.

It's interesting. I think it's sort of a typical comment I get. I talked to a gentleman who had a quadruple bypass at the local hospital. He was in my office, and I said, "Didn't you get great service and doctors and so forth?" He said, "Yes, fantastic doctors, a fantastic hospital." And I said, "And that's covered by the public health care system." He said, "Yes, fantastic. But that darn parking fee I had to pay—$40. I had to pay $40. You've got to do something about the $40." I said, "Okay. I get it."

But just getting back to our purpose here: It's to try to look at the legislation as it pertains to LHINs and see how we can improve it and make recommendations to improve it so that the Ontario Hospital Association and all your partners will be able to basically provide better, more efficient and more effective health care and just to get rid of some of the obstacles or encumbrances.

I guess it comes down to: What would be one area, one thing—I know it's too simple to say "one thing"—where we might be able, as a committee, to make some recommendations to make all the 440 hospitals across Ontario—

Mr. Anthony Dale: A hundred and forty-nine.

Mr. Mike Colle: How many?

Mr. Anthony Dale: One hundred and forty-nine, with 225 sites.

Mr. Mike Colle: I don't know where I got the number 440. But anyway, so how—

Interjection.

Mr. Mike Colle: Yes, municipalities. Excuse me.

What should we recommend and look at recommending that might seem fruitful for improved delivery of services in our hospitals especially?

Mr. Anthony Dale: I think I would go back to the core theme of our presentation, which is that the ministry and LHINs, along with their providers, create a very deliberate, evidence- and population-based approach to planning for future health system capacity building and that we get on with building it. How many community services, how many extra thousands of hours do we need in York community and in others? How many new long-term-care beds do we need, not just next year but five years and 10 years from now? Because again, as you move toward that balanced-budget target, which all three political parties acknowledge is absolutely necessary—we're talking about quite significant compression on the system—let's make sure that we're building the pressure valves that can take the patients out of hospital as they're being discharged in a very timely manner, get them to the right place where they get the right level and quality of care that they deserve, and we don't readmit them to hospital and go through the whole cycle over again, where the patient isn't getting the kind of care that they frankly deserve. That's what capacity planning and capacity building is all about.

Mr. Mike Colle: So therefore we should enrich, enhance, the LHINs' capacity planning enhancement function—

Mr. Anthony Dale: We need to arm the LHINs with evidence and data and information that is going to guide strategic decision-making into the future about what they need.

Mr. Mike Colle: Better arm the LHINs?

Mr. Anthony Dale: Better arm the LHINs, with the help of the ministry, with evidence, data and hard information about precisely what's needed in northwest Ontario: How many extra thousands of home care hours? How many extra long-term-care beds? How many new assisted living spaces are needed, and primary care access in terms of hours of coverage? You can predict this with a reasonable degree of precision, and that's what we're saying we need to do. Right now, what we do is, we have decisions made on a kind of annual basis, or an incremental basis, maybe two years out. We need to get out of that habit and we need to start thinking about the long term.

1530

Mr. Mike Colle: So the LHINs should be somehow—again, what we're looking at is structural change here,

because legislative change is structural change. So something that we could recommend that the LHINs—an added function within the LHINs or an added emphasis within the LHINs that would enable them to basically do almost an ongoing analysis of the data that not only analyzes present data but future projections, and that would be a more comprehensive, more robust part of the LHIN function. As a layperson, I'm trying to express it as best I can.

Ms. Andrée Robichaud: I think it's hit and miss right now for northwestern Ontario. We had a huge issue around ALCs, and your government announced $14 million to help our community, but our LHIN had done the work. Our LHIN had projections on ALCs. My hospital was—I have 375 beds, and at one point in time I had 81 ALC patients within my beds. So it was really affecting—we had to cancel surgery.

But given the data and the information, we, with the LHIN, could speak to the government and say, "Look, here's the reality of the situation." I think what we're saying is that we have to do that consistently. If you're going to really look at the capacity of your health care system, it has to be done consistently throughout the 14 LHINs with a view of, "Here's where we're going. This is what we're going to need in the future." Because otherwise, you're always reacting like we did in northwestern Ontario.

Mr. Anthony Dale: There's probably a straight line in your constituency offices between complaints and concerns that you hear—rightfully so—from patients and clients about, "I can't get enough home-care hours for my mom; I can't get my grandparents into a long-term-care facility." There's probably a direct line between that gap and the need for the system to forecast and make deliberate decisions about how many more long-term-care beds you're going to need in your community to prevent that from ever happening again to another patient. We're trying to connect it to the person, but that's what we're saying.

Mr. Mike Colle: But in part, what I hear from Andrée is that the LHIN may have that capacity—

Ms. Andrée Robichaud: But it's not consistent. Some plan on certain things, and others plan—as a healthcare system, as a government, you need to know what exactly is coming in the next 10 years: What do I need to be able to fund and what are my needs? So you really need to have the system view versus—

Mr. Mike Colle: The system what?

Ms. Andrée Robichaud: The system view of what's coming in the next 10 years and what are my needs, in order to be able to allocate the funds that you have in an efficient manner.

Mr. Mike Colle: Unless you put in a framework or a legislative parameter—because it appears it isn't there in a robust, comprehensive fashion. Therefore, you're saying we have to somehow find a way in our recommendations, in terms of this legislation—that we find a mechanism that enables this type of analysis to happen regularly, routinely, and that there's almost a direct connection with this routine analysis and the Ministry of Health.

Mr. Anthony Dale: Yes. And you wouldn't necessarily need a legislative change to do that, but yes.

Mr. Mike Colle: That's where we can do something, though. That's why I'm trying to find out how we could maybe help achieve that through our recommendations. But we could put that forward in a recommendation—

Mr. Anthony Dale: The terms of reference for this review are very broad. They're not restricted just to the language of the Local Health System Integration Act. So I think, personally, you've got the latitude to comment on that.

Mr. Mike Colle: We have latitude to comment, but I think it might be more effective to have some very, very focused proposals that might get attention. That's why I look for your guidance on that, because you're in the front lines on this.

The other thing that comes to mind is, I think, Mr. Dale, you mentioned the hospital restructuring commission that we went through back in the 1990s. I lost two hospitals basically overnight; they have not been replaced. They are finally building—12 years later, we're getting the Humber River Regional built. It took 12 years to fill a gap.

What I'm trying to bring to mind is that you've got the LHINs; you've got the Ministry of Health. There seems still to be some kind of disconnect, and it's not, I think, the fault of the hospitals. We were just at an event last night about cancer care at Scarborough Centenary and the Rouge Valley Health System and an amazing staff there that deals with cancer patients, oncology, on a regular basis. But it just reminds us of the fact that sometimes there is a lack of buy-in by the public because the system is very complex, and you're usually interfacing with the system at a time of trauma. We have the LHINs, and most people don't even understand what they do unless you're inside the business. Then you've got the Ontario Hospital Association. You've got the hospitals that are working 24/7 keeping people alive, and you've got the hospital boards etc.

Is there anything that we might be able to look at creating that would almost bridge that gap, that would give ordinary people an opportunity to understand this very, very complex system that is very technical, very scientific, sometimes very distant? I think that's one way that you might sort of—you're never going to get rid of everybody's anxiety, but I'm saying in terms of just making people understand that this work is going on, that you are being taken care of by this future planning, and it's for your good. Other people, when they see change or they say, "Well, I want something today, but tomorrow I'm not worried about," and meanwhile you're looking at future projections. Right?

But there isn't anybody out there to try and explain how this is to their benefit. Everybody says, "I want my health care. I want my doctor. I want that operation. I want that home care." They want it. Is there a possibility of some kind of blended focus point where people could

somehow connect, not on a daily basis, but just something that's out there that connects the LHINs to the hospital association, to the Ministry of Health? Because everybody is obviously working to the limit. Whether it's PSWs, doctors or nurses, community health centres, I can't remember a time when it wasn't busy in these places. There was never such a thing. So is there any mechanism that we might be able to explore?

Mr. Anthony Dale: I think that's the very purpose behind the government's health links proposal, which is now growing to some 70-plus individual projects. Just to describe them for a second, what we're doing is we're thinking about the people in any local community who have the most intense needs, typically frail elderly, chronic conditions, perhaps there are some mental health concerns as well, and through the health links initiative that the ministry is sponsoring, we're trying to treat every single one of those patients—we know them by name; we know who they are—and design the services around each and every individual need. That's what a health link is, in principle, supposed to do.

You're then getting the providers trying to concentrate on—instead of 10,000 people across their whole community, they're focusing in on, say, 80 or 100, the people who they know are bound to come back to their emergency room because they can't get the primary care that they should or the community services. We're trying to design an entirely new way of caring for those people as individuals at that local level. When I listened to what you were saying, I think that's the germination of the government's very own health links proposal.

In response to something else that you said, for us it means building on the action plan, which I think is a comprehensive and clear and well-articulated short- to medium-term plan for the transformation of the system. But what we want to do is build on top of that and go even further out and pick some very clear and specific objectives that the provider community—

The Chair (Mr. Ernie Hardeman): We'll have to go further out on the next round.

Mr. Mike Colle: Okay.

Mr. Anthony Dale: Sure.

The Chair (Mr. Ernie Hardeman): To the official opposition.

1540

Mrs. Jane McKenna: Thank you so much. Do you go by Anthony?

Mr. Anthony Dale: Yes.

Mrs. Jane McKenna: Sorry; I wasn't here at the beginning. Hi, Anthony. Hi, everybody.

I haven't had time to read totally through this and I do apologize, as well, because I like to sit from beginning to end so that I have proper questions to ask. But I am grateful for you being here because, in the end, we ultimately have been sitting through all this. I know that you made a comment to Ms. Gélinas that all of a sudden, after—it was supposed to be reviewed, I think, at five years, and all of a sudden you just got this, and so it was hard to get all that information together. We're very grateful. It is time-consuming to put a proper presentation together.

I guess I want to run through a few things. One consistent thing that we've heard said over and over again is that the LHINs, maybe by no fault of their own—or fault of their own—are very much stuck in their own silos. Communicating, from one to the next LHIN when you had a great idea—clearly, one size doesn't fit all and they've got different issues in each place. Would you say that's a pretty fair statement, that they're not communicating one to the next?

Mr. Anthony Dale: I wouldn't say that's entirely fair, no. I think over the years, in our experience with LHINs—you have to keep in mind that they were created from scratch and they've grown and developed over the years. We've seen lots of evidence of them communicating well with each other or engaging well together with, say, the hospital community. Before you got here, I cited that a major partnership that we have with them relates to designing the planning and accountability framework for hospitals and the annual cycle of accountability.

Where I think we run into some grey zones is when we start dealing with what are, in effect, very powerful strategic decisions at a local level that may not be being made based on the same considerations and policy framework in another part of the province. That always makes people ask questions.

What we do think needs to be done is to make sure that we're looking very carefully at any kind of very important grey zones where we need to think ahead and decide if some policy is needed. The future of health system funding reform is a very good example. In the next 10 years, you will see a total transformation in the way that hospital services are delivered in this province, all designed around improving quality and making the system even more efficient. That means, probably, changes in the places and the ways in which services are delivered to people.

Let's think ahead and say, "Okay, are there policy considerations? Are there things that we should think about before anybody goes into making a decision?" Maybe it relates to access and how far somebody has to travel or drive to get this kind of care before we say, "Aha! Yes, let's go ahead."

We've seen historical examples of that using emergency departments and obstetrics—those are typically the ones that people are most familiar with—but in the future I think we need to make sure we're looking at the host of hospital-based services and understanding those policy considerations.

Mrs. Jane McKenna: Thank you. We had Dr. Wooder here last week, and he was saying that there were some LHINs that were very successful; clearly, some that were not. Why do you think that is? If you're all running—I guess I'll jump in here, because that's kind of an open-ended question.

Mr. Anthony Dale: Why don't you go ahead and answer it?

Mrs. Jane McKenna: I'm not going to answer it. The number one theme that we've heard over and over

again—and anybody else can say if they've maybe heard it differently than myself on this committee—is the understanding of everybody's job description. You brought this up; I haven't gone through this completely, but clearly that seems to be an issue here. Would that not have a huge barrier on how successful you are if you don't really understand your job description and what that is?

Mr. Anthony Dale: It's certainly a hindrance, but I guess I would just put a little asterisk beside what you're saying in that this is a really, really complicated area and it's not always going to be easy to draw a neat and tidy box around everybody's role and responsibility either. There is a lot of integrated responsibility between the LHINs and the ministry, just out of the subject matter they deal with.

What are the areas where there's a strategic provincial interest? That actually exists in the legislation today. It's quite clear that where there are areas of clear strategic provincial interest, the ministry and government retains the right to involve itself. I think that understanding those areas and future access to services because of, say, funding reform, is a very good example of the kind of thing that we need to work on further together—the providers, LHINs and the ministry.

Mrs. Jane McKenna: Yes. I guess the most important thing is that the success of how you're doing is measured by the success of the patient, right?

Mr. Anthony Dale: Yes.

Mrs. Jane McKenna: That's the bottom line, following that person from beginning to end. And I see here, on the second page, that you have done numerous—I think you have a committee here with all the CEOs for the 14 LHINs, the hospitals. When you got all that information together, clearly that's what came out with your recommendations in the end, but that's an ongoing process, right? The thing that I think I struggle with most is that the LHINs have been functioning for eight years, and yet we still have to keep going further, because clearly there are major issues, right?

I recognize the fact, so by no means am I saying I don't understand it is very complex, but so are MPPs' roles, and we couldn't say to you today, "Well, that's really not my job description. I really don't know what it is." You just jump in with two feet and you've got to do it and that's the end of it, right? There's no saying, "Well, it's complex. I really don't understand. There's jobs, bureaucrats, silos." We've heard those kinds of statements numerous times over and over again. Do you think there's fairness in saying that, and that there's duplication and people are just very confused on what their actual roles are?

Ms. Andrée Robichaud: MPPs have existed for many, many years, and when you make governance changes in a health care system—I used to be a deputy minister in another jurisdiction. When you develop a piece of legislation, you have all kinds of intents for it, but it really does surprise you as it evolves, because it doesn't really happen like you thought it would.

Mrs. Jane McKenna: Yes.

Ms. Andrée Robichaud: You guys know that more than I do. The LHIN is in evolution, and I think that you as a group have an opportunity to say, "Okay, here's where we need to tweak it to make it more where we wanted it to go initially. Maybe it's better that that now is done at the provincial level and this is done at the local level." You have a wonderful opportunity here to help in clarifying those roles and moving us to another level, because it had to be evaluated. I think people recognize that when you put in a new piece of legislation, you need to evaluate it, because it's not going to grow up to be what you thought it was going to be.

We're now at the stage here saying, "Here's what we think are some of the tweaks in the document that we're putting forward," and I'm sure you've heard a lot of other pieces where people have a different view of things. I think if you put that altogether, you'll probably help us move it in the right direction.

Mr. Anthony Dale: Absolutely.

Ms. Elizabeth Carlton: I can just briefly add that one of the things that was—you know, hindsight is 20/20, but when you look at when the legislation was brought in, none of the things we take for granted now, in terms of the health system transformation, were in play, right? So even when we look at this, some of the murky areas for our members is the funding: "Who's on first? Who do we go to?" But the whole funding reform hadn't happened at that time. There was no Health Quality Ontario at the time; no Excellent Care for All Act. None of these things were in play. In terms of primary care, some of the changes there hadn't taken place.

So it is, in a sense, a very opportune time to take stock and say: Given where the system is now, does this roster of competencies and functions still make sense? Do we need to give it greater clarity, given where we are? I could certainly see there being some ambiguity about, "Oh, is this my role? Is it the ministry's? Is it public health's? Who is it?" So it is time to kind of take stock.

Mrs. Jane McKenna: Really, when you say, "Whose role is it?" I just find it odd that someone would even be asking that question. I mean, MPPs have been around for a long time, but I've only been in it for two and a half years. So it's, "Here you go, here's your office, see you later, figure it out," kind of thing.

I find it odd when we have people come in and sit here and say, though, that the clarity—clearly it is, because if you've read any of the Hansards we've had in here, it is the clarity and the definition of what each role is doing, the duplication, the silos. It's been repetitive over and over again. I personally find it odd that you would need clarity on who's doing what. Clearly you do, but—

Ms. Elizabeth Carlton: Well, if we just work through the funding examples, maybe, in the past it was global funding in the ministry, and then it might have just flowed to the LHIN and they would allocate, but now—maybe Anthony or Andrée want to speak to how that's changed dramatically—the ministry has a significant role in terms of allocation of funding. So it's not crystal clear the way it might have been intended here.

1550

Ms. Andrée Robichaud: The way I would see the confusion is: When do you need a provincial standard and when do you need local input? Sometimes that's contradictory in certain areas; all right? I think that Member Gélinas talked about devolving certain things to the community. In certain areas, devolving certain procedures to the community will be an opportunity for them to do other work, because they're racked up in the queue; there is more work to be done. In other areas, that's probably their livelihood. Therefore, you need that local input, but you also need those provincial standards. I think that's where the confusion starts. If you don't really have a good collaborative relationship, that gets tense. I think that's what you heard.

I've been here three and a half years, and every time I see that happen it's because you have the ministry that's trying to do their role and set that provincial standard, because every Ontarian should have the same standard of care everywhere they live, but when you look at the local reality, it becomes very complex. I think that's where it becomes very tense.

Now that you have almost a decade of experience, we can go back and say, "Here are some of the areas"—and you can say to the ministry and the LHIN, "Go back and look at where your problem areas were," and in retrospect, look at that and say, "How do we handle that better, and how can we put the mechanisms to ensure that?"

Mrs. Jane McKenna: That's great. Thank you so much. It is going to be a process. That's what we're here for, is to make things better and find the recommendations to obviously do that. I can speak as one MPP—I won't speak for anybody else here, but it is—

Mr. Mike Colle: You can speak for me too.

Mrs. Jane McKenna: Okay, thanks, Mike. I'm going to speak for Mr. Colle.

It is very much a fragmented system; right? When you're in it as an MPP, and the people who are coming—you think, "My gosh, I'm struggling trying to get through this; how the heck is the actual layperson who is out there trying to do this because I'm struggling?"

As much as we have all those tools in our hands, it can't be this difficult if we're trying to be patient-centred. If the success of measuring where we're going is measured by the success of the patient, then we clearly have to make recommendations to make things better and clarify what is the best route for all of this.

Mr. Anthony Dale: You're right. I guess what we would add is that sometimes structure isn't the solution you think it is. If structure was the solution that you think it is, then by all reports, Alberta would have the country's highest-performing health care system because they've centralized everything. So by centralizing everything you would easily assume, "Of course things are going to get better," because you've got one scope of authority and one set of decision-making levers and it will all fall into place. I think the reality they experience in Alberta is dramatically different.

What is most important to us is the patient experience. The individual patient and client is on a journey through the system at probably the most difficult time in their life, and how does the system better concentrate its time, energies, focus, and care around them as a person? There is so much work going on to try and accomplish that, it's just that structure isn't always the answer that everyone thinks it is.

Mrs. Jane McKenna: I respect that.

My colleague is going to take a turn. Thank you.

Ms. Lisa M. Thompson: Quickly, I was intrigued by the fact that you brought up BC as possibly a model to follow or not to follow. In my riding, I have a hospital CEO who came from that system, and I'm just wondering: Are there best practices that we should be thinking about when you talk of community governance, married with what we have today?

Mr. Anthony Dale: There is no community governance in BC. There's a regional health authority with a board that's appointed by the provincial government. What BC does have is—my reference earlier was about policy around access standards. So when they look at things like emergency departments—just because it's a clear example to use—they literally have a policy that guides decision-making that says that 97.5% or 98% of a population within this geographic area should be able to access an emergency department within one hour—

Ms. Elizabeth Carlton: Thirty minutes.

Mr. Anthony Dale: I believe it is one hour; the 30 minutes and then the 30 minutes golden rule. That's what guides their decisions on service location and service change. That's the kind of best practice that, yes, Ontario, should look for. We made that submission to the rural and northern panel that Hal Fjeldsted chaired, actually, because it touched on issues that were related to the Niagara Peninsula at the time.

Ms. Lisa M. Thompson: Okay. Thank you for clarifying.

Mr. Anthony Dale: Not at all. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time of all three parties. Thank you very much for being here today. We very much appreciate you taking the time and preparing. I apologize for having to cut some of the answers short.

Mr. Anthony Dale: Not at all, Mr. Chair.

The Chair (Mr. Ernie Hardeman): As you can see by the look on my face, I'm very sorry.

Thank you all. That concludes the hearings, the delegations, that we have today.

SUBCOMMITTEE REPORT

The Chair (Mr. Ernie Hardeman): You will notice on the agenda that our next item is committee business. We have a programming motion, as was requested by the committee—I think it was at our previous meeting or two meetings ago—where they wanted a programming motion for those items that were on the committee's agenda

at the time. We have that programming motion from the subcommittee.

Ms. Forster, you have the report from the subcommittee.

Ms. Cindy Forster: Thank you, Chair. Your subcommittee met on Tuesday, March 25, 2014, to consider the method of proceeding on Bill 135, An Act to protect pupils with asthma, and all the other bills referred to the committee as of March 25, 2014, and recommends the following:

On Bill 135, An Act to protect pupils with asthma:

(1) That the committee meet in Toronto on Tuesday, April 8, 2014, for the purpose of holding public hearings.

(2) That the committee Clerk post information regarding the hearings on the Ontario parliamentary channel, the Legislative Assembly website and Canada NewsWire.

(3) That the deadline for requests to appear be 4 p.m. on Friday, April 4, 2014.

(4) That witnesses be scheduled on a first-come, first-served basis.

(5) That witnesses be offered 10 minutes for their presentation followed by 10 minutes of questions divided equally among the three caucuses, for a total of 20 minutes.

(6) That the deadline for written submissions be 4 p.m. on Wednesday, April 9, 2014.

(7) That the committee meet for clause-by-clause consideration on Tuesday, April 15, 2014.

(8) That the deadline to file amendments with the committee Clerk be 4 p.m. on Thursday, April 10, 2014.

On Bill 172, An Act to amend the Ministry of Training, Colleges and Universities Act to establish the Advisory Council on Work-Integrated Learning:

(9) That the committee meet in Toronto on Tuesday, April 29, 2014, for the purpose of holding public hearings.

(10) That the committee Clerk post information regarding the hearings on the Ontario parliamentary channel, the Legislative Assembly website and Canada NewsWire.

(11) That the deadline for requests to appear be 4 p.m. on Friday, April 25, 2014.

(12) That witnesses be scheduled on a first-come, first-served basis.

(13) That witnesses be offered 10 minutes for their presentation followed by 10 minutes of questions divided equally among the three caucuses, for a total of 20 minutes.

(14) That the deadline for written submissions be 4 p.m. on Wednesday, April 30, 2014.

(15) That the committee meet for clause-by-clause consideration on Tuesday, May 6, 2014.

(16) That the deadline to file amendments with the committee Clerk be 4 p.m. on Thursday, May 1, 2014.

On all the other bills:

(17) That the remaining bills referred to the committee be considered in the following order:

(1) Bill 104, An Act to provide protection for minors participating in amateur sports;

(2) Bill 137, An Act to amend the Public Transportation and Highway Improvement Act and the Highway Traffic Act to construct paved shoulders and permit bicycles to ride on them;

(3) Bill 142, An Act to proclaim Major William Halton Day;

(4) Bill 166, An Act to amend the City of Toronto Act, 2006 to allow the city of Toronto to pass a ranked ballot bylaw for city council elections; and

That the subcommittee meet at a future date to further consider the method of proceeding on the above-noted bills.

(18) That the committee Clerk, in consultation with the Chair, be authorized prior to the adoption of the subcommittee report to commence making any preliminary arrangements necessary to facilitate the committee's proceedings.

I move that the report of the subcommittee be adopted.

The Chair (Mr. Ernie Hardeman): Thank you very much. You've heard the motion. Discussion on the motion? Ms. Jaczek.

Ms. Helena Jaczek: Yes, Chair, I would like to propose an amendment to this motion, and I do have copies here for the Clerk. This programming motion relates to private members' public business. This is a situation where we're all equals here. It is not, I don't think, and should not be, a partisan issue. As I argued during the subcommittee meeting, I think it is only fair that private members' business, one from each party, be considered in the top three. My amendment will put Bill 166 second in the order, subsequent to Bill 135. So this does follow a chronological order. In other words, as you will see from the wording of the amended motion, we would go with Bill 135, Bill 166, Bill 172—so that's one from each caucus chronologically—and then the remaining four, I believe it is, chronologically after that.

1600

The Chair (Mr. Ernie Hardeman): Thank you very much. An amendment has been moved. The amendment now is up for debate. We can move to debate on the amendment to the original motion. When we get the amendments debated, we then go back to the motion as amended or as not amended—

Ms. Helena Jaczek: And I will be asking for a recorded vote.

The Chair (Mr. Ernie Hardeman): Okay. With that, you all have a copy of the amendment. Further debate on the amendment? Yes, Ms. Forster.

Ms. Cindy Forster: Can I move a subamendment?

The Chair (Mr. Ernie Hardeman): An amendment to the amendment?

Ms. Cindy Forster: An amendment to the amendment.

The Chair (Mr. Ernie Hardeman): Okay.

Ms. Cindy Forster: The amendment would be—I don't have it in writing, but we'll put it together—that Bill 166, An Act to amend the City of Toronto Act,

would follow Bill 172, which was the decision of the subcommittee, that Bill 135 be followed by Bill 172, and then chronological order. But I would move that Bill 166 be third in line.

The Chair (Mr. Ernie Hardeman): So just for clarification, your amendment would be, in number 17, we change number 1 and put number 4 above number 1.

Ms. Cindy Forster: That's correct, and then everything—

The Chair (Mr. Ernie Hardeman): And renumber it back down.

Ms. Cindy Forster: Everything else would move down.

Interjection.

The Chair (Mr. Ernie Hardeman): I'm just informed—to make sure we keep everything in priority, the amendment you're making is an amendment to the amendment, so we have to amend it and put 166 following 172. The amendment has Bill 166 as number 2, and your subamendment is to move it down and move 172 ahead of 166.

Ms. Cindy Forster: Under 17, 166 would be number 1 and then everything else would just move down.

The Chair (Mr. Ernie Hardeman): My challenge is that—

Mr. Mike Colle: Could we have this in writing? Because it's confusing—

The Chair (Mr. Ernie Hardeman): I'm just going to suggest that we can vote on this amendment, because what the present amendment to the amendment does is it amends the original motion. You can do that after we deal with the amendment that's before us now, rather than amending the amendment, because once we vote on the amendment, there's debate on the motion again and you can make that amendment then. Rather than trying to amend the amendment, you really want to go back to the original motion first.

Ms. Cindy Forster: Normally, you would debate the subamendment, and then if the subamendment passes, you would then debate the amended amendment.

Mr. Ernie Hardeman: If that's the case, then we have to get it printed, because then, as Mr. Colle says, it gets too complicated having people vote and debate it without actually seeing what we're debating. Because if you're going to amend the amendment, you have to take 166 out of the amendment and and put 172 back in the amendment to the amendment.

M^me^ France Gélinas: Just to be clear, all we do is we take the bold line that says "Bill 166," and we replace it by the bold line that says "Bill 172". That's all. Our subamendment wants to switch 172 for 166?

Ms. Cindy Forster: No, no.

Ms. Helena Jaczek: No. We want 166—

Ms. Cindy Forster: With dates.

Mr. Mike Colle: We need it in writing. This is confusing.

Ms. Cindy Forster: And that was going to be part of my amendment, if I ever get to it.

The Chair (Mr. Ernie Hardeman): I'm at the committee's mercy here. Do you want to amend the amendment, or do you want to deal with the amendment and then amend the original motion with a second amendment?

Ms. Cindy Forster: Well, Chair, should we take a break for five minutes, and we'll give you the amendment to the amendment?

The Chair (Mr. Ernie Hardeman): A break has been requested; a five-minute break.

The committee recessed from 1606 to 1611.

The Chair (Mr. Ernie Hardeman): Committee, come back to order. We're presently dealing with the amendment to the amendment. Ms. Forster?

Ms. Cindy Forster: I will withdraw the amendment to the amendment at this point.

The Chair (Mr. Ernie Hardeman): Okay then, the amendment to the amendment is withdrawn. We will be open for discussion on the amendment to the report. Yes, Mr. Colle?

Mr. Mike Colle: I'm speaking in favour of the amendment to the report. As you know, Mr. Chairman, when the subcommittee report came back and said that the chronological order would be 135, which deals with protecting pupils with asthma, then Bill 172, to amend the Ministry of Training, Colleges and University Act, and then it says "other bills," I don't think the subcommittee report—does it even mention 166?

Ms. Helena Jaczek: It's at the bottom of the list.

Mr. Mike Colle: Okay, yes. It was my understanding that—yes, it's with the other bills, if I'm not mistaken.

The Chair (Mr. Ernie Hardeman): They're all listed, yes.

Mr. Mike Colle: Because I thought in the discussion we had here that the agreement was that, as a committee, we would look at this in chronological order in terms of the way they were presented in the House. My understanding is, Bill 135 was there, then 166 was introduced and then 172. That's my understanding. Is that correct, Madam Clerk, in terms of the way they were—

The Chair (Mr. Ernie Hardeman): I think at the last meeting, there was much discussion as to what the committee should or shouldn't be doing. But I think the direction to the subcommittee was to bring back a report on how to deal with all the business that was on the agenda for the committee and to put it in an order of how the committee would then propose to deal with it for the committee to discuss. That is what this subcommittee report does, but it only actually itemizes the first two because circumstances could change and they will have to meet again to deal with the actual timing of hearing the other bills.

Mr. Mike Colle: But I just want to get the clarification in terms of the way they were introduced in the House; am I correct?

The Clerk of the Committee (Ms. Valerie Quioc Lim): Bill 166 was referred to the committee on March 6, 2014, and Bill 172 was referred to the committee on March 20, 2014.

Mr. Mike Colle: And Bill 172?

The Clerk of the Committee (Ms. Valerie Quioc Lim): March 20, 2014.

Mr. Bas Balkissoon: And 135?

The Clerk of the Committee (Ms. Valerie Quioc Lim): Bill 135 was referred to the committee on December 5, 2013.

Mr. Mike Colle: Let's get that straight again. So 135 was referred to the committee what date?

The Clerk of the Committee (Ms. Valerie Quioc Lim): Bill 135 was December 5, 2013.

Mr. Mike Colle: Okay, so that was first. Second, 172: When was that referred to the committee?

The Clerk of the Committee (Ms. Valerie Quioc Lim): Bill 172 was March 20, 2014.

Mr. Mike Colle: And 166?

The Clerk of the Committee (Ms. Valerie Quioc Lim): March 6, 2014.

Mr. Mike Colle: March 6. Yes. That was usually the way things were done, I think—a chronological reference to the committee. So all of a sudden, the subcommittee report, to my astonishment, has bumped 172 ahead of 166.

We had talked extensively about the urgency of 166. We have had many members of the community who were interested in 166, to amend the City of Toronto Act—they have been here at many of our meetings. We discussed 166 and the need to bring it forward, because all it is is enabling legislation that goes back to the city of Toronto for them to debate.

Yet all of a sudden, I find, to my astonishment, that the subcommittee report basically doesn't even put 166 in context and throws in 172. I just find that to be a real abuse of process. We usually go chronologically, and one from each party, which we agree to.

I find nothing wrong with 172 following 166, but to basically not even refer to a date for 166 in the subcommittee report, and then to push 172 ahead, when it was not to be before this committee until two or three weeks later, I think, is really astonishing. Where that came from, and the rationale behind this, is amazing to me.

The Chair (Mr. Ernie Hardeman): Further debate? Ms. Forster.

Ms. Cindy Forster: Thank you. I'd like to know, actually, when Bill 137 and Bill 142 were referred to committee.

The Clerk of the Committee (Ms. Valerie Quioc Lim): Bill 137 was referred to the committee on December 12.

Ms. Cindy Forster: And Bill 104?

The Clerk of the Committee (Ms. Valerie Quioc Lim): Bill 104: December 5.

Ms. Cindy Forster: And 142?

The Clerk of the Committee (Ms. Valerie Quioc Lim): Bill 142: February 20, 2014.

Ms. Cindy Forster: Mr. Colle's argument does not hold water, because there are other bills there that were certainly referred to this committee far sooner than Bill 166 and Bill 172.

I wasn't at the last subcommittee meeting. However, the information that I got from our member who was here was that all the parties agreed. If the Liberals say they didn't agree, I think everyone who is here today needs to know that they certainly didn't move forward Bill 166 at that meeting, to follow next.

We respect the subcommittee's decision, and we're willing to accommodate and support that Bill 166 follow Bill 172.

The Chair (Mr. Ernie Hardeman): Ms. Jaczek.

Ms. Helena Jaczek: I have to refute that totally. I was totally opposed to this particular subcommittee report. We voted on it in subcommittee. I moved 166 up. So your information is incorrect, Ms. Forster.

The Chair (Mr. Ernie Hardeman): Okay. Further discussion on the amendment?

Mr. Mike Colle: Yes.

The Chair (Mr. Ernie Hardeman): Yes, Mr. Colle.

Mr. Mike Colle: Again, we've had discussions about various bills. It's just strange for me, when there was so much public interest displayed in 166 going forward, and all the work that has been done by the city of Toronto and their council and the community. It's of great public interest. They have been here three or four times. I just think it's flabbergasting—whatever the word may be—to all of a sudden see this 172 pushed ahead of a public interest bill that is basically to be discussed so that the city of Toronto can deal with it. I just find it astonishing.

The key thing is that 166 was here before 172. You could have proposed another bill earlier, but you didn't. You put forth this 172 out of the blue.

We said at this committee—I remember—we said, "Bring forward Jerry Ouellette's bill, because it has been there a long time." No; what do I find? Out of the blue, the NDP put forward 172, and they pushed aside—again, as a sitting member of the city of Toronto—they don't come to us for many things, and many of us may not even agree totally with the bill. But we're saying that they have really done a lot of work; they had a lot of meetings and a lot of grassroots involvement. They have just come to Queen's Park on a rare occasion and said, "Just give us a hearing on this." Then all of a sudden, this manoeuvre that the NDP pulls in shoving 172 ahead of 166—it's beyond me, where this comes from.

The Chair (Mr. Ernie Hardeman): Further debate? I just want to caution: We just want to debate the amendment. Incidentally, Mr. Colle, your debate was on the motion, not on the amendment. We want to debate the amendment, which is the one that was put forward by—

Mr. Mike Colle: I'm speaking in favour of the amendment.

1620

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

Ms. Cindy Forster: Thank you, Chair. There's nothing in the rules that says that bills have to be moved in a chronological order, and in fact, that isn't the norm.

The norm is that the committee determines, each time they meet, how and what bills are going to be coming forward. In fact, there are bills from probably the very beginning of this session that have never had a hearing because the government has chosen not to bring them forward.

We support Bill 166, but we also support Bill 172. That is what the committee decided on last week. That's why we're here today, to get on with this, and so I suggest that we move forward.

The Chair (Mr. Ernie Hardeman): Any further debate? This is not an argument. Just state the—

Mr. Mike Colle: On the amendment: The committee did not agree with this. There was a dissension in the subcommittee because the committee, in our discussions, talked about the number of people who have come to this committee asking for 166 to be heard. That's all. Nobody came for 172. Is there anybody here for 172? I've never seen anybody, but people for 166 have been here repeatedly just to be put on the agenda.

You can talk about all the procedures, but generally speaking, this committee is trying to be fair to people who have expressed a democratic interest in discussing this bill and have been talking to MPPs. They've done a lot of work to get on the agenda the city of Toronto. They've come here just for a hearing on it, and then, as I said, if people had come here for 172, maybe we could have had this debate about 172 or 166, but I have never seen anybody ever call my office about 172.

I don't know, Ms. McKenna, if you have, but they've certainly come to my office and called me about 166. Ms. Forster, are they coming to you about 172? Not to mine. That's what I'm saying. Be fair to the people who, in their diligence and hard work, have brought this forward. I'm saying, give them a couple of days of hearings so this bill can be heard and get its due process. That's why I support the amendment by my colleague who voted against this trumped-up motion that basically omits 166 and puts in 172. We should amend it to put 166 as the second bill after 135.

The Chair (Mr. Ernie Hardeman): Okay. Further discussion? Ms. Forster.

Ms. Cindy Forster: One last, Chair. If we move forward with this motion right now and get it out of the way and get our vote done on it, I will move another amendment that will see this whole issue cleared up. Bill 166 would be up for hearings in May. They would have their public hearings. They would have their clause-by-clause and it'll all be done.

The Chair (Mr. Ernie Hardeman): Okay. We can't discuss what will happen after the vote, only before.

Ms. Cindy Forster: No, I know.

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

M^me^ France Gélinas: I very much want to thank the people who take the opportunity to be involved with what we do at Queen's Park. I represent a riding from northern Ontario. There are issues that are very important to a lot of people in northern Ontario. They just don't live in Toronto, they just cannot come here to be seen, but they are just as important as everybody else. I'm happy that you're engaged, that you live in Toronto and that you're able to come to Queen's Park. If you live in Shining Tree, you won't be here.

What we're talking about is a difference of two weeks.

The Chair (Mr. Ernie Hardeman): Okay. Anything new to add? Yes, Mr. Colle.

Mr. Mike Colle: Again, I think it's a bit condescending. The people in Toronto come from all parts of Toronto. Toronto's a big city. For people to come here—we rarely get this many people for any bill who come from Toronto. So they have shown this interest because at city hall in Toronto, representing 2.5 million people, this has been a bill of great discussion. So to sort of condescendingly say, "Well, you Toronto people can come any time you want. This may be important to you"—everything's important, but this is a rare occasion, when there's a lot of democratic fervour in the city of Toronto.

I don't know if you read the newspapers, but people are very upset at what's happening in terms of the way their council gets elected and the way their mayor gets elected. So these good people, and they represent—many of them have gone out of their way to fight the obstacles at the city of Toronto to look at this change that they're proposing. Then they came here to Queen's Park and were told, "Well, you people in Toronto can come here any time, so we're going to go on with 172"—which I've never heard of anybody advocating for—"and we're going to bump it ahead. You can come later in May," which means basically never. If you're going to do the right thing and listen to people who are here and express interest repeatedly, you've got to do the right thing and put 166 to be heard on April 29. Everything else is just a sham if you don't do that.

The Chair (Mr. Ernie Hardeman): Any further discussion on the bill? Or we'll put the question.

Ms. Cindy Forster: Bill 172—have we heard from people about it? Yes, we have, because it's a bill about youth employment. It's an important bill that affects youth across this province, who have the highest unemployment rates of any age group here in the province. This is a matter of a two-week delay from what the government is looking for; if we move forward, this will all be dealt with by the end of May. Once again, we totally support Bill 166 moving forward, following Bill 172.

The Chair (Mr. Ernie Hardeman): Further discussion?

Ms. Helena Jaczek: Recorded vote.

The Chair (Mr. Ernie Hardeman): A recorded vote has been requested.

Mr. Mike Colle: One last comment.

The Chair (Mr. Ernie Hardeman): Yes?

Mr. Mike Colle: All bills have importance, whether it's 172 or 135. All we're saying, in fairness, is that there's been no one here at this committee three or four times asking to be heard on 172. People have come here and told this committee, "Please give this some consideration." They have expressed this interest. Again, it

reflects a critical issue of representation in the city of Toronto. All they're asking is for a hearing on this.

Again, this thing about, "Well, you'll be heard down the road. We'll bump up 172," I think is really something that almost says to the people who've worked so hard on 166, "We'll deal with you later." But I say we should deal with this on April 29, give them a fair hearing and listen to the people of Toronto who have asked this committee to give them what is their due, because they were referred to this committee before 172 was.

The Chair (Mr. Ernie Hardeman): Okay—

Interjection.

The Chair (Mr. Ernie Hardeman): I hope this is going to add to the discussion, not just to banter back and forth.

Ms. Cindy Forster: I hope so too, Mr. Chair. We are not bumping up Bill 172. Bill 172 was a decision of the subcommittee, last week or the week before, whenever that happened; I think it was last week. In fact, we're ready to move forward here with this vote.

The Chair (Mr. Ernie Hardeman): Any further discussion? If not, a recorded vote has been requested.

Mrs. Jane McKenna: Chair?

The Chair (Mr. Ernie Hardeman): All those—

Ms. Lisa M. Thompson: Ernie?

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

Mrs. Jane McKenna: We'd like to ask for a recess for 20 minutes, please.

The Chair (Mr. Ernie Hardeman): A recess for 20 minutes has been requested.

The committee recessed from 1628 to 1646.

The Chair (Mr. Ernie Hardeman): I call the committee back to order. I have a fast watch.

The vote is on the amendment, and a recorded vote has been requested.

Ayes

Balkissoon, Colle, Dhillon, Jaczek.

Nays

Forster, Gélinas, McKenna, Thompson.

The Chair (Mr. Ernie Hardeman): And the Chair is opposed to the amendment, so the amendment is lost.

Mr. Mike Colle: Shame on the NDP.

The Chair (Mr. Ernie Hardeman): We have another amendment. Ms. Forster?

Ms. Cindy Forster: I move that Bill 166 follow Bill 172 and that public hearings be held on May 13, 2014, and clause-by-clause on May 27, 2014, and that the remainder, 1 to 8, under each of the bills be consistent with what the subcommittee has already agreed to, with the exception, of course, of the dates.

The Chair (Mr. Ernie Hardeman): You've heard the motion. Further debate?

Mr. Mike Colle: I would like the NDP to explain why they're blocking Bill 166, why you're so insistent on putting Bill 172, which came to this committee long after Bill 166 came—you've had members of the public here repeatedly asking for a hearing. You have refused to listen to them.

The ironic thing is this bill is about democratic process. It's about improving democracy in Canada's largest city. The NDP sits there and says, "We don't care what you say in the largest city in Ontario, because you can come here anytime to Queen's Park, so therefore you're not important."

I think you've got to maybe understand what's going on in the city of Toronto. There are a lot of people upset that they're not being heard and they're not being represented properly under the present structure. They're asking for the power to basically look at the structure and see if they can make it better so there's more representative democracy. That's what the people here who represent Bill 166 have asked for.

You may not have been here, but we went through the Mike Harris years when they brought in forced amalgamation; 76% of the people of this city said no to forced amalgamation. The people of Toronto spoke out loudly and clearly: 10,000 of us walked up Yonge Street to basically say that you can't impose forced amalgamation on us, because it takes away our right to decide the future of local democracy. Some 10,000 people were there.

We had a vote in Scarborough, in North York, in the city of Toronto, in Etobicoke, in the city of York and in East York. Ask your member from Beaches–East York what we went through to try to tell that arbitrary government that forced amalgamation was wrong and that it wouldn't work; it wouldn't save any money. And the people were right: With forced amalgamation, the cost of running the city of Toronto has risen and representative democracy has declined, because you've got 2.6 million people—

The Chair (Mr. Ernie Hardeman): If I could just stop you for a moment, the motion we're debating is moving Bill 172 down and Bill 166 forward. If we could stay with the debate on the motion we're debating.

Mr. Mike Colle: Mr. Chairman, 166 is a very significant bill. The tenor of the bill—the purpose of the bill—is improving democracy and representative government in Toronto. I'm putting the context of 166 to the democratic process that they're trying to enhance. It's not just numbers and moving 172 ahead of 166; it's about years of people in Toronto trying to basically make their huge government more representative.

They come here and say, "The Mike Harris government took away representative democracy. Now we want to try to fix it." So they come to Queen's Park, and we say, "We don't want to hear from you." You're going to be—the NDP leading the way to bump their attempt—

The Chair (Mr. Ernie Hardeman): I would point out again, Mr. Colle, that you're speaking to the full motion, not the amendment. The amendment is actually going in the direction you're saying it should be going, which is moving it up the ladder in the original motion.

Mr. Mike Colle: No, no, no. It's not. It's basically still keeping—172 bumps out 166. That is what I'm

speaking to. Bumping 166 is a very sensitive issue, especially in light of the fact that so many people have been here. You've seen them here, day after day, at your committee, Mr. Chairman. They've been—

Ms. Cindy Forster: Chair, he's not speaking to the amendment.

The Chair (Mr. Ernie Hardeman): That's what I'm trying to suggest. That debate may very well be the appropriate debate on the total motion, but this motion is repositioning in the direction you want to reposition it. You want to move it further up than it is.

Mr. Mike Colle: No, no, no. I'm moving it to where it should be. Bill 166 should be next. This motion basically blocks 166 with 172, and I think that's wrong.

The Chair (Mr. Ernie Hardeman): Then my suggestion is that when the motion comes to a vote, you vote against the motion. The motion we're debating is whether we should do this or not do this into the main motion. You can debate the main motion with what you're suggesting now.

Mr. Mike Colle: But I'm also debating this amendment. I think that what it does is block 166 from proceeding by bringing forward this other bill, 172, which I think is a flagrant attempt to block 166 for whatever reasons the NDP have; I don't know. It just blows my mind why they would block a bill that basically discusses improved democratic representation in the city of Toronto.

We as a committee have seen them come here and say, "Please hear us," and we say, "No, we have no time for you, because we've got other more important things," and all of a sudden the NDP pull out 172 and push it aside. I think that pushing aside 166 is significant, because 166, as I said, is not a number. It represents the hours and hours of volunteer, grassroots democracy that's been in play in Toronto for the last couple of years, where people have tried to basically make the system better.

They're not asking you to change the law. They're basically saying, "Give the city of Toronto the right to do this and debate it." It's not even something we're enabling; we're just giving them the power to make the decision. Under the City of Toronto Act, they're supposed to have more power. This basically neuters them again, because we're saying, "We won't even let you discuss it."

It's quite galling for the NDP to tell the people of Toronto, "You can't even discuss Bill 166." That's what you're doing here, and you know that what you're doing—

The Chair (Mr. Ernie Hardeman): Mr. Colle, I would call you to order. The motion that we are debating is, as it says: "I move that Bill 166 follow Bill 172 and that the public hearings be held on May 13 and clause-by-clause on May 27, 2014." That's the issue. And that moves it from number 4 to number 1 in the list of items. That's what changed in the original motion. Your discussion—

Mr. Mike Colle: No, no. Excuse me, Mr. Chair, but it doesn't move it. Number 1 is 135, number 2 is the NDP's 172—

The Chair (Mr. Ernie Hardeman): I'm suggesting that's—

Mr. Mike Colle: It's number 3, which may never see the light of day.

The Chair (Mr. Ernie Hardeman): Mr. Colle, I would point out that that's in the main motion. In the amendment, it is strictly moving it up in the order.

Mr. Mike Colle: Yes, but it still moves it to number 3.

The Chair (Mr. Ernie Hardeman): Yes, but you haven't got an amendment to move it anywhere else. This is an amendment doing what you were asking to do. So I'll just say, your debate—

Mr. Mike Colle: No, I'm asking to move it to number 2. Remember, we lost that—

The Chair (Mr. Ernie Hardeman): As Chair, I'm saying your debate is to the amendment or it's not debate-appropriate.

Mr. Mike Colle: Yes, and I'm still speaking to the amendment that I think is wrong, because of the fact that it doesn't follow the chronological order, because Bill 166 came before Bill 172. Here in the committee of the whole, we talked about the chronological order. The Tories had a bill. The NDP had a bill. We were pushing for 166. So all of a sudden, the chronological order goes out the door, and with this amendment here, they bump—

The Chair (Mr. Ernie Hardeman): I would point out, Mr. Colle—and then we're going to finish the debate on this amendment—that the committee directed the subcommittee to come up with a list and a chronological order of how they wanted the bills to be heard. This is the subcommittee report that we are debating here today. So if you want to speak to the amendment, speak directly to the amendment. If not, then we will have a vote on the amendment and then you can speak to the motion in the whole.

Mr. Mike Colle: Just to the amendment?

The Chair (Mr. Ernie Hardeman): Yes. To the amendment.

Mr. Mike Colle: I was still speaking to the amendment.

The Chair (Mr. Ernie Hardeman): Well, it had better be to the amendment or you're won't still be speaking.

Mr. Mike Colle: Well, we're all talking about democracy right here, aren't we?

Again, if you look at this, by bumping it forward—bumping it back, I should say to May 13, May 27—I mean, we could have an election before then. This is the other thing. There may not even be hearings. There may be nothing here. That's the other game that they're playing, and the public understands that. I just want to make sure that the implication of doing what they're doing by bumping 166, and replacing it with the NDP's 172—they're basically, perhaps, denying the people that have been working on the ranked ballot item the right to ever be heard on this thing. So I just think it's totally wrong, and it's really upsetting to see that the NDP would block 166 when they don't have to. We should

listen to the people who've said, "Please hear us." I'm saying that this motion really blocks 166, sadly.

The Chair (Mr. Ernie Hardeman): Further debate?

Ms. Cindy Forster: In fact, the NDP has not bumped anything. There was a subcommittee report. The subcommittee had a lengthy discussion about these bills. The subcommittee ranked them in order—

Mr. Mike Colle: Not all members—

The Chair (Mr. Ernie Hardeman): Order.

Ms. Cindy Forster: The majority of—the subcommittee ranked them in order. In fact, this bill came up in fourth place, and today, we are making an amendment to move it up to the third spot, following Bill 172.

There are many important bills before this House, at this committee and at many other committees. There's a bill to provide protection for minors participating in amateur sports. There's a bill to amend the Highway Traffic Act to make sure that we have paved shoulders and that people riding bicycles are safe. A lot of these issues are important to many people.

In fact, we're prepared—we moved an amendment. We're supportive of Bill 166. We'd like to get on with this because, of course, as we know, as we continue to debate this, if we get to 6 o'clock, it won't be dealt with today either. So you can filibuster all you want about it—

Mr. Mike Colle: Who's filibustering?

The Chair (Mr. Ernie Hardeman): Order.

Mr. Mike Colle: You are. You're blocking the bill.

The Chair (Mr. Ernie Hardeman): Order.

Ms. Cindy Forster: We're not blocking the bill.

Mr. Mike Colle: You're blocking 166.

Ms. Cindy Forster: Mr. Chair, we're not blocking the bill. In fact, we are supportive of the bill. It's going to be a two-week delay. We'll have public hearings, we'll have clause-by-clause, and we'll move on with this bill.

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

Ms. Helena Jaczek: I would like to express my concerns about these particular dates that have been chosen: May 13, May 27. As we all know, the possibility of an election is a very real one. It is in the hands of the NDP. We know the Tories are bound to vote against the budget, if they even read it. These dates are very problematic for us, and so I'm speaking against this amendment, because the consideration of these dates may mean that we will never, ever have the possibility of hearing Bill 166 in this committee.

The Chair (Mr. Ernie Hardeman): Okay. If there's no further debate, we'll call the question.

Yes?

M^me^ France Gélinas: It seems like the members from the Liberals know when the budget is going to be tabled and when the vote on it is going to take place. It would be nice if they could share that with us, because then that could certainly influence how I'm going to vote on this. Right now, there is no reason for me to believe that two weeks this way or two weeks that way—if they know when the vote and when the budget's going to be, they ought to share it with us. They cannot continue like this.

The Chair (Mr. Ernie Hardeman): Thank you very much, but that's not directly to the amendment either.

Is there any further debate on the amendment? If not—

Mr. Mike Colle: A 20-minute recess, please.

The Chair (Mr. Ernie Hardeman): A 20-minute recess for the vote? Adjourned for 20 minutes.

The committee recessed from 1701 to 1721.

The Chair (Mr. Ernie Hardeman): The committee will come back to order after the recess. We have an amendment:

"I move that Bill 166 follow Bill 172 and that public hearings be held on May 13, 2014, and clause-by-clause on May 27, 2014."

You have heard the motion. All those in favour? All those opposed? The motion is carried.

Now we debate the report of the subcommittee, as amended. Further discussion? No further discussion.

We'll call the vote. All those in favour of the report, as amended? Opposed? The motion is carried.

Thank you very much. That concludes the subcommittee report.

LOCAL HEALTH SYSTEM INTEGRATION ACT REVIEW

The Chair (Mr. Ernie Hardeman): There is one other thing that we need to deal with right now. I have here a request. The committee has been receiving documents from the CCAC last week which have been distributed. The documents from the remaining CCACs have also been received by the Clerk. Most of the CCACs have requested if they could be advised if the information will be used publicly so they can let their employees know. Their transmittal letter has been distributed to you for information, and before the Clerk distributes the remaining documents, the committee should decide on how they wish to handle the documents and whether it would accommodate the CCACs' request to keep them confidential. With that, comments?

Ms. Helena Jaczek: I just wanted to clarify because, of course, we received just the covering letters, and they referred to attachments which we did not receive.

M^me^ France Gélinas: Except for the one from the North East that came on a CD.

Ms. Helena Jaczek: Yes, but obviously the Clerk has them and will distribute them.

The Chair (Mr. Ernie Hardeman): Yes. The reason that they weren't distributed is that they wanted this issue to be dealt with before we distributed them. If the answer is that you're not going to keep them secret, they will be distributed anyway.

Ms. Helena Jaczek: Mr. Chair, if I may, I would like to see them before I decide whether they should be kept confidential or whether they can be made public. That's what we've been doing on public accounts. We, as committee members, get to see them. They're held confidential until we make a decision, but I want to see them.

The Chair (Mr. Ernie Hardeman): Okay. There's no problem with doing that if you wish to do that. I'd just ask the committee's indulgence then. We have kind of committed to the CCACs that before we do make them public, we will let them know, so they can—

Ms. Helena Jaczek: Yes, but we need to see them.

The Chair (Mr. Ernie Hardeman): Okay. So after you get them, don't make them public until we've had that opportunity to notify them. Okay?

M^me^ France Gélinas: The only caveat I will say to this is that there are a number of salary disclosures that are on the front page of every newspaper, because the sunshine list has gone out, so whether we quote from—the contracts that they shared with us, nobody else has seen those, but for the salaries, for everybody over $100,000, their salary is already on the public record.

The Chair (Mr. Ernie Hardeman): Yes. The one issue that might come out of that is that the salaries that we are getting are the band. Not everyone who is on the sunshine list is making what the band says they could, so you could see whether they're at the top or the bottom of it. But, again, there's no reason in my mind that you should keep them secret. I think you're right. I found out how much our CCAC director makes as soon as I read the sunshine list.

Okay, that one is dealt with. What was the other one?

I've been asked to deal with the motion that Ms. Gélinas had put forward pursuant to standing order 11(a) on the Standing Committee on Social Policy. Do you want to address that, Ms. Gélinas?

M^me^ France Gélinas: Do I read it? I thought I had read it into the record already.

The Chair (Mr. Ernie Hardeman): Yes, you have read it into the record. We just turn it over to you as the first person to debate it.

M^me^ France Gélinas: All right. Well, my comments will be brief. We've just gone on a tour for the LHINs review. You'll all agree that when people took the time to come and talk to us, a lot of them talked to us about services that were offered by CCACs. This led me to believe that there is a pent-up demand out there to be heard. They saw no other way. They saw us coming into their town and they said, "Well, I have something to say. Here are people from the government. I'm going to let them know what I have to say."

I feel that it's incumbent upon us to give them this opportunity to be heard. Some of what they brought forward I think some of us knew. Some was news, but a lot of it was quite disturbing and pointed to what I would call systemic failings in our home care system that need to be heard.

I was quite happy when the motions from Mrs. Elliott went through at public accounts and that the Auditor General will do a value-for-money audit of CCACs. But the role that we would take on would not go to value for money as much as it would look at: What is the structure, what works, and have we got suggestions to make this work better? Those suggestions could come from policy experts, from people with lived experience, from people working within the CCAC. I'm quite open. But to turn our backs on people who are trying to talk, to connect with us—I would like to give them an opportunity to be heard.

The Chair (Mr. Ernie Hardeman): I just want to make sure I understand it, as Chair. Is this suggesting that this would be a review after the LHIN review, or is this part of the LHIN review? Where do you fit it in?

M^me^ France Gélinas: It would not be connected to the LHINs review. The LHINs review would take its course.

The Chair (Mr. Ernie Hardeman): So this would be after the LHIN review was completed.

M^me^ France Gélinas: It could be. We can decide together the timing. I'm not married to the timing. The motion I'm putting forward is more of a motion as to, did my colleagues feel the way I did, that there are people out there who want to be heard? If we don't give them this opportunity to be heard, I think we would be failing in what we had to do.

We heard a lot about CCACs in our travels, and we were studying the LHINs. That tells me that there are a number of people that need to be heard. I think we could give them an opportunity to be heard and, from this, make some recommendations to make things better.

The Chair (Mr. Ernie Hardeman): Okay. Yes, Ms. Jaczek.

Ms. Helena Jaczek: I guess my question was similar to yours, actually, Chair. I think that certainly as part of the review of LHSIA, we have heard a lot about CCACs, and we probably need to hear more, such as some of the correspondence that we've requested as relates to compensation. So we're getting pieces of it as part of the LHIN review.

I guess I was, again, going to say, in terms of the practicality, that Mondays are for the LHSIA review. Tuesdays are now going to be busy up until, hopefully, May 27. So it was a question of not diverting focus. I was thinking, as I read what you had here, that we might be able—and I don't think there is anything that would preclude us, in terms of the mandate of the LHSIA review, from calling more witnesses or inviting more to address CCAC issues. So I just put that forward for your consideration.

As part of a LHSIA review—what we have heard is that the CCAC piece is something that needs to be really delved into. I'm just wondering if we necessarily need to have a separate process. I think it might be more useful to get at the issues that your motion suggests, because we have until the end of 2014—we hope—to complete that review. So I just put that out.

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

M^me^ France Gélinas: I would be open to something like this if everybody agrees that, in the course of doing our work, we would pay special attention, under the LHSIA review, to improving CCACs at the same time. Does everybody agree?

The Chair (Mr. Ernie Hardeman): From the Chair's perspective, it's quite possible that in fact, because of the

LHIN review—and we've heard a lot about the CCACs—the committee could decide to do, shall we say, a sub-review, because the impact of what the decisions on the LHIN review will be is greatly related to what the CCAC review would come up with. If you look at the structure and the pay in the CCAC, that could have a large impact on how you deal with that as you relate to how you deal with the whole LHIN situation.

I think we could find a way to just—at this point, it would likely just require doing a request to get more input from CCACs, and advertising that we're looking further into the situation by digging deeper into the CCACs.

M^me^ France Gélinas: I wouldn't mind hearing from the PCs to see if they are agreeable to that. Yes? Okay. I will let my motion stand, as a backup, but for now—

The Chair (Mr. Ernie Hardeman): I would suggest that you don't have to do it as a backup. Actually, we could vote on the motion, because I think the committee could make the decision to do what you're asking, right within the LHIN review.

M^me^ France Gélinas: Is that correct, Clerk?

The Chair (Mr. Ernie Hardeman): Is that possible?

The Clerk of the Committee (Ms. Valerie Quioc Lim): It would still be considered a separate study, so if you would like to—

The Chair (Mr. Ernie Hardeman): They could be done at the same time, though.

The Clerk of the Committee (Ms. Valerie Quioc Lim): At the same time—but my understanding is that you would just like to dig more into CCACs, under the LHIN review, which is from the House. If this motion passes, it would be a separate study.

M^me^ France Gélinas: Okay, I'm going to let my motion stand, not work on it, and just work upon the goodwill around the table. As we do our LHINs review, if questions about CCACs arise, or if the need for more witnesses arises, then we'll work together to get that work done. I'm not going to push the motion that we have in front of us. Just leave it there, though.

The Chair (Mr. Ernie Hardeman): Okay. Very good. With that—

Ms. Helena Jaczek: Chair?

The Chair (Mr. Ernie Hardeman): Yes?

Ms. Helena Jaczek: Could we just confirm that the terms of reference for the LHSIA review would accommodate the opportunity to call witnesses and so on—to perhaps the Clerk?

The Clerk of the Committee (Ms. Valerie Quioc Lim): I will look into that.

The Chair (Mr. Ernie Hardeman): We'll check that for the next meeting.

Ms. Helena Jaczek: I think you would want that assurance.

The Chair (Mr. Ernie Hardeman): Okay, we'll have that information for you for the next meeting.

Anything else? Ms. Gélinas.

M^me^ France Gélinas: I just want everybody to know that I have booked the media studio tomorrow for 4 o'clock. I know, Chair, that you will be tabling the report. If anybody from the committee wants to come, they are welcome to. It will be a short message from me, basically saying that we have written the report with a view of giving answers to the people affected, and that we felt it important for the people of Ontario who were affected, whether directly or indirectly, to have answers as to what went wrong and what we will do so that it never happens again. That's basically my speech for tomorrow. If any of you want to come, you are welcome to. It's at 4 o'clock in the media studio tomorrow.

The Chair (Mr. Ernie Hardeman): Okay; thank you very much. For the committee's information, we will be tabling the report tomorrow.

With that, if there's no other business for the good of Rotary, this committee stands adjourned.

The committee adjourned at 1734.

CONTENTS

Monday 31 March 2014

STANDING COMMITTEE ON SOCIAL POLICY

Chair / Président
Mr. Ernie Hardeman (Oxford PC)

Vice-Chair / Vice-Président
Mr. Ted Chudleigh (Halton PC)

Mr. Bas Balkissoon (Scarborough–Rouge River L)
Mr. Ted Chudleigh (Halton PC)
Mr. Mike Colle (Eglinton–Lawrence L)
Mr. Vic Dhillon (Brampton West / Brampton-Ouest L)
Ms. Cheri DiNovo (Parkdale–High Park ND)
Mr. Ernie Hardeman (Oxford PC)
Mr. Rod Jackson (Barrie PC)
Ms. Helena Jaczek (Oak Ridges–Markham L)
Mr. Paul Miller (Hamilton East–Stoney Creek / Hamilton-Est–Stoney Creek ND)

Substitutions / Membres remplaçants
Ms. Cindy Forster (Welland ND)
M^{me} France Gélinas (Nickel Belt ND)
Mr. Douglas C. Holyday (Etobicoke–Lakeshore PC)
Mrs. Jane McKenna (Burlington PC)
Ms. Lisa M. Thompson (Huron–Bruce PC)

Clerk / Greffière
Ms. Valerie Quioc Lim

Staff / Personnel
Ms. Elaine Campbell, research officer,
Research Services
Ms. Carrie Hull, research officer,
Research Services