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Monday 14 November 2016

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Lundi 14 novembre 2016

Standing Committee on the Legislative Assembly

Comité permanent de l'Assemblée législative

Patients First Act, 2016

Loi de 2016 donnant la priorité aux patients

Chair: Monte McNaughton
Clerk: Trevor Day

Président : Monte McNaughton
Greffier : Trevor Day

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON THE LEGISLATIVE ASSEMBLY

COMITÉ PERMANENT DE L'ASSEMBLÉE LÉGISLATIVE

Monday 14 November 2016

Lundi 14 novembre 2016

The committee met at 0901 in committee room 1.

PATIENTS FIRST ACT, 2016
LOI DE 2016 DONNANT LA PRIORITÉ AUX PATIENTS

Consideration of the following bill:

Bill 41, An Act to amend various Acts in the interests of patient-centred care / Projet de loi 41, Loi modifiant diverses lois dans l'intérêt des soins axés sur les patients.

The Chair (Mr. Monte McNaughton): Good morning, everyone. Welcome to the Standing Committee on the Legislative Assembly public hearings on Bill 41, An Act to amend various Acts in the interests of patient-centred care.

Madame Gélinas.

M^me^ France Gélinas: I would like to present a motion to the committee in order to allow more people to present. How do I go about doing that?

The Chair (Mr. Monte McNaughton): It is your right, obviously, to present a motion. I would just ask that you keep in mind that this morning we have to end at 10:15, so we would be taking the time from a presenter today. We can deal with this now, or I'll gladly stay behind and have a subcommittee afterwards.

M^me^ France Gélinas: Can I just put them on the docket now so that everybody knows that the motions are coming? I take it that the Clerk would have prepared photocopies of them.

The Chair (Mr. Monte McNaughton): We can prepare photocopies, yes.

M^me^ France Gélinas: You're preparing photocopies now? Should I put them into the record and then we do this so we don't hold back?

The Chair (Mr. Monte McNaughton): Can we distribute them first?

M^me^ France Gélinas: We can distribute them first and we'll get started.

The Chair (Mr. Monte McNaughton): Great.

ASSOCIATION OF ONTARIO HEALTH CENTRES

The Chair (Mr. Monte McNaughton): We'll begin with our first presenter. You'll have nine minutes for your presentation, followed by two minutes of questioning from each party, beginning with the official opposition. Please state your name for Hansard.

Ms. Jacquie Maund: Good morning. My name is Jacquie Maund. I'm here representing the Association of Ontario Health Centres. We have 108 community health centres and other members across the province. Some of you may know them because they're in your ridings. They include community health centres, aboriginal health access centres, nurse practitioner-led clinics and community family health teams. As you may know, our members serve people who experience barriers accessing health care. Many of the clients and the people we serve are low-income people, indigenous people, people who are LGBTQ, francophones, people from racialized communities, refugees, and people in rural and northern remote communities.

We support Bill 41, the Patients First Act, but we have a number of amendments that we'd like to propose to strengthen the bill, and they come from the perspective of the people we serve.

I'm going to present six categories of recommendations, and they all relate to the Local Health System Integration Act, the act that governs the LHINs.

Starting with our first set of recommendations that relate to the objects of the LHINs: We are very pleased to see that a new object has been developed that refers to health equity. We suggest, and we provide, some wording to amend and to add to that object, to ensure that the LHINs combat racism and discrimination, as they affect health outcomes.

We also propose that a new object of the LHIN be added to reflect Ontario's aboriginal health policy. This is a policy from 1994 that sets out the holistic framework that maintains the integrity of indigenous rights to determination in health.

We also recommend that a new object for the LHINs be added regarding responsibility for health system planning, which we believe should include planning to ensure access to public oral health programs for vulnerable populations. Teeth and gums are part of our body, but we do not have any public organization that is planning and funding access to public programs for vulnerable people.

We also suggest that there be a new object of the LHINs added related to health promotion, and we've provided some wording for that.

The second area where we have a series of recommendations is around the suggestion that key terms in this bill be defined; for example, the term "health" and the term "health equity." We'd also like to see a definition for the term "health promotion." We provide suggested definitions for those key terms, which we believe should be added to the act.

Our third series of recommendations relates to the LHINs' role in planning and community engagement. This bill increases the size of the LHIN board of directors. We're suggesting that there be an amendment to the bill that requires each LHIN board of directors to dedicate at least one seat for an indigenous person and at least one seat for francophone representation. We also suggest that the act ensure that the Ministry of Health activates the aboriginal and First Nations health council that's referred to in the bill and rename it to "indigenous advisory health council." With regard to the new patient and family advisory committees that are being set up through this bill in each LHIN, we suggest that wording be added to ensure that they reflect the diversity of the community, including francophone representation.

Our fourth series of recommendations is around the need to add wording to ensure that third-party community support organizations are held accountable for the quality of the services they provide. For example, we'd like to see wording added to ensure that they comply with the French Language Services Act, and we'd like to see wording to ensure that third-party contractors are held directly accountable to the LHINs to provide high-quality, culturally appropriate care when they are providing services to indigenous communities.

Our fifth series of recommendations is around the increased LHIN powers in this act, specifically as they relate to the ability of the LHIN to appoint a supervisor of a health service provider. Our members—community health centres, aboriginal health access centres, nurse practitioner-led clinics and community family health teams—are all governed by community boards. They all receive funding from not just the LHIN but other types of funders as well. We are recommending a number of changes around section 21.2 of the bill. It needs to define more specifically, through guidelines, the conditions under which it would be termed in the public interest for the LHIN to appoint a supervisor of a health service provider. We'd also like to see the requirement of ministerial and cabinet approval before the LHIN would appoint a supervisor. That's required for directives and investigators; we believe it should be required for a supervisor as well. We'd like to see a mechanism for a health service provider to request a review or to appeal the appointment of a supervisor. And we'd like to see more specific guidelines from the Ministry of Health to identify the conditions under which a supervisor could govern a health service provider which has multiple funding sources, such as is the case for all of our members. So we're saying: How could a supervisor appointed by the LHIN take over a community service provider when the LHIN does not provide all of the funding for that organization?

Our sixth area of recommendations is around care coordination. We very much believe that care coordination must be a function of primary care. The LHIN role is funding, planning and evaluating local health systems, not service delivery. We believe that there should be an amendment in the bill to make it clear that care coordination will be moved to health service providers and primary care as part of a three-year transition plan, or sooner.

Those are our comments. I'm happy to take your questions.

The Chair (Mr. Monte McNaughton): Thank you very much. We'll move to Mr. Yurek from the official opposition for two minutes of questioning.

Mr. Jeff Yurek: Thank you, Jacquie, for coming in today, and for your report coming forward. You made mention, with regard to health promotion—adding it as a new object to fill in on health promotion. Have you noticed a decrease in this government's use of health promotion or having a sole entity of health promotion within the Ministry of Health—that this is a concern?

Ms. Jacquie Maund: I would say that what we're interested in seeing is a greater emphasis on health promotion. By putting it specifically in legislation, it's there and it provides direction to the LHINs, who, in turn, work with funded health service providers. So we want you to be more explicit. We know from our work—because our service providers very much do focus on promoting good health, on ensuring that people have access to nutritious food, to safe housing, to the kinds of supports that not only treat an illness but prevent it—we know that that leads to better health outcomes. So we're saying that by embedding this in legislation, indeed the government, the LHINs and the health service providers who are funded through the LHINs will be empowered and required to put in practice that very key part of health and well-being.

0910

Mr. Jeff Yurek: You brought up the increased LHIN powers in your question as to the legal analysis with regard to when a LHIN can appoint a supervisor. You mentioned about not having more than 50% of the funding. Are you concerned that if a LHIN maybe provides 5% of the funding to an organization, they would be able to appoint through this act a supervisor and take virtual control of that organization? Is that a concern, considering that there are other funding sources out there in the health care system?

Ms. Jacquie Maund: Yes, it is a concern for our members because, as I mentioned, they're all community governed. They have community-governed boards that report to the community, so the idea of a LHIN-appointed supervisor—

The Chair (Mr. Monte McNaughton): Sorry, we have to move to Madame Gélinas. We ran out of time.

Madame Gélinas?

M^me^ France Gélinas: First, I wanted to ask you: Did the government consult with your agency before they brought forward Bill 41?

Ms. Jacquie Maund: Not formally, no. But we have provided input on a number of occasions. We certainly provided detailed reports as part of the consultation process around Patients First. In that sense, we certainly provided input and had our views on the record.

M^me^ France Gélinas: Okay, thank you. I know that your membership is very concerned about the appointment of a supervisor. Many of your members have come to me to share that. What will happen, if this goes through, if a supervisor was allowed to be appointed to a community health centre, let's say, that only receives 40% of their funding from the LHINs and receives the other 60% from federal—from anybody but the Ministry of Health, basically?

Ms. Jacquie Maund: We're not sure. I guess the question would be back to the committee: Is that legal? Is it legal when, say, a minority of health service providers' funding is from the LHIN that the LHIN would appoint a supervisor to take over what is essentially a community board? We have concerns about that.

Our programs are very much designed based on the community needs and they're designed to the specific situation of local people. So by having an external supervisor come in and take over all of those programs, it means that the organization is not as accountable to the community as the original plan that was put in place. So we would like a legal opinion to see if that is possible—for a LHIN-appointed supervisor when not necessarily the majority of the funds are actually from that organization.

M^me^ France Gélinas: Has the government given you a legal opinion that says that?

Ms. Jacquie Maund: No. We would request it of the committee and suggest that there be clarification.

The Chair (Mr. Monte McNaughton): Thank you very much. We're going to move to Ms. Kiwala for questions from the government.

Ms. Sophie Kiwala: Thank you very much, Jacquie, for being here today. You've done an excellent job at your presentation, and I really appreciate the work of the community health care centres. We have one, as I'm sure you know, in Kingston and the Islands. I work very closely with them on a number of different issues. I'm pleased to say that we did have a consultation in Kingston where they were present. We had some excellent discussions. So I do appreciate your work enormously.

I just want to ask some more high-level questions, in two parts. I know we don't have much time. The association has mentioned in a submission to the committee that the Patients First Act will help ensure stronger provincial stewardship of the health care system. Why do you believe that stronger provincial stewardship is necessary to improve the delivery of health care to Ontarians?

Ms. Jacquie Maund: We're interested in seeing greater provincial direction in terms of a provincial health care plan so that the LHINs are then carrying out and delivering health services in a high-quality, more uniform way. We very much look at the goal of health and well-being and what we can do to promote a health system that looks at the full person but also achieves health equity. We know that there are different health outcomes for different parts of the population. Indigenous people have a shorter lifespan and higher rates of chronic diseases compared to other groups. That's an example where there is not health equity; there are health disparities.

We believe that with stronger provincial direction, a strong provincial plan and clear definition of the objects of the LHINs in legislation, that will lead to more high-quality, uniform delivery of health services that achieve and move towards health equity.

Ms. Sophie Kiwala: Any time?

The Chair (Mr. Monte McNaughton): Time. The clock is done.

Thank you very much for your presentation today.

PATIENTS CANADA

The Chair (Mr. Monte McNaughton): We'll call on Patients Canada. You'll have nine minutes for your presentation and then two minutes of questioning, beginning with the third party. If you could just state your name for Hansard, please.

Mr. Michael Decter: Certainly. Michael Decter, proudly chair of the board of Patients Canada and currently searching for my glasses—

Ms. Sophie Kiwala: Do you want mine?

Mr. Michael Decter: No, thank you. Mine might work better. Here we go.

I am pleased to present a brief on behalf of Patients Canada. We are a charitable organization dedicated to bringing the patient voice to bear on health care, both its delivery and its policy-making. We strongly support a patients-first agenda for health care. It is, in fact, long overdue. However, we are hard pressed to find patients first within the actual substance of Bill 41, and we are concerned about the bureaucratization of our health care system, where decisions of care will be subject to administrative priorities and not care priorities. We have experienced and witnessed this before with the CCACs.

We start each of our meetings at Patients Canada with a patient story, and I think it's appropriate to do the same here. A brief story that I think gets at some of our concerns: It's a real story about a frail elderly patient with complex issues who breaks her hip and requires a hip replacement. After the surgery, her surgeon approaches her family and explains that she would need to be placed on a wait-list for a rehab bed. It is crucial in this circumstance because this is a patient at very high risk of an infection, given all of her co-morbidities. The surgeon explains that he cannot help, nor can the hospital. The family is told that they will have to wait until a second assessment is done by the CCAC, the gatekeeper of community services.

It takes four weeks in the hospital before the CCAC coordinator arrives and assesses the patient. The coordinator comes to exactly the same conclusion as the surgeon, which had been communicated four weeks earlier: that the patient needs to be moved to a community rehab facility. The family asks to have the patient moved out of

hospital as soon as possible. They are informed by the CCAC coordinator that the CCAC manages all patients on a first-come, first-served basis. Had the patient been put on the wait-list four weeks earlier, she would have already been moved from hospital. Two days later, this patient is diagnosed with nosocomial pneumonia—that is, hospital-acquired pneumonia—and requires another two weeks in hospital.

This story, in our view, shows the remarkable difference between a culture of care—that of the physician—versus the culture of process that is typical of bureaucracy. It shows how bureaucracy can bottleneck a patient journey, to the detriment of the patient. Patient care organizations have a sense of urgency not found in administrative organizations. Our view is that multiple assessments delay the movement of patients and do not put patients first. Bill 41 does little to address this well-known redundancy.

Two Auditor General reports have concluded that patients have not been well served by either LHINs or CCACs, yet Bill 41 essentially merges these two failed organizations, with the expectation of improved results. We believe this is not likely. Here are our five most important concerns.

Patients Canada favours local governance because it is more responsive to patients. Bill 41 consolidates the CCACs and the LHINs and puts them squarely under the control of the Ministry of Health. It eliminates the governance role of local boards and replaces them with oversight from the ministry. This makes all community organizations directly answerable to the Ministry of Health. Just as government has amended Bill 41 to exempt hospitals from LHIN governance, it must now also consider restoring governance to home and community care.

0920

The second concern we have: We do hear many stories of patient delay and harm in the transition from hospital to home. Patients Canada believes that care coordination needs to be located closer to the patient journey and integrated into family health teams, home care organizations and hospitals. This would really put patients first. We believe that they must be answerable to these provider groups instead of to government officials. We did recommend this to Minister Hoskins. We had submitted a brief previously and I had the opportunity to discuss this particular recommendation with him. I think there's considerable enthusiasm in the care community about having care coordination located with providers, not in a separate entity.

We do acknowledge the government's central role in planning, funding and policy-making. However, we strongly believe that the direct management and delivery of health services by government is not in the interest of patients. We do not support a continuation of the direct delivery role of the CCACs and LHINs in providing home care. We believe that home care should be provided by health care organizations that are managed by health care professionals whose focus is on patient care. The CCACs' direct hiring of nurses was found by the Auditor General of Ontario to be far more expensive and did not deliver for patients, unlike services that are provided by long-established and well-accredited home care organizations. We believe that patients would benefit by the government exiting this ineffective and unnecessary direct delivery role. The action would provide more money for actual home care visits.

Fourth, we recommend that key measures based on what matters to patients be put in place and that patients be involved in their development. Patients need an unadulterated voice in developing these—a voice that really brings the patient to bear on decision-making.

Finally, we are extremely concerned about the impact on patients when the overseer and funder of health services also delivers them. We feel that Bill 41 potentially promotes a conflicted system that stifles dissenting voices because of the elimination of local governance and the installation of government in a direct delivery role. I was privileged to sit on the interview committee for the Patient Ombudsman. We were proud, as an organization, to host a town hall for the Patient Ombudsman. We do think that the Patient Ombudsman should be made an officer of the Legislature, independent of control by government.

Thank you for listening to our brief. We hope you will consider our concerns and proposals.

The Chair (Mr. Monte McNaughton): Thank you very much. We'll move to Madame Gélinas for questions.

M^me^ France Gélinas: Thank you so much for being here this morning.

You clearly said that you are unable to see how a major restructuring of boards and bureaucracies will result in more responsive, effective and compassionate delivery of care, and I think your brief said that. Are you also concerned that patients may fall through the cracks as we transition?

Mr. Michael Decter: Yes, and more than that, what we're hearing is, many providers have been pulled into planning meetings of some length, so people who are actually in front-line care—physicians, nurses, others—are now trying to figure out how a planning body, the LHIN, and essentially a care coordination and delivery vehicle, the CCAC, get merged. So time is already being taken away from patient care, and that's our fundamental concern about all of this.

M^me^ France Gélinas: Do you see any difference between a for-profit home care provider and a not-for-profit home care provider?

Mr. Michael Decter: Personally, I don't see a lot of difference. I chaired the board of Saint Elizabeth Health Care for nine years. It's a not-for-profit charitable organization. I think it's still the largest provider in Ontario. There are good and not-so-good home care providers, and I don't think for-profit/not-for-profit would sort them completely. There are a variety of reasons. Some just do better than others because of their leadership.

M^me^ France Gélinas: So you would like all of the care coordinators to be moved to either family health teams or community health centres, and none of them—

they would transition to the LHIN and then transition to primary care organizations, home care organizations and hospitals?

Mr. Michael Decter: What I specifically said to the minister was that having it all at the LHINs is a bad idea—

The Chair (Mr. Monte McNaughton): Thank you very much. We have to move to the government now. Mr. Fraser.

Mr. John Fraser: Thank you very much for being here this morning, Mr. Decter, and for your work with Patients Canada. I met a few of the representatives at the Palliative Care Matters conference in Ottawa. It was good to see them there. I liked your story at the beginning. Transitions are the biggest challenge in our health care system, I think. That's where people fall between the cracks. We used to have a thing in the grocery business which is, if they asked you where something was, you took them to it. That does not happen across our health care system and that's a problem of culture.

Where I differ with you in your presentation is that I believe that strengthening the local component of health care and local decision-making and priorities is key to changing culture. If you take a look at the organizations that exist around representing health care providers, no one has been able to solve that problem of, "Take them to the peas," or that culture change that ensures that we hand people off. Could you just comment on that?

Mr. Michael Decter: Well, I think that having, in many cases, three assessments done—one by the hospital, one by the CCAC and one by the receiving organization—in many, many cases, you know where you're going. There's one rehab facility in the community. Someone who's elderly and recovering from a hip replacement is obviously going there. Why do you need three separate assessments to come to the same conclusion? I guess I don't see, in this, eliminating that, in the combination. I do worry that local control gets displaced by ministry control in some of the provisions of this bill.

The Chair (Mr. Monte McNaughton): Fifteen seconds.

Mr. John Fraser: Fifteen seconds. Gosh, I didn't think I had 15 seconds left.

You're exactly right. I think, when we do take people to the peas, if there are problems, locally you find them and you make a decision to say, "We can't do it this way any longer, because it's not working for patients." You're right—

The Chair (Mr. Monte McNaughton): Thank you, Mr. Fraser. We'll move to Mr. Yurek now.

Mr. Jeff Yurek: Thank you for coming in today. Important note: You mentioned the bureaucratization of this bill and the fact that it seems to be a bill creating more bureaucracy or more power to the bureaucracy. Was Patients Canada involved at all with the creation of this bill?

Mr. Michael Decter: We submitted a brief and I had a meeting with Minister Hoskins subsequent to us submitting the brief to elaborate on the points we'd made, which were very similar to the points in the brief this morning.

Mr. Jeff Yurek: But nobody from the Ministry of Health reached out to Patients Canada and said, "We want to create this bill. Can you help us out here?"

Mr. Michael Decter: We were consulted a little farther along, when I think the bill was already drafted. It was more of a consultation on, "Here is the bill. What are your thoughts?" Not earlier on.

Mr. Jeff Yurek: So would you maybe have a concern with this bill going forward, that they've waited until after it's been created to ask your opinion, that now they're going to create this bill and have the LHINs have more control, more power through the Ministry of Health? Do you think it's really going to benefit patients at all when they're going to be an afterthought?

Mr. Michael Decter: I should be careful in how I answer this because I used to run the Ministry of Health, but it was a long time ago. I would say the Ministry of Health spends most of its time worrying about provider groups because those are the groups with power, and patients are a bit of an afterthought. I think that's a hard corner to turn. I give the minister full marks for trying, but I don't think this bill really puts patients first in what it actually accomplishes.

Mr. Jeff Yurek: So this bill won't increase access to doctors, won't decrease wait times, won't increase the amount of long-term-care homes and won't get people out of the hospital quicker?

Mr. Michael Decter: I don't see, without moving the care coordination to where the care actually happens, that you're going to get there. We don't favour one-size-fits-all. I think in different LHIN areas, care coordination—

The Chair (Mr. Monte McNaughton): Thank you very much for your presentation.

0930

ONTARIO PUBLIC SERVICE EMPLOYEES UNION

The Chair (Mr. Monte McNaughton): We will now move to OPSEU, please.

Good morning. As you know, you'll have nine minutes for your presentation, followed by two minutes of questions, starting with the government.

If you could just read your names for Hansard, please.

Ms. Lucy Morton: Good morning. My name is Lucy Morton, and I am here representing the Ontario Public Service Employees Union. I am chair of the OPSEU community health care professionals division as well as our health care divisional council. Joining me today is Kim Johnston, an OPSEU staff.

We are honoured to be here representing OPSEU's 45,000 health-care-sector workers across the province, and we thank you for the opportunity to present.

Of major concern to OPSEU and central to our presentation here today is that the proposed legislation does not address one of the fundamental flaws inherent in the current CCAC structure and the proposed future LHIN structure. That flaw is the privatization that is em-

bedded within the health care system, including the contracting out of home care services to private, for-profit agencies.

The existence of a contracting-out system stands in stark contradiction to the minister's promise to protect our universal, public health care system, and it is a major impediment to patient-centred care. The competitive bidding process has been a major catalyst in driving down wages and benefits for those working in the home care sector. In a system rife with privatization, workers are increasingly faced with precarious work where they are underpaid and unprotected.

The movement of CCACs to the LHINs will not itself create a public, non-profit home care system. Bill 41 would see the continuation of this highly flawed system.

One only needs to look at the 2015 Auditor General's report to see the real cost of contracting out and the public resources that are wasted through contracting out.

OPSEU is recommending that all new capacity in the health care system be created under the model of public, non-profit ownership only. This is in line with the Patients First promise to protect public medicare. We are calling for the elimination of the contracting-out system and the implementation of a fully public, not-for-profit home care system. This will remove the duplication of administrative costs under the current system and also stop the removal of public dollars from health care to pay for private profits.

Bill 41 does enable the LHINs to assume responsibility for the direct delivery of home and community care. This eliminates the structural barriers that were in place previously and allows for the workers to be brought in as direct service providers employed by the LHINs.

We believe the ministry should explore its options for termination or non-renewal of all contracts with provider agencies. This would also allow the ministry to develop and enforce provincial standards more easily because, as we see in the current system, there are major discrepancies in standards and care levels between the numerous service provider agencies. This is because profits, not patients, are put first.

I'll now review some of the key concerns we've identified in the legislation.

(1) Bill 41 sees changes to the language around payment for home care services and opens the door to make patients pay out-of-pocket fees for service. This not only stands in contradiction to the principles of public medicare but would also put an insurmountable burden on many patients receiving care in their homes.

(2) Bill 41 also adds power for the minister to issue operational or policy directives to private hospitals. The minister of the day may use this policy directive power to broaden the services provided by private hospitals and provide the funding to do so. Bill 41, section 45 should be removed from the proposed legislation.

(3) Front-line workers are the backbone of the public health care system, and OPSEU's mandate is to ensure fair terms and fair working conditions. Under Bill 41 in its current form, the LHINs would fall under the Crown Employees Collective Bargaining Act, or CECBA, and this will significantly change how the union negotiates on behalf of its members that are currently employed by the CCACs.

Among other things, moving to CECBA will change the way grievances are handled, and by whom, and will take away CCAC employees' ability to file classification grievances. OPSEU is calling for the LHINs to be removed as a crown agency from CECBA as soon as is practicable.

(4) While creating the LHIN sub-regions could be an opportunity for improved communication and planning, we are also concerned that the government's overall strategic direction will take precedence to local input and the needs identified within communities; for example, rural communities.

There has been no guarantee that resources will flow based on an assessment of population needs. It's worth noting that accountability flows upwards in this structure—from the LHINs to the minister—not downward to the patient.

Demographics are changing, and we have an aging population. There is a real rural/urban divide in this province. The needs of rural communities differ from urban centres. For example, residents in rural communities face geographic challenges in just accessing health care. Rural Ontarians, oftentimes seniors, have felt largely excluded from the dominant discourse and from the government's overall strategic direction. This is why local input and assessing local population needs is so important.

Additionally, where the minister identifies key issues—issue areas like French-language services, engagement with First Nations and Indigenous communities, and improved mental health services—these ought to be supported with their own funding envelopes. Funding for these priorities should not lead to competition with other services funded within the general LHIN budget.

Accountability: It is worth noting that the primary function of the LHINs legislation has been to give the LHINs and the Minister of Health powers to overrule local boards of directors and force restructuring. The focus of the LHINs needs to change. The primary focus should be on planning for population need. For example, where the LHINs negotiate accountability agreements with hospitals, there needs to be an assessment of population need in determining performance measures and funding levels.

But perhaps of most significant importance is the need to improve accountability to the public. Plainly put, LHINs in their current form are not accountable to the public; they are appointed by cabinet and accountable upwards. Local communities have virtually no meaningful buy-in. Under this legislation, the LHINs are being given more power, but not more accountability. This is troubling because they have existed as a force for endless restructuring, which has not been in the public interest.

In order to make LHINs more accountable, we recommend establishing democratically elected LHIN boards of directors that are accountable to their communities and

representative of diversity; enshrining patients' right to access publicly funded home care; and closing the wide loopholes that allow the LHINs to hold closed, in camera board meetings and keep their discussions outside of the public realm and away from proper scrutiny. The public must have clear rights to access information.

Consultation with the community and workforce is crucial to health system planning. While there is a lot of rhetoric used around public engagement and its importance, the reality is that the LHINs are not required to consult meaningfully with the public or the workforce. The same applies to the key stakeholder groups that have been identified by the ministry.

There is nothing in the legislation that structurally formalizes these relationships or ensures that the input collected is to be used meaningfully. In fact, the legislation weakens the language around the establishment of health professional advisory committees. The LHINs are no longer required to have such committees, despite the fact that workers are on the front line and have a lot of valuable insight into the system.

There must be a legislated requirement for meaningful public consultation, including a system for redress. There must be formalized relationships between the LHINs and key stakeholders and an open and transparent consultation process that empowers these stakeholders. The health care professionals advisory committee must be considered a key stakeholder. All future integration decisions should undergo the same notice period of 90 days, in which public consultations are undertaken, submissions accepted and board notices and minutes made accessible to the public.

At the end of the day, the public and the workforce possess a wealth of knowledge and experience when it comes to the health care system. We need to inject democracy back into health care if we want it to be about putting patients first. This legislation does provide a real opportunity for positive change, but amendments are needed in order to create a system that will truly put patients first.

We'll be pleased to take any questions.

The Chair (Mr. Monte McNaughton): Excellent. Thank you very much.

We'll move to the government. Ms. Wong.

Ms. Soo Wong: Thank you very much, Mr. Chair.

Thank you, Ms. Morton, for coming here today and also for your written submission because it helps us follow up with today's presentation.

I note, in your written submission, you mention on page 10 about the engagement process. Anytime we have a transition, communication is the biggest concern. Can you elaborate a little bit further about communication? How do we improve that communication, whether it's with your members, the community or what have you? If you could elaborate, that would be really helpful.

Ms. Lucy Morton: Go ahead.

Ms. Kim Johnston: Well, I think that when it comes to Bill 41—

The Chair (Mr. Monte McNaughton): Sorry to interrupt; would you just mind just stating your name for Hansard?

Ms. Kim Johnston: Oh, it's Kim Johnston. I'm OPSEU staff.

What our presentation is about is infusing, structurally, systems for having consultation that actually is meaningful, where that input is used. What we're seeing is that there's a lot of talk around engagement, but it's very arbitrary. Whether it be with respect to integrations of hospitals that are going on in this province—those engagement processes are actually not protected in the way that that input is being used.

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We see Bill 41 as an opportunity to actually enshrine some of those mechanisms more and to embed them within the legislation.

Ms. Soo Wong: Because time is of the essence, what I'm particularly interested to know from your organization is: How do we, as a government, improve communication with your members, and what other stuff that you could specifically—more tangibles that you can present to us?

Ms. Lucy Morton: I think that there was an attempt to put some engagement with the public and our members. However, at the end of the day, there's no responsibility or accountability to reflect what those findings were except for the final decision. It's difficult to believe, although we do have some consultation, that we're actually being heard and—

The Chair (Mr. Monte McNaughton): Thank you very much. We have to move to the official opposition now. Mr. Yurek.

Mr. Jeff Yurek: Listening to your presentation—you're feeling that the ability of local input is being removed from Bill 41?

Ms. Lucy Morton: Yes.

Mr. Jeff Yurek: Do you want to elaborate on that?

Ms. Lucy Morton: The responsibilities of the LHINs are now a direct line to the Minister of Health. With that, that's where the directive flows—in between those two sites, not the public.

Mr. Jeff Yurek: So, basically, the patient is being left out?

Ms. Lucy Morton: Yes.

Mr. Jeff Yurek: No voice?

Ms. Lucy Morton: Yes.

Mr. Jeff Yurek: The group before us mentioned the Patient Ombudsman getting more teeth and becoming an independent officer. Would OPSEU support that move?

Ms. Lucy Morton: It would certainly be a move in the right direction, yes.

Mr. Jeff Yurek: So better oversight is needed for patients.

Ms. Lucy Morton: No question.

Mr. Jeff Yurek: And just quickly: A private organization PSW and a nurse, and a publicly funded PSW and a nurse: the quality is the same? Same quality between the nurses? There's no difference in the actual health care professional providing the treatment?

Ms. Lucy Morton: No, that's not true.

Mr. Jeff Yurek: No? There is a difference?

Ms. Lucy Morton: Every nurse has different levels of skills in care, and it depends on the education component that's given by each agency. That will define the level or the benchmark that each individual has.

Mr. Jeff Yurek: But does it matter where they're employed?

Ms. Lucy Morton: I believe, and I have seen, that for-profits have to put money in their pocket first, and that is a direct line to precarious work for these staff that are in community care.

Mr. Jeff Yurek: But an RN is an RN is an RN, whether they work at a hospital, for CarePartners or—

Ms. Lucy Morton: Again, your skill levels are completely different depending on your work. And, including in the hospital, depending on the floor, your skill level is different.

Mr. Jeff Yurek: Thank you.

The Chair (Mr. Monte McNaughton): Any other questions? We'll move to Madame Gélinas.

M^me^ France Gélinas: Thank you for coming. I will go to my question. You made it clear that to fix our broken home care system, we should be looking at not-for-profit agencies, which is not in Bill 41. Why do you think that the Liberal government is not interested in a not-for-profit home care system?

Ms. Lucy Morton: I can't answer that. I don't know why. At a time when we are trying to count every penny that we have, I really don't understand why, on such restricted dollars, we would allow people to remove that and line their pockets. So I can't answer that. I don't know.

M^me^ France Gélinas: What percentage of the money going into home care do you figure gets sent to profit rather than to care?

Ms. Lucy Morton: What I'd like to say and what I know—oh, go ahead.

Ms. Kim Johnston: The Auditor General's report did identify, I believe, that 39 cents to the dollar are—and it's, of course, within that unknown because the private companies don't open their books for scrutiny, so it's impossible to see exactly what that dollar amount is going specifically to profit. But it's within the range of 39 cents per dollar.

M^me^ France Gélinas: Through your organizations, some of the members whom you represent work for for-profit agencies. Do you have any opportunities to see how much of the money that comes to that for-profit agency is going to profit for any of the members whom you represent?

Ms. Lucy Morton: I can tell you that there is a gross difference in benefit packages. I can give you, for example, CarePartners in Niagara compared to VON in Hamilton that works right next door under the same HNHB. The nurses in Hamilton make a good wage, a fair wage, but the nurses in Niagara under CarePartners, which is private, get paid per visit regardless of the time they're in there. For example—

The Chair (Mr. Monte McNaughton): Thank you very much. That's all the time we have. Thanks for your presentation today.

ONTARIO MEDICAL ASSOCIATION

The Chair (Mr. Monte McNaughton): I'd now like to call upon the Ontario Medical Association. Good morning. You'll have nine minutes for your presentation, followed by two minutes of questioning, starting with the official opposition. If you would state your names for Hansard, please.

Dr. Stephen Chris: Thank you, Chair. My name is Stephen Chris. I've spent most of my long career practising comprehensive-care family medicine. I'm president-elect of the Ontario Medical Association.

With me is Dr. David Schieck, who's chair of the section of general and family practice and a comprehensive-care family doctor in Guelph, working within a FHT.

Mr. Peter Brown is a senior adviser on health policy at the Ontario Medical Association.

We welcome the opportunity to address this committee regarding the proposed legislation, which lays out the government's plan to transform the way primary care is provided in this province.

Bill 41 is deeply disturbing to Ontario's doctors. The government has developed this plan without the expert advice from the family physicians who care for 155,000 patients every day. Over the last two years, Ontario's doctors have been subjected to unilateral decision-making by government which has caused physicians to feel devalued and disrespected, and Bill 41 continues that trend.

High-performing health care systems around the world respect and meaningfully engage physicians in change. It is essential for success, and this is missing with Bill 41. There was no meaningful consultation with Ontario's doctors. We received "communication" from government that was vague about the direct impact the bill would have on family doctors and was silent on the effect this transformation will have on focused-practice GPs, community-based specialists and hospital-based specialists. The OMA believes that diverse medical input is needed now more than ever.

Bill 41 demonstrates this government's indifference to health professionals by making professional advisory committees optional. The LHINs should not make decisions based on the recommendations of a few hand-picked physicians whom they employ and who do not have a mandate to represent community and grass-roots physicians. The professional advisory committee is an essential part of proper governance and should be obligatory.

In the place of professional advisory committees, Bill 41 requires LHINs to establish patient and family advisory committees. We support this initiative as the voices of patients and their families are important, but so, too, is the expertise brought by front-line physicians.

Many sections of Bill 41 are unclear and give the minister and LHINs substantial powers far beyond the

government's stated intentions. This has created needless anxiety for physicians.

A prime example relates to inspections of health service providers. The government has repeatedly stated that physicians' offices are not captured and also that inspectors will not have access to clinical records held by physicians. However, the legislation clearly permits inspectors to compel physicians to provide access to patient medical records. Physicians are not health service providers as defined by legislation, but inspections may arise indirectly when LHINs seek records from family health teams. This is viewed by Ontario's doctors as a violation of their professional autonomy and, more importantly, the privacy of the physician-patient relationship. LHINs are an extension of government, and it is difficult to fathom why they need to trawl through confidential medical information in order to manage the health care system. We need concrete assurances that this will not be the case.

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This is just one instance where the government's stated intent does not match the scope of authority in the legislation as written. The government's policy intent needs to be clearly articulated in the body of the legislation.

I now want to review a number of other specific concerns. Bill 41 takes a command-and-control approach to the management of the health system. The bill allows the Minister of Health to impose standards for the delivery of health care services. Why is this provision included in a bill that is intended to create infrastructure for the funding and management of local health services?

The government has been very clear on their need and intent to limit spending on health care and, in our opinion, to underfund utilization and growth. We believe that these standards could be used to limit funding for health services. A narrowly defined standard will restrict services, thus limiting patient choice.

How will government not resist the ability to utilize these provisions for budgetary reasons? Excellent patient care must be the sole motivator of care decisions. Patients trust their doctors—not government bureaucrats—to make decisions that are in their best interest, and doctors require care options for their patients.

Bill 41 significantly expands the LHINs' scope and authority. Given that the government has not reported upon its legislatively mandated LHSIA review, we have no evidence that the LHINs operate effectively. The OMA has grave concerns whether the LHINs have the ability to effectively manage the diffuse and complex primary care environment.

Bill 41 establishes sub-LHIN entities. Physicians see these sub-LHINs as yet another layer of bureaucracy, siphoning scarce health care dollars away from direct patient care.

Bill 41 gives LHINs authority for physician human resources planning. When coupled with the LHINs' ability to amend physician contracts, this means that LHINs can effectively dictate where physicians can practise. This is a violation of the OMA's representation rights agreement, which requires that the government deal with the OMA regarding physician working conditions.

The bill requires physicians to provide reports to the local health integration network about the opening and closing of practices, extended leaves, and retirements, as well as service capacity to address local population needs. It is not clear what the LHIN will do with this information. It is clear that this creates an unnecessary new burden upon physicians. We must already report significant practice changes to the College of Physicians and Surgeons.

In addition, physicians in line models already report these elements to the ministry. None of these reporting requirements are being eliminated or changed. The new reporting requirements are simply layered on top. So we ask: Why does the government want to add more red tape to medical practices?

In section 38, entitled "LHIN as agent," it is proposed that the LHINs can carry out any function of the minister. This violates the OMA's representation rights agreement. The ministry has an obligation to negotiate matters relating to physician services and the associated accountabilities with the OMA. It can delegate responsibility—

The Chair (Mr. Monte McNaughton): Thank you very much. That's all the—

Dr. Stephen Chris: May I do my two sentences? Two more sentences—is that all right?

The Chair (Mr. Monte McNaughton): Go quickly.

Dr. Stephen Chris: It can delegate responsibility for only those matters that are agreed upon with the OMA. We insist that the government abide by its—

The Chair (Mr. Monte McNaughton): Okay. We have to move to questioning from the official opposition. Mr. Yurek?

Mr. Jeff Yurek: You can finish.

Dr. Stephen Chris: Oh, thanks. It's only two sentences.

We recommend that you delete that section.

I want to just conclude by saying that you will be receiving our submission with a number of proposed amendments shortly. I'll be happy to take any questions.

Mr. Jeff Yurek: Thank you very much. You've said a lot in such a little time.

It's quite concerning. We just heard earlier that patients weren't involved in consultation. Now we're hearing that doctors weren't involved in consultation. Do you have any idea who was involved with the consultations?

Dr. Stephen Chris: I have no idea who was involved in consultations. We certainly weren't involved. We think only the LHINs were involved.

I wanted to add, if I might, in response to your question about involvement, an issue that is of concern to me, which is the consequences of system change, which only show up very slowly. For example, the reduction in medical school enrolments in the early 1990s resulted in a disastrous shortage of family doctors by the later part of that decade. Over three million Ontarians could not find a family doctor, and it took a decade to repair the damage.

For longer than any of us have been alive, family doctors have efficiently managed and paid for the infrastructure of community care, not governments. But it requires confidence to sign long-term leases and hire staff with all the obligations that creates. Bill 41 and the present environment of physician relations has created anger, fear and deep insecurity among doctors. As doctors of my generation leave practice, who will take on the obligations of managing community care? Young doctors may not. You may find, in the not-too-distant future, that, once again, poorly-thought-out decisions will lead to serious consequences for patients in Ontario.

The Chair (Mr. Monte McNaughton): Excuse me; we'll move now to the third party. Madame Gélinas?

Dr. Stephen Chris: Thank you. I appreciate the opportunity to say that.

M^me^ France Gélinas: I just want to welcome you to Queen's Park, president-elect. It's a pleasure to hear what you have to day.

You did cover quite a bit. I will focus on two areas. The first one is: Has any improvement been made between the Liberal government and your association to restore a good working relationship?

Dr. Stephen Chris: Not that I'm aware of.

M^me^ France Gélinas: Okay. And we all know the consequences that that has on patients throughout our province.

Dr. Stephen Chris: Yes. I think that's the serious issue that we should all be worried about: How is this going to play out in the care of patients in the coming months and years?

M^me^ France Gélinas: I'm worried, also.

My second question has to do with the power in this bill to require that physicians and other primary care providers share patient records. This is unbelievable. The only way government can have access is through the court. You go through a judge. This is how it has worked. Can you think of a good reason why the government would gain access to your members' records, or patients' records, really?

Dr. Stephen Chris: I was here on this issue once before, and I will say what I said then: I think it's incomprehensible that, in a democracy—I'm speaking now as a citizen, not as anything else—that my government would like to see my medical records with my name on it. I think it's just unbelievable. I wish the public understood it more so they would speak about it. It's an essential piece of democracy.

M^me^ France Gélinas: I agree. Pretty scary.

When you talk about changing the way you practise, because we have a government that chooses to fight with our physicians rather than respect them, what do you see in the short, medium and long term for—

The Chair (Mr. Monte McNaughton): Madame Gélinas, the two minutes is up.

We'll move now to Mr. Fraser, the government.

Mr. John Fraser: Thank you very much, Dr. Chris, for being here this morning, and thank you for the work that you do.

I do have to say that your concerns for privacy, I think, will be further addressed. But I'm sure you're aware that we have PHIPA legislation that puts a half-a-million-dollar fine—and jail time—for anybody using somebody's patient record or accessing a patient's record without permission, the ability to do that.

One of the things I struggle with is that, as physicians—and I know you struggle with relativity inside the OMA, and I know with family physicians that's a tough thing: How do you fit into the whole picture of the practices that you're in?

But the concern that I have around autonomy is—and I said this before in my earlier question. I'll give you a very quick story, and this is why I think we need local input and local solutions, and this is what this bill does.

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My father was diagnosed with an inoperable oral cancer. The doctor said, "You're not going to get well. You can get three palliative radiations on Wednesday. On Friday, somebody will call you to organize those." By that Friday, nobody called. By the Friday after, nobody called, and it only took intervention.

Where I come from, in the grocery business, when someone came and asked us where the peas were, we took them there. What I'm trying to get to is, that responsibility for transition has to be something that's taken up as a culture at a local level. I think the only way you can drive that change is locally.

That's not the only example I have. I know that there are a lot of practitioners that do that, but it's not the culture. It's not the culture.

Dr. Stephen Chris: I'd like my colleague to respond.

The Chair (Mr. Monte McNaughton): If you could just state your name, please.

Dr. David Schieck: I will. My name is David Schieck. I'm a family doctor from Guelph and chair of the OMA section on general and family practice. I'm grateful for Dr. Chris to invite me along to participate this morning.

On your comment about integrating and helping with transitions in care—and you speak to culture change—I agree with you that those are vital pieces to help us—

The Chair (Mr. Monte McNaughton): I'm sorry, sir; the two minutes are up. I'd like to thank you very much for your presentation today.

I remind everyone: You have two minutes for questions.

HOME CARE ONTARIO

The Chair (Mr. Monte McNaughton): I'd like to call Home Care Ontario, please. If you could state your name for Hansard, and you have nine minutes for your presentation, followed by two minutes of questioning, starting with Madame Gélinas. Go ahead.

Ms. Sue VanderBent: Good morning. My name is Sue VanderBent. I'm the CEO of Home Care Ontario. With me today is Linda Knight, board chair of Home Care Ontario and CEO of CarePartners, one of our largest Home Care Ontario providers in Ontario.

Thank you very much for asking Home Care Ontario to present this submission this morning.

Home Care Ontario commends the government on the introduction of Bill 41, the Patients First Act, and the overarching goal to create a further improved and integrated home and community care system for Ontarians. With the passage of Bill 41, LHINs will have the opportunity to work directly with existing providers within the Home Care and Community Services Act, 1994, and harness the innovation of those providers not yet known to them.

As the voice of Home Care Ontario, the association represents member home care organizations that deliver front-line home care—nursing, therapy and personal support—to Ontarians in their homes and communities across all parts of this large and diverse province. Home Care Ontario providers have well-developed care delivery procedures and processes. They've invested in research and development technology, training, education and clinical practices specific to the home care setting.

Home care providers have established risk management mechanisms and liability protection. They're accountable for direct clinical care at the front line, responsible for clinical expertise and evidence-based practice, risk, performance, quality management, provincial privacy legislation requirements, and the achievement of patient outcomes.

As experts in care delivery in the home setting, home care providers are eager to offer innovative practices and welcome the opportunity to contract with LHINs and be measured on the outcomes they achieve.

With LHIN renewal, it is understood that the role and function of the current CCACs will be absorbed by the local health integration networks. Home Care Ontario offers the following recommendations to further improve and strengthen Bill 41 in order to achieve the system goals envisioned by the Patients First Act, 2016.

Given the extensive nature of the role, function and responsibility of the front-line home care provider in the home setting that I've just described, it's critical and it's self-evident that the contracts between the LHINs and home care providers must continue uninterrupted in order to ensure a smooth, seamless and transparent transition process to patients and all the system partners with whom home care providers interact on a daily basis.

Accordingly, our first recommendation is that Bill 41 and/or the related regulations should expressly commit to the nature of a contractual relationship between LHINs and home care providers. Specifically, this would include a continuation of contracts between the LHINs and home care providers regardless of corporate tax status, as is the case now, for the delivery of home and community care services as defined in the Home Care and Community Services Act, 1994; the establishment of a standing provincial contract review committee responsible for ensuring best contract practice and agreeable rate structures; and the ability for LHINs to enter into contracts with home care providers, regardless of tax status, for services beyond that described in the Home Care and Community Services Act, 1994.

Our second recommendation relates to health information custodians. The recommendation, specifically, is that Home Care Ontario recommends that Bill 41 clarify that home care providers are successor health information custodians of CCACs, and that the role of health information custodian cannot be negated by contract. The rationale is the following: Bill 41 repeals the CCAC designation as health information custodian, or HIC, under the Personal Health Information Protection Act, 2004, commonly known as PHIPA. Home care providers—service providers within the Home Care and Community Services Act, 1994—are designated as health information custodians, HICs, under PHIPA. However, the CCAC contractual agreements with home care providers expressly state that the CCAC is the HIC, and that contracted providers are agents of the CCAC for the purpose of and within the meaning of PHIPA. This has the effect of limiting direct clinician access to client information. Home care providers must have full access to relevant care information. That will support care delivery and reduce duplication and risk of error.

Bill 41 is also silent with respect to the records of personal health information currently in the custody of the CCACs. Section 42 of PHIPA does provide provisions with respect to the transfer of personal health information to a successor of a custodian. However, we are concerned that the absence of a provision to amend PHIPA under Bill 41 to designate a successor health information custodian will create some confusion regarding the disposition of personal health information presently in the care of the CCACs. Currently, there is no provision in Bill 41 that would amend PHIPA by adding LHINs as HICs. The absence of a provision to amend PHIPA to designate a health information custodian as the CCAC successor creates some uncertainty at this time.

Our third recommendation is to define the scope and parameters of the new shared services organization. While the opportunity for administrative efficiencies through the establishment of a shared services organization is a welcome aspect of Bill 41, the absence of specifics regarding the services to be provided creates a concern regarding the risk of scope creep through the transition, especially when staff and structure remain essentially the same.

Home Care Ontario believes that the shared services organization entity must be accountable for protecting, improving and standardizing business processes to support consistent home care administration and thereby reduce costs and hopefully increase home care services across the province. It needs to be clear that the organization provides supportive services only, such as payroll, technology, and data analysis, and that the communications related to the role and function of the shared services organization should be managed through the ministry and/or the LHINs.

Accordingly, Home Care Ontario recommends that the act and/or related regulations define the scope and parameters of the shared services organization so as to ensure a true change in function vis-à-vis the home care

sector. The supportive role must be clearly mandated and the limitations on a public voice expressly described.

Our fourth and final recommendation is to establish a provincial performance council responsible for working with LHINs to identify best practices in inter-organizational operations in order to reduce redundancy and unnecessary costs in the health care system. Home Care Ontario believes that there is a need to create a provincial performance council to which the shared services organization would be accountable, with the mandate to support the LHINs to identify best practice in inter-organizational operations. The council would seek to understand operational practices, such as intake, assessment, service delivery, human resources and use of technology, in order to remove system barriers and reduce redundancy and unnecessary cost in the system. The provincial performance council would have the authority and influence to support the LHINs in challenging assumptions about current practice and to inspire change that would deliver the desired changes to further improve and strengthen the home care system.

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In conclusion, the importance of patients and families underpins home care service delivery. Home care providers across Ontario are very familiar with the delicate balance of respecting individual rights in the home with the provider care agenda. Bill 41 provides a framework to further improve, strengthen and integrate the home care system. With LHINs as planners and enablers, and home care providers as responsible for care outcomes at the front line, Home Care Ontario—

The Chair (Mr. Monte McNaughton): Thank you very much. The nine minutes is up. We'll move to Madame Gélinas.

Ms. Sue VanderBent: Thank you.

M^me^ France Gélinas: Excellent presentation. Unfortunately, I have to present a quick motion before I can ask questions. You all have it in front of you. It's motion number 3. I will read it into the record:

(1) That the Chair request of the House leaders that a motion be moved in the House authorizing the committee to meet until 6 p.m. on Wednesday, November 16 and 23, 2016, for the purpose of public hearings in order to better accommodate the requests to appear that could not be satisfied by the original scheduling of public hearings.

(2) That the Clerk of the Committee provide the members of the subcommittee with a list of requests to appear consisting of the applicants who were not scheduled in the initial round of public hearings on Tuesday, November 15, 2016, at 10 a.m. and that the members prioritize and return the list by 4 p.m. the same day.

I move this motion because, so far, three agencies have reached out to me—the Hôpital Montfort; the AFO, which represents 650,000 Ontarians; as well as the FARFO, which represents tens of thousands of Ontarians who want to come and present on this bill but do not have an opportunity to do so because of the limited time for deputants.

Interjection.

The Chair (Mr. Monte McNaughton): Just one motion at a time. Does anyone want to speak to the motion that's in front of us now? Does anyone want to speak to this motion? Are the members ready to vote? Shall the motion carry? I heard a no. All those in favour, say "aye." All those opposed, say "nay." In my opinion—

Interjection.

The Chair (Mr. Monte McNaughton): Sorry, the hands have to go up.

All those in favour? All those opposed?

M^me^ France Gélinas: Recorded vote.

The Chair (Mr. Monte McNaughton): The motion has been lost. It's too late.

Ms. Wong?

Ms. Soo Wong: Thank you, Mr. Chair. I have a motion. I have written ones for the Clerk as well, Mr. Chair. I don't know if we have enough, but anyway, I'm going to read it for the record:

That the Chair request the House leaders that a motion be moved in the House authorizing the committee to meet from 1 p.m. until 3:45 p.m. on November 16 and 23 for the purpose of public hearings; and

That those originally scheduled to appear before the committee remain on the list in their original order; and

That the Clerk of the Committee provide the members of the subcommittee with a list of requests to appear consisting of those requests received by the original deadline for such requests but not currently scheduled to appear by noon on November 15, and that each subcommittee member, or their delegate, return a prioritized list by 3 p.m. the same day; and

That groups and individuals be offered up to five minutes for presentations followed by up to two minutes of questions and comments by each caucus.

The Chair (Mr. Monte McNaughton): Would anyone like to speak to this? Do you want to speak to the motion? Go ahead.

Ms. Soo Wong: I think, given the comments made at the last committee meeting—remember, we had this conversation from the opposition that we extend the time on Wednesday. And remember that we had that conversation to—

The Chair (Mr. Monte McNaughton): We have under one minute before we have to adjourn the committee.

Ms. Soo Wong: Yes. Anyway, I have it in front of you, so we can vote on this, if that's—

The Chair (Mr. Monte McNaughton): Ms. Gélinas?

M^me^ France Gélinas: The motion in front of us would mean that six more people will be allowed. We had 67 organizations that asked; 22 made it. That left 45 out. We will add six more. What happened to the 39 organizations that have asked to appear—

The Chair (Mr. Monte McNaughton): We have to adjourn. The committee stands adjourned until 1 o'clock on Wednesday.

The committee adjourned at 1015.

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Vice-Chair / Vice-Président
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Mr. Michael Mantha (Algoma–Manitoulin ND)
Mr. Monte McNaughton (Lambton–Kent–Middlesex PC)
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