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Official Report of Debates (Hansard)

Tuesday 28 October 2008

Journal des débats (Hansard)

Mardi 28 octobre 2008

Standing Committee on Government Agencies

Intended appointments

Comité permanent des organismes gouvernementaux

Nominations prévues

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON GOVERNMENT AGENCIES

COMITÉ PERMANENT DES ORGANISMES GOUVERNEMENTAUX

Tuesday 28 October 2008

Mardi 28 octobre 2008

The committee met at 0900 in room 228.

INTENDED APPOINTMENTS

The Vice-Chair (Ms. Lisa MacLeod): Welcome, committee. Good morning. Our first order of business is the deferred determination of the intended appointment of Judith Keene as member and vice-chair, Human Rights Tribunal of Ontario. Concurrence in the intended appointment of Ms. Keene was previously moved by Mrs. Sandals. At the request of Mr. Hillier, the committee's determination on the intended appointment of Ms. Keene was deferred until today's meeting.

Concurrence in the appointment was previously moved, as I indicated. Any discussion?

Mr. Michael A. Brown: Recorded vote.

The Vice-Chair (Ms. Lisa MacLeod): If not, I'll call the question. I would remind members that a recorded vote was already previously requested and again today.

Ayes

Brown, Flynn, Ramsay, Sandals, Sousa.

Nays

Hillier.

The Vice Chair (Ms. Lisa MacLeod): The motion is carried.

SUBCOMMITTEE REPORT

The Vice-Chair (Ms. Lisa MacLeod): Our second order of business this morning is the report of the subcommittee on committee business dated Thursday, October 23, 2008.

Mrs. Liz Sandals: I move adoption of the report of the subcommittee dated Thursday, October 23, 2008.

The Vice-Chair (Ms. Lisa MacLeod): Mrs. Sandals has moved adoption of the report. Is there any discussion? If not, all in favour? Thank you. The motion is carried.

INTENDED APPOINTMENTS

STEPHANIE COYLES

Review of intended appointment, selected by third party: Stephanie Coyles, intended appointee as member, Toronto Central Local Health Integration Network.

The Vice-Chair (Ms. Lisa MacLeod): We will now proceed to review of intended appointments.

Our first review this morning is with Stephanie Coyles, intended appointee as member, Toronto Central Local Health Integration Network. You may come forward. As you may be aware, you have the opportunity, should you choose to do so, to make an initial statement. Subsequent to that, there are questions from members of the committee.

We will commence the questioning today with the third party. Each party will have 10 minutes allocated for questions and we will go in rotation. As indicated, the third party will start with questioning. As is also the practice of the committee, any time you take in your statement will be deducted from the time allocated to the government party. Welcome.

Ms. Stephanie Coyles: Wonderful. Thank you. Good morning. I did think I would spend just a little bit of time describing myself. My name is Stephanie Coyles, and I'm currently senior vice-president and chief of strategy and knowledge for Loyalty One, the company that, among other things, brings you the little blue Air Miles loyalty card. So, with that, you might be scratching your head and thinking, "What are you doing here?" So let me try and describe it.

It truly is my pleasure to be with you and an honour to be considered for an appointment to the board of Toronto Central LHIN. You might ask, why did the chair of the board approach me to join the Toronto Central LHIN? What does being the head of strategy for a loyalty company have to do with tackling the critical issues facing health care today? Well, he explained it to me, and I am quite hopeful that I can bring that level of support to the board based on his interest, given the experience that I gained prior to my current role, which I took as of August.

Prior to my current role, I was a principal, a partner in a consulting company called McKinsey and Co. I worked for that management consulting company for 18 years, eight of which I was a partner there. During that time and for the last four years of that time, I led our health care practice in Canada. I worked with a breadth of clients, including helping Canada Health Infoway think through their strategy on e-health and designed what that should look like for the next five years, working with Alan Hudson and Hugh MacLeod at the time on wait times strategy. Also, I supported Helen Stevenson in some of

the work that we we did around generic drug pricing and the evolution there—so a number of different pieces.

In addition, last fall, I actually did a pro bono effort for the Toronto LHIN, because it's a tremendous passion for me, the health care space. That's how I got to know the board. Then, when the chair realized I was no longer in conflict because I had moved outside of the consulting realm, he reached out and said, "It's such an interesting set of background that you might be able to bring to the board, bringing that strategic consulting side of the equation and health care experience in Canada and abroad. Would you come join our board? Given that what we think we need to do over the next period of time is really look at our strategy, it would be a nice complement."

So I'm honoured to be considered. Health care reform is something that I'm highly passionate about, and I look forward to being able to be of service.

The Vice-Chair (Ms. Lisa MacLeod): Thank you very much, Ms. Coyles. We will now commence with the questioning from the third party.

Mme France Gélinas: Thank you very much, and welcome to Queen's Park. A couple of quick questions, the first one being—you realize that as a member of the LHIN, you will have some very important decisions to make that will have an impact on the health care system and people in your LHIN boundaries for years to come. Right now, the hospitals are signing their accountability agreements with the LHIN. You are familiar with this?

Ms. Stephanie Coyles: Absolutely.

Mme France Gélinas: Part of what the hospital has to do is make sure that they put forward a balanced budget. So the amount of resources is known and is fixed, but the amount of expenses sometimes can vary widely. Some of the hospitals are facing tough decisions, having a hard time balancing their books. So some of them have looked at decisions—and I will put a few of them in front of you just to see what you will do, because you will have to make these decisions.

A hospital cannot balance their books, so they decide to divest of their outpatient physiotherapy. Basically, the outpatient physiotherapy offers physiotherapy services to all kinds of people who need them. People don't have to pay because it's a service that is provided in the hospital. In order to justify their decision, the hospital says, "Well, on one side we have to balance the books and divesting of physiotherapy services will save us a million dollars"—or whatever the amount—"which will allow us to balance the books and stay within our accountability agreement. Services won't be cut back because there is a huge, private, for-profit physiotherapy clinic across the street from the hospital so people won't have to travel any further. It's not going to be any different. It's not going to be a cut in service."

Would you approve their restructuring plan to meet their budget?

Ms. Stephanie Coyles: The first thing I would do is, with the board, work with that hospital to understand opportunities they might have to actually manage down their costs. Some of the experience that I have garnered over the last four years has been around hospital and operational efficiencies, so I would bring a bias that would start there first before we actually looked at cutting services.

The second thing on services is, you need to be able to step back as a LHIN and make sure that the full breadth of service is provided, which would mean that if that was a set of capacity that was funded by government that was accessible to all, we would need to make sure that there was another source of capacity that was accessible to all and that was available. It's not sufficient to say, "They can go purchase that across the street." We would need to look at what the demand is and where they could meet that before you would make any decision along the lines of what you describe.

I would start first by saying, "Gosh, do we need to do that? Second, I would look at total capacity and make sure that you weren't eliminating capacity that was needed. Then, third, it would be how you do it appropriately.

0910

Mme France Gélinas: The second example that I would like to put forward to you is that more and more hospitals are looking at contracting out housekeeping services. You see it in new hospitals built under P3 or alternative financing and procurement. For years, those employees were employees of hospitals in Ontario; now, more and more hospitals are contracting it out to housekeeping services that come into the hospital and do the cleaning.

Here again, if a hospital was to present to you a change in their operation that would show going to outsourcing for housekeeping services, how would you handle this?

Ms. Stephanie Coyles: That one is more straightforward, I think, than the first example. You need to look at the contract and say, "What's the benefit from outsourcing? Are we going to improve service levels and lower costs, which will allow us to reinvest those dollars in providing services back?" I would much prefer that was an option that they were bringing to the table to balance the budget, rather than one in which you were cutting back services. I recognize that, if done properly, it can be structured so that it is a win-win: It's a win to providing better services back to health care delivery and allowing you to manage your costs. But it needs to be done properly, so that would be the way that I would approach that one on the board.

Mme France Gélinas: Just for your information, with the outbreak of C. difficile in our different hospitals and examples in other jurisdictions, there is a clear cause-and-effect link between hospitals that have gone the way of outsourcing their housekeeping and the outbreaks of C. difficile in those establishments, to the point where people who have done this before us are actually reversing those decisions and realizing that although it was well managed, although they thought they were getting value for their money, they end up paying so much in treating

people with hospital-acquired infections that, at the end of the day, it was not worth going at it.

Ms. Stephanie Coyles: Absolutely. That's why I started with the statement that you need to understand what service level you're going to be getting and how you ensure that you maintain the level of quality that you need. I absolutely agree with you on that statement.

Mme France Gélinas: My third and last question has to do with alternative financing and procurement, a term that describes P3s, which basically are public-private partnerships for building hospitals. In those, there is a grey line as to what constitutes client services, health care services and auxiliary services. Most people would agree that snow plowing a parking lot has very little to do with health care. Other people will tell you that housekeeping has little to do with health care. Other people will tell you that portering clients from the X-ray department back to their beds or to their rooms has little to do with health care.

I would like your view as to where you draw the grey line. In a hospital setting, what is part of patient care and what isn't?

Ms. Stephanie Coyles: That's a great question. I would look to my colleagues on the board to help me with that question, because I'm not sure my experience that I bring to the table is—I think I need to be educated on that side of the equation. That said, I'm a quick learner, and that's part of the objective. I think what I would do is continually go back to those principles of asking, "What does it mean? What's the impact on the front line, both for doctors, nurses, as well as the patient? What are the metrics, measurements and controls that we're putting in place to make sure that this service that we're achieving is at the level that we want to achieve whenever we start to look at the set of services within a hospital?"

The Vice-Chair (Ms. Lisa MacLeod): Thank you very much, Madam Gélinas and Ms. Coyles. We will now proceed with questions and comments from the governing party.

Mrs. Liz Sandals: Ms. Coyles, we really appreciate your coming forward to testify this morning. Clearly, you've got some wonderful experience in your previous role consulting in health, and I'm sure that that will be a great asset to the LHIN.

The Vice-Chair (Ms. Lisa MacLeod): We will now conclude with the official opposition.

Mr. Randy Hillier: I'll be very short and brief. Thank you very much for being here today. I have no questions. It's nice to see somebody come before the committee who is well qualified. We'll be supporting your appointment.

The Vice-Chair (Ms. Lisa MacLeod): That concludes the time allocated. Thank you very much, and you may step down.

ROBERT LAWLER

Review of intended appointment, selected by third party: Robert Lawler, intended appointee as member, Hamilton Niagara Haldimand Brant Local Health Integration Network.

The Vice-Chair (Ms. Lisa MacLeod): Our second and final interview is Robert Lawler, intended appointee as member, Hamilton Niagara Haldimand Brant Local Health Integration Network. You may come forward.

As you may be aware, you have an opportunity, should you choose to do so, to make an initial statement. Subsequent to that, there will be questions from members of the committee. We will commence questioning with the government party members. Each party will have 10 minutes allocated for questions, and we will go in rotation. As is also the practice of the committee, if you make a statement, your time will be deducted from the time allocated to the government party. Welcome, and you may begin.

Mr. Robert Lawler: I do have a statement to present, although I think you probably have most of it in front of you. As was mentioned, my name is Bob Lawler. I'm a resident of the city of St. Catharines, in the region of Niagara. I'm here to put my name forward for possible appointment to the LHIN. I feel I meet the criteria needed, based on my education, experience and community involvement.

Education: I graduated in business administration from Ryerson University. I have an accounting designation from the certified accountants' association. I have a diploma in health administration from the Canadian Hospital Association. I was a certified health executive from the Canadian College of Health Service Executives. Not that it's related, but I am also a certified financial planner. That was my second career.

Experience: I started working for the St. Catharines General Hospital as chief accountant and progressively assumed more responsibility. I was president and CEO from 1993 to 2000. At the same time, I was also executive director of the Niagara-on-the-Lake Hospital from 1995 to 2000. I was also the interim executive director for Hospice Niagara in the fall of 2007, until a new executive director could be found.

I'm currently the executive director of Credit Counselling of Regional Niagara, which is a non-profit registered charity that assists people in financial crises. This is a position I have held since 2000. I was also involved with the Ontario Hospital Association. I was on their finance committee and on the human resources committee. I was also on provincial negotiations with the SEIU for a number of years for the OHA.

Community involvement: Currently I'm chair of Community Care, which is the local food bank. I'm also a member of the Hotel Dieu Shaver Hospital in Niagara. I'm treasurer of the Rotary Club of St. Catharines. I am past director of Hospice Niagara, past chair of VON Niagara, past director of Ina Grafton Gage Nursing Home and past director of United Way of St. Catharines.

I'm currently a member of the federal Liberal Party, and I may or may not be a member of the provincial Liberal Party—I'm not sure if I've paid my dues or not.

In summary, I feel I have the education, experience and desire to contribute to the local LHIN.

The Vice-Chair (Ms. Lisa MacLeod): We'll start with questions and comments from the governing party.

Mrs. Liz Sandals: Thank you very much for appearing before us this morning. We really appreciate your coming in. I note your background in accounting and health administration, and when we listen to your volunteer career, you obviously have a huge understanding of the community as well. We wish you well, and I'm sure you'll be a great asset to the board of the LHIN.

The Vice-Chair (Ms. Lisa MacLeod): We'll now proceed with questions and comments from the official opposition.

Mr. Randy Hillier: Thank you very much for being here. I have no questions at all.

0920

The Vice-Chair (Ms. Lisa MacLeod): Thank you very much, Mr. Hillier. We will now proceed with our final comments from Ms. Gélinas of the NDP.

Mme France Gélinas: Welcome to Queen's Park, Mr. Lawler.

Mr. Robert Lawler: Thank you.

Mme France Gélinas: I have a couple of questions for you. One of the first ones is, what are your values or views regarding private for-profit health care?

Mr. Robert Lawler: I support the current publicly funded system. I guess I go back to my background, where you just have finite finances and sort of unlimited demands on the system. I wouldn't like to see privatization, but on the other hand, I think at some point we have to look at how we're delivering health care. We must do things smarter with the same resources. I don't know if that addresses your comments.

Mme France Gélinas: Yes, it does, to a certain extent. I saw from your resumé in the information that we have in front of us, and some of what you've shared with us this morning, that a lot of your experience in health care is with hospitals and what we call big institutions. Do you have any work experience working in the community side of the health care sector?

Mr. Robert Lawler: I was on the board of Hospice Niagara, which is a—just last year it opened up a 10-bed palliative care unit. But before that, it was all outpatient and day-stay. I was a director there. I was also the chair of VON Niagara, and I was also, at one point, a director for VON Ontario. It's really been taken over by the CCAC; they farmed that out. So I think I have a lot of community involvement.

Mme France Gélinas: Some LHINs have grappled with the idea of a one-way valve; that is, the hospital sector is such a big part of the LHIN budget when you compare this with the needs in the community sector. I should know, but I don't know exactly—in your LHINs, I think there are three community health centres and quite a few small mental health agencies. But basically, if you compare them dollar-wise, your LHIN is very much dominated by big-budget hospitals, with a very small percentage going to community-based health.

I can see that the demands from the big institutions will be huge and take a lot of your time, energy and effort just to understand. How do you see this balancing act of small community-based players with small budgets, being just as complicated, with your background being in finance? Understanding that—I will say 90%, but I'm not sure this number is exact—a very large percentage of your budget is going to a few large institutions, how do you see this tug-of-war between the two?

Mr. Robert Lawler: I would agree with you that I think the hospitals are the big boys in the system. You're right: I would think 90% is probably an accurate figure.

I have talked to small agencies in my other life. They always felt that the hospitals got the lion's share of everything. But you're right: There has to be some kind of a balancing and some kind of a way of protecting the resources that are allocated to them.

I would think, over time, the idea is to really move people out of the costly hospitals into other areas. I think there should be a shift and a focus into more resources into that, to have the resources in the community that would allow the hospitals to move patients out, like ALC patients and so on and so forth.

Mme France Gélinas: I think you were in the room when I gave the example of a hospital having difficulty balancing their budget—

Mr. Robert Lawler: Yes.

Mme France Gélinas: —going to the LHIN, and wanting to sign an accountability agreement that would include divesting of physiotherapy, one of the reasons being that there is, in their neighbourhood, a for-profit private physiotherapy clinic. How would you handle such a request from a hospital coming to you as a member of the LHIN?

Mr. Robert Lawler: Based on your—it was the hospital, and there was a private clinic across the road. Is that correct?

Mme France Gélinas: That's correct.

Mr. Robert Lawler: I would not support that. I would support it if there was a public clinic down the road, or another hospital within a reasonable distance, and they said, "Look, we're going to reduce our services, but those services are available," or if there was some trade-off between the two organizations, I would support that.

Mme France Gélinas: Very good. I think you were also in the room when I asked—

Mr. Robert Lawler: About the housekeeping?

Mme France Gélinas: No, the one about where you draw the line as to what constitutes services that enhance patient care versus services that are not patient-care-related. My example was that plowing the parking lot of a hospital—most people wouldn't think of this as patient-care-related. But as you start looking into housekeeping, portering, food services, where would you draw that line as to what is part of the health care services and what is not?

Mr. Robert Lawler: I think anything that comes into direct contact with a patient is patient services. You're right to some extent: the housekeeping, because they're interacting with the client, they're doing the sterilization of the room and cleaning of the room; but laundry, for

example—it doesn't matter if the sheets are washed in St. Catharines or Toronto—I wouldn't consider that direct patient care, and that has been to a large extent sort of farmed out. Even lab to some extent: The lab tests don't need to be done on-site. Anything that's done on-site and in interaction with the patient I would consider, to some extent, patient care.

Mme France Gélinas: Very good. Thank you.

The Vice-Chair (Ms. Lisa MacLeod): Thank you very much. That concludes the time allocated. We appreciate your standing today here, Mr. Lawler. You may step down.

Mr. Robert Lawler: Thank you.

The Vice-Chair (Ms. Lisa MacLeod): Colleagues, we may now proceed to deal with concurrences. We will first consider the intended appointment of Stephanie Coyles, intended appointee as member, Toronto Central Local Health Integration Network.

Mrs. Liz Sandals: I move concurrence in the appointment of Stephanie Coyles as a member of the Toronto Central Local Health Integration Network.

The Vice-Chair (Ms. Lisa MacLeod): Concurrence in the appointment has been moved by Mrs. Sandals. Any discussion? If not, all in favour? All opposed? Congratulations.

We will now consider the intended appointment of Robert Lawler, intended appointee as member, Hamilton Niagara Haldimand Brant Local Health Integration Network.

Mrs. Liz Sandals: I move concurrence in the appointment of Robert Lawler as member of the Hamilton Niagara Haldimand Brant Local Health Integration Network.

The Vice-Chair (Ms. Lisa MacLeod): Concurrence in the appointment has been moved by Mrs. Sandals. Any discussion? Seeing none, all in favour? Motion carried.

That concludes our business on intended appointees. Any other business? Seeing none, the meeting is adjourned until 9 a.m. on Tuesday, November 4, in committee room 228, when we will resume our agency review of Infrastructure Ontario. Have a wonderful day.

The committee adjourned at 0926.

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