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ISSN 1180-436X

Legislative Assembly
of Ontario

Second Session, 41st Parliament

Assemblée législative
de l'Ontario

Deuxième session, 41e législature

Official Report of Debates (Hansard)

Wednesday 16 November 2016

Journal des débats (Hansard)

Mercredi 16 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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111 Wellesley Street West, Queen's Park
Toronto ON M7A 1A2
Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario

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

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Wednesday 16 November 2016

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON THE LEGISLATIVE ASSEMBLY

COMITÉ PERMANENT DE L'ASSEMBLÉE LÉGISLATIVE

Wednesday 16 November 2016

Mercredi 16 novembre 2016

The committee met at 1300 in committee room 1.

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

Currently, there is a motion that was put forward at the last meeting by Ms. Wong. Her motion refers to a date that's in the past, so I will rule the motion out of order.

SUBCOMMITTEE REPORT

The Chair (Mr. Monte McNaughton): We will move now to the report of the subcommittee on committee business. Ms. Wong?

Ms. Soo Wong: I will read the report for the record.

Your subcommittee on committee business met on Monday, November 14, 2016, to consider a method of proceeding on Bill 41, An Act to amend various Acts in the interests of patient-centred care, and recommends the following:

(1) That the Chair request of the House leaders that a motion be moved in the House authorizing the committee to continue to meet past its normal time of adjournment until 6 p.m. on November 16 and 23, 2016, for the purpose of public hearings.

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

The Chair (Mr. Monte McNaughton): Thanks. Any discussion on the subcommittee report? Shall it carry? Carried.

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.

ADDICTIONS AND MENTAL HEALTH ONTARIO

The Chair (Mr. Monte McNaughton): Now I would like to call upon Addictions and Mental Health Ontario, our first presenter today. If you could just state your name for Hansard, you'll have nine minutes for your presentation, followed by two minutes of questioning from each party.

Ms. Gail Czukar: Thank you, Mr. Chair. I'm Gail Czukar. I'm the CEO of Addictions and Mental Health Ontario. There is a written presentation and, just for convenience, I'll follow along with that. We welcome the opportunity. Thank you very much for inviting us to comment on Bill 41, the Patients First Act.

AMHO represents more than 220 organizations that provide mental health and addictions care in Ontario. Last year, our members provided over $400 million worth of service to 150,000 people. Our membership includes community-based agencies, hospitals, peer support organizations and provincial associations. We are a comprehensive voice for community-based mental health and addictions service organizations in Ontario.

We're an active part of Ontario's ongoing discussions for improving the mental health and addictions system. I am a member of the Mental Health and Addictions Leadership Advisory Council, which was formed to advise the government on the implementation of Open Minds, Healthy Minds.

We support person-centered care. As we indicated in our response to the Patients First discussion paper earlier this year, AMHO embraces the challenge of crafting a person-centered, comprehensive system of health care services and supports. We endorse the discussion paper's assertion that we must strengthen mental health and addiction services. Our full response is available on our website.

There are elements of Bill 41 which we believe will advance the goals of a better integrated health system. I'd like to highlight those:

—the requirement to identify sub-LHIN planning units should support more effective planning and delivery across service systems and health care providers;

—the requirement for LHINs to have one or more patient and family advisory committees; such entities are already embedded in most mental health and addictions service providers, and those can serve as models for patient and family engagement; and finally

—we also endorse the establishment of formal linkages between health care services and public health officials.

However, improving the integration of Ontario's health system does not address the capacity challenges in

the mental health and addictions sector. It may make it more seamless for individuals to find where they can access care, which is important, but our members are currently facing operational pressures that compromise their ability to meet the demand for services. Most of our member agencies have faced flatlined base budgets over the past five to 10 years. Without critical investments to increase capacity, Ontarians will continue to face lengthy wait times for mental health and addiction services.

Turning to our recommendations: We're focused primarily on amendments to section 21. Our concern is that the legislation provides significant new authorities to LHINs without direction about how such authorities are to be used to support a stronger, more responsive and more accountable health service system.

Section 21.2 gives each LHIN the authority to appoint a supervisor "when it considers it to be appropriate to do so in the public interest." Such a supervisor would, unless otherwise stipulated, have "the exclusive right to exercise all of the powers of the governing body of the provider and its directors, officers, members or shareholders." This authority does not require provincial approval, nor does it need to be justified by anything other than a LHIN's interpretation of "the public interest."

For hospitals or long-term care, the appointment of such a supervisor cannot be made without the approval of cabinet. It is not clear to us why the government would treat different types of providers so differently.

It's complicating, also, that a number of community mental health and addiction providers hold multi-service accountability agreements with the LHINs, yet receive less than 100% of their funding from them—in many cases, far less. They receive funding from multiple sources: federal or provincial ministries, the United Way, foundations, private client fees, donations and so on.

If the LHIN appoints a supervisor as indicated in the legislation, it could result in the LHIN controlling all those assets, programs and property, including those over which they do not have funding authority. The LHIN would have the authority to replace a community board and govern an organization in the interests of one minority funder, potentially. That could put non-LHIN-funded programs, services and other source funding at risk that the organization has worked hard to build.

We make the following recommendations with regard to the authority to appoint a supervisor. It should be accompanied by guidelines or regulations for when such authority should be used. Specifically, we would amend the section to:

—stipulate that the appointment of a supervisor to any health service provider must require the approval of cabinet, or at least the ministry;

—require notice to the provider on the appointment of a supervisor. That requirement applies only to the appointment of an investigator;

—provide for a mechanism by which the health service provider may request a review or appeal of the appointment of a supervisor;

—allow for regulations or guidelines established by the ministry governing the appointment of a supervisor for providers that are funded by diverse sources. As an interim measure, the legislation should not give LHINs the authority to appoint a supervisor in cases where a minority of the organization's revenue is derived from the LHIN.

Again, section 21.2 should stipulate that voluntary integrations may not proceed while a supervisor controls a health service provider. The act provides provisions governing integration and has very distinct processes for those integrations which are involuntary. It requires the approval of the ministry, who is responsible to the Legislature to answer questions about those important decisions. The LHIN should not be able to circumvent that process by appointing a supervisor who then provides notice to the LHIN that an integration is voluntary.

We support section 10 of Bill 41, which gives the minister the authority to issue operational or policy directives to LHINs. We think that that authority is a reasonable tool for the government to assert the provincial interest in a system of health services that is reasonably consistent and equitable across Ontario. We strongly suggest that this provision be used by the minister to provide LHINs, providers and the public with clear information about how the significant new authorities of LHINs are to be exercised, including interpretations of what's in the public interest.

The current criterion for the appointment of a supervisor, that it serve the public interest, is broad. Such an unconstrained authority could potentially be used in dramatically different ways in each of Ontario's 14 LHIN areas, creating very different health systems. AMHO would strongly urge the government to delay proclamation of those parts of the legislation that give LHINs increased authorities until the minister has provided guidance on how such authorities are to be used.

It's also our understanding that under the Home Care and Community Services Act, approved agencies must be not-for-profit organizations, and that the proposed Patients First Act would not change that. We feel strongly that that's an important requirement that should not change today or in the future.

I'm happy to answer questions.

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The Chair (Mr. Monte McNaughton): Great. Thank you very much. We'll move to the official opposition. Mr. Yurek?

Mr. Jeff Yurek: Thank you very much for coming in today and giving us this information. You raised a concern, which I agree with, that there's the potential with the appointments of the supervisors that we could create different systems throughout the province, which is clearly not the goal of this legislation at this point.

Can you touch upon that, and maybe how, if at all, this bill affects the addiction or mental-health patient, and how this is helping those patients?

Ms. Gail Czukar: Addictions and mental health are not mentioned specifically in the legislation. That's one

thing, and I know you've noted that in terms of the submissions from CAMH that have also highlighted that.

We think that there's good potential for improving the system for people with mental health and addiction issues by integrating with primary care, by promoting a lot more integration between home and community care and mental health and addictions. We just don't know what that's going to look like in each LHIN. The LHINs are there, obviously, to adapt provincial systems to their local circumstances, which is good. But how it will improve care for people—it needs to be consistent from one LHIN to another. That would be a huge improvement, because we currently have a very uneven system for mental health and addictions from LHIN to LHIN and across the province.

Mr. Jeff Yurek: Right. It's a concern of mine as well that northern Ontario and rural Ontario aren't going to have the same level of services available as in urban Ontario, which we hope will be fixed down the road.

You also mentioned something about costs. Are you concerned at all that this experiment the government is creating with regard to the creation of different levels of bureaucracy is going to eat away at money that might be readily available to your patients?

Ms. Gail Czukar: We don't know what additional costs might be generated. It's not their goal—

The Chair (Mr. Monte McNaughton): I'm sorry to interrupt. We have to move to Madame Gélinas.

M^me^ France Gélinas: Thank you. I want to have a sense of how important it is that subsection 21.2, about the appointment of a supervisor—how important is it to you and to the agencies that you represent?

Ms. Gail Czukar: It's extremely important, because we don't know how that power is going to be exercised. Obviously, we would want to see it exercised sparingly, only when absolutely needed, when efforts to work with providers to work better together and integrate their services for the benefit of clients have failed in some way. It's extremely concerning that there aren't the guidelines about what's in the public interest—that's a huge issue—and that there is no oversight of that from the ministry level or the Lieutenant Governor in Council.

M^me^ France Gélinas: Thank you. You are right that the Home Care and Community Services Act defined "agencies" as not-for-profit agencies. The way Bill 41 is written right now, "agency" could be a for-profit agency. You did mention that on the bottom of page 4. How important is it to you that we fix this within Bill 41? Because right now, in Bill 41, "agency" is not a not-for-profit agency. It opens the door to privatization.

Ms. Gail Czukar: I think it's important to fix that. It's particularly important in the context of the broader community health care system, particularly for home and community care services, which many of our clients also use.

M^me^ France Gélinas: The bill gets rid of the board of the CCAC and the CEO of the CCAC, but everything else stays the same. How is this going to improve people's access to mental health? What is it that the CCAC—

The Chair (Mr. Monte McNaughton): Madame Gélinas, we have to move to the government now, to Mr. Dhillon.

Mr. Vic Dhillon: Thank you very much for being here today.

We've heard that some individuals struggling with mental health and addictions sometimes experience gaps when moving to different parts of the health care system. How important is it that those struggling with mental health and addictions experience continuity of care when moving from health care service settings or providers?

Ms. Gail Czukar: It's extremely important. One of the questions that gets raised by the difference in the treatment of appointment of a supervisor between hospitals and community is that we're questioning how we're going to have an integrated system if the LHIN can appoint supervisors and inspectors and so on directly for community mental health and addiction agencies, but not for hospitals. So how, if they can't issue any directives to hospitals about how to integrate their care with the community agency—it just seems to us that that has the potential to increase the transition issues and the coordination issues for clients, when it's extremely important that those transitions and that access be streamlined and coordinated. It seems to us that the LHINs should have the power to issue the same directive to a hospital and a community agency to make it work together better.

Mr. Vic Dhillon: Thank you.

The Chair (Mr. Monte McNaughton): Thanks for your presentation today.

Ms. Gail Czukar: Thank you.

DOCTORS FOR JUSTICE

The Chair (Mr. Monte McNaughton): I will now call upon Doctors for Justice. Good afternoon. You will have nine minutes for your presentation, and the questions this time will begin with the third party. If you could just state your name for Hansard before you begin.

Dr. Sharadindu Rai: Thank you, Chair. My name is Dr. Sharadindu Rai. I'm a relatively new family medicine graduate, having started in practice in 2008. I am speaking today on behalf of Doctors for Justice, and we welcome this opportunity to address this committee regarding Bill 41.

This committee has already heard from the Ontario Medical Association, and we strongly share their sentiment that this bill should be rescinded or substantially redacted. We also share their sentiment that Bill 41 was developed without broad-based input from family physicians. Bill 41 is a continuance of a pattern of unilateral decision-making and systematic disrespect by the government for Ontario's physicians.

We agree with the OMA: Bill 41 is nothing less than a command-and-control approach by the government to the management of the health care system, and it adds unnecessary bureaucracy and unnecessary costs to the

health care system at a time when health care funding is constrained.

We will use this opportunity to specifically point out the sections of Bill 41 that we take issue with.

Section 11.2 of the act gives the Minister of Health the power to unilaterally issue provincial standards for the provision of health services. There is a lack of accountability or oversight of the minister's actions, and there is no opportunity for health service providers to provide any substantive feedback to the minister as to whether a standard is appropriate or not.

Section 12.1(1) gives the minister the power to appoint one or more investigators to investigate and report on the quality of the management and administration of a local health integration network, and subsection (2) allows the investigator to enter the premises of a local health integration network and inspect the premises and the records relevant to the investigation. These are very intrusive powers and give the minister broad powers of search and seizure without any appropriate checks and balances.

This section of the act is so broadly worded that it potentially gives a LHIN-appointed investigator access to the medical records of patients within a family health team, which does fall within the purview of the proposed act. This potentially compromises the confidentiality of patients' medical records, and in doing so, it certainly does not put "Patients First." This act gives the LHINs too much power over patient care and allows investigators, who may not necessarily have medical training, to potentially investigate medical matters that fall outside their experience and training.

Section 14.1 forces each LHIN to establish geographical sub-regions for the purposes of planning, funding and integrating services within those geographic sub-regions. This adds another layer of bureaucracy and added costs to the health care system at a time when health care funding is substantially constrained. Arguably, the government is not adequately funding the health care system as it stands, so it makes no sense to add additional costs to the system. The geographic sub-regions appear to be modelled after the patient care group model in the Baker-Price report. However, there is no substantive evidence that these geographic sub-regions will improve patient care. The Baker-Price report itself quoted research from the Institute for Clinical Evaluative Sciences that "has shown that current primary care delivery patterns generally match geographic areas in most parts of the province," hence it is illogical to effect these province-wide changes in primary care delivery.

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Subsection 20(11)(c) essentially states that in the event of a failure to reach a mutually agreeable service accountability agreement between the health service provider and the LHIN, the act ultimately gives the LHIN the power to unilaterally dictate the terms of the service accountability agreement. This gives LHINs extraordinary and unchecked power over how family health teams operate. There is no remedy within the act itself in this event.

Subsection 38(2.1) allows the minister to appoint the LHIN as his or her agent for the purposes of carrying out the functions listed in clause 2(2)(a) of this act. In our view, and in the view of the Ontario Medical Association, this arrangement violates the Representation Rights Agreement between the government and the OMA. The government has an obligation to negotiate matters relating to physician services and the associated responsibilities with the OMA, and we insist that the government abide by its previous agreement with the OMA.

We hope that the committee will give serious thought to rescinding or amending these problematic sections of the act. Thank you.

The Chair (Mr. Monte McNaughton): Thank you. Madame Gélinas?

M^me^ France Gélinas: I will start with a similar question. If I take the section of the act that talks about the appointment of an investigator—by the way, I read the act in the same way you do, and when I took the briefing with the people who wrote the act, I gave a scenario of something having gone wrong in a family health team that had to do with service providers. They confirmed that if it was relevant, they would ask for access to the patient's record.

This worries me, and I can see by your submission that it worries you. I just want to have a quantification of this: How worrisome is this for you?

Dr. Sharadindu Rai: Thank you for the question. We are greatly concerned that this act, despite having the title "Patients First," is actually potentially compromising the confidentiality of patient data.

It says in the act specifically in—sorry, I'm having trouble locating it, but there's a specific reference to medical records within the act itself. We're greatly concerned that as this act stands, the patients in Ontario could potentially have investigators—particularly those patients who are in family health teams. Investigators could come in and potentially access those records without our patients' consent.

If this government truly wishes to put patients first, let it listen to the feedback that it is receiving from front-line primary health care providers like myself.

M^me^ France Gélinas: Agreed. Were you consulted at all about this bill by the government?

Dr. Sharadindu Rai: I personally was not consulted regarding this.

M^me^ France Gélinas: How about Doctors for Justice?

Dr. Sharadindu Rai: I was not aware of a consultation process, nor was I invited to appear.

The Chair (Mr. Monte McNaughton): Thank you very much. We'll move to Mr. Dhillon.

Mr. Vic Dhillon: Thank you, Dr. Rai, for being here today.

Through the work of the Patients First: Action Plan for Health Care, Ontario is committed to connecting a family doctor or nurse practitioner to everyone who wants one. Based on the recent health care experience survey, 94% of Ontarians have a regular primary care provider. However, access to primary care services has been an ongoing

issue for Ontarians: 57% of Ontarians cannot see their primary care provider the same day or the next day when they're sick, and 52% find it difficult to access care in the evenings or on weekends.

How do you suggest your members work collectively to improve access to primary care services?

Dr. Sharadindu Rai: With respect, we have one of the most bureaucratized health care systems in the world. What this bill, as it is written, stands to do is add yet another layer of bureaucracy and associated cost to the health care system. This is not putting patients first; it's putting bureaucracy first.

What we need to do is redirect those health care funding dollars, which this bill proposes to direct toward bureaucrats for the sake of managing access to care, and instead actually increase the access to care for patients—not add yet another level of bureaucracy. Let us truly put patients first; let us eliminate unnecessary levels of bureaucracy in the health care system.

Mr. Vic Dhillon: Thank you.

The Chair (Mr. Monte McNaughton): Mr. Yurek.

Mr. Jeff Yurek: Thanks very much for coming in today. I noted that you complemented what the OMA spoke of yesterday. Maybe you can comment on this line: In an article, the Minister of Health said that the OMA's testimony "was as close to a lie as one can humanly get." Do you have comments on the Minister of Health actually saying that about the medical association and you, obviously, since you're in agreement with the OMA?

Dr. Sharadindu Rai: Thanks for the question. I said in my submission that what was missing from this process was broad-based consultation with physicians of every stripe. The reality is that most physicians in this province were unaware—if there was a consultation process taking place, they were unaware that that consultation process was taking place.

It behooves the government to work alongside physicians. We're the folks who are looking after patients every day. They need to consult with us before they start rearranging the health care system en masse and doing things that will potentially be to the detriment of patient care.

Mr. Jeff Yurek: What we've heard so far is that doctors weren't consulted. We heard the other day that patients weren't consulted. The bureaucracy is growing. In your opinion, do you think this bill is going to fix what ails health care at this point?

Dr. Sharadindu Rai: I think that this bill is going to contribute to the problem, not solve it. Already in Ontario, we are seeing family physicians leave the province. I'm seeing many of my colleagues retire, saying they've had enough. They don't want more bureaucracy in the health care system. They're fed up. They want to just leave the health care system before this government drives it even further into the ground.

Mr. Jeff Yurek: Thank you.

The Chair (Mr. Monte McNaughton): Thank you very much for presenting today.

DR. DARREN CARGILL

The Chair (Mr. Monte McNaughton): The next presenter has phoned in. Dr. Cargill, can you hear me? Is Dr. Cargill on the line?

Dr. Darren Cargill: Hello, it's Dr. Cargill. Can you hear me?

The Chair (Mr. Monte McNaughton): We can.

Dr. Darren Cargill: Good.

The Chair (Mr. Monte McNaughton): Thank you very much. You'll have nine minutes for your presentation, followed by two minutes of questioning. The two minutes of questioning will begin with the government. If you could please state your name for Hansard, and present.

Dr. Darren Cargill: My name is Darren Cargill. I'm a family physician in Windsor, Ontario. I would like to take this opportunity to thank the committee for the opportunity to make a presentation regarding Bill 41.

I bring a very unique perspective to the committee for consideration today, but my concerns remain the same as those raised by Ontario's 30,000 physicians. I'm a palliative care physician. I work in Windsor, Ontario, and I visit patients daily in their homes, providing symptom management and end-of-life care for Ontario's sickest patients.

Since graduation, I have seen our system struggle to provide care for these patients and the resulting damage that this has done not only to patients, but to their families and caregivers who survive them.

In the past decade, I have seen slow but steady progress made in this area, with the building of residential hospices and the signing of the declaration of partnership, a multi-stakeholder document committing the signatories to improving palliative care in Ontario. Prior to 2011, I would have been standing before this committee optimistic and rather hopeful for the future. Instead, I am feeling very pessimistic and dejected.

In the past five years, I have seen the relationship between physicians and government erode to the lowest levels that I have ever experienced. Gone is the collaboration and co-operation that marked the first five years of my career. Instead, it has been replaced with acrimony, disagreement and utter disregard for one another. This serves no purpose, and it certainly does not serve the patients of Ontario.

Bill 41 represents a flashpoint in this ongoing dispute. This bill is an unfortunate attempt to control and command aspects of the health care system that are best built through collaboration and co-operation. Sadly, this bill was created using the input of only a few hand-picked physicians, rather than broad-based input and reflection from Ontario's representative organization, as represented by our Representation Rights Agreement signed in 2012.

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Individual physician participation in LHIN sessions has been misconstrued as appropriate physician input, and this misrepresentation has led the section of general

and family practitioners, known as the SGFP, which represents Ontario's greater than 12,000 family physicians, to disengage from discussions with their LHINs regarding Bill 41.

Without an engaged and active primary care sector, meaningful health care transformation and the advancement of palliative care services in Ontario simply will not happen. A recent article in the CMAJ—the Canadian Medical Association Journal—and a report by the Canadian Society of Palliative Care Physicians both show that we are woefully under-resourced in the palliative care specialists needed to provide the care necessary for Ontario's aging patients. Our only hope is to mentor and support and grow an engaged primary care sector at a time when they are likely the most disengaged in recent memory.

Perhaps the most egregious concern I have about Bill 41 is the lack of consultation with the Ontario Palliative Care Network, OPCN. Formed in March 2016, OPCN was created as the principal adviser to the government on all issues regarding palliative care in the province of Ontario. Bill 41 contains specific references to hospices, and yet not once was OPCN consulted with regard to Bill 41. I have spoken to and confirmed this with the co-chair of the network. Unfortunately, I fear that the fledgling work of this group to build primary-level palliative care capacity within our primary care sector will be wasted due to the ongoing dispute between governments and officials. As a founding member of OPCN, I am doubly concerned.

Successful health care transformation requires bottom-up ownership and not top-down buy-in. Bill 41 is a command-and-control-type bill that may not be the wedge between our doctors and the government, but it is certainly a hammer that will drive the wedge deeper. Passed in its current form, without meaningful input from physicians, this bill will serve as a point of contention for years to come.

Not only am I a clinician, but I am also a teacher. Every day, I teach medical students and residents. In addition to their clinical training, we spend much of our time discussing current events and future plans. There is a great deal of uncertainty among our trainees these days. Many view Ontario as a hostile environment in which to practise medicine, and they see Bill 41 as a tool to control and command primary care in Ontario. Many future family doctors are delaying the substantial investment involved in opening family practices, and they are doing so in lieu of locum work or additional training in order to see how this current conflict plays out.

Ontario is the only province in Canada facing this impasse with their physicians. It is not hard to imagine that young, well-trained professionals may choose to begin their careers elsewhere rather than inherit the conflict of this current government and its doctors.

It is with great respect that I propose that Bill 41 not proceed in its current form until proper consultation is sought with Ontario's physicians. I fully support and echo the comments and the presentation made by Dr. Stephen Chris, who I understand presented on Monday. His presentation, as I understand, did provoke some comments from the Minister of Health which I do find unfortunate.

I certainly hope the committee will take my comments under consideration. I am hopeful that a meaningful solution to Bill 41 can be achieved.

The Chair (Mr. Monte McNaughton): Great. Thank you, Dr. Cargill. The first question will come from Ms. Wong of the government.

Ms. Soo Wong: Thank you, Dr. Cargill, for your presentation. I'm to pass on best wishes from my colleague John Fraser to you. So that's the first comment.

Dr. Darren Cargill: Thank you very much.

Ms. Soo Wong: As you know, in the 2016 budget, the government has invested an additional $75 million over three years dealing with patients and more options about palliative and end-of-life care. Given that additional investment on this particular strategy, I want to hear your opinion, Doctor, about your advice to us in terms of the LHINs, in terms of ensuring more continuity of care for palliative care planning and meeting the needs of our patients. I know in Windsor, where you're from, it's a very diverse community. Can you share with us, because you are a front-line palliative care physician, in terms of the coordination and ensuring this money, the new investment of an additional $75 million over three years to service our community?

Dr. Darren Cargill: Right. First, I'd like to return the greetings to MPP John Fraser. I'm very appreciative of the work he has done in palliative care, and the government's investment in palliative care services overall.

In a lot of ways, when we're talking about the investment of money, we know that, unfortunately, the need for palliative care services is much greater than we can ever provide in sub-specialist palliative care services. We know that only 16% to 30% of Canadians—and we can probably analogize that to Ontario—can access palliative care services when and where they need it.

We know—and this is one of the goals of OPCN—that the only way to truly provide universal access to palliative care services is by building a very strong and robust primary care sector that has the foundation, the basic clinical skills, and overall specialization to provide palliative care services. That's why we need a strong—

The Chair (Mr. Monte McNaughton): Dr. Cargill?

Dr. Darren Cargill: Pardon me?

The Chair (Mr. Monte McNaughton): We have to move now to the official opposition and Mr. Yurek for questions.

Dr. Darren Cargill: No problem. Thank you.

Mr. Jeff Yurek: Good afternoon, Doctor.

Dr. Darren Cargill: Good afternoon.

Mr. Jeff Yurek: Thanks for joining us. I wish the government had asked you that question a year ago, when they started creating this legislation, as opposed to whenever the legislation has already been written.

We've heard numerous times from people who have been here that the doctors weren't consulted, the patients

weren't consulted. You made mention with regard to the power being taken away and concentrated up in the higher levels of the Ministry of Health. Can you elaborate further on that, please?

Dr. Darren Cargill: Yes. Certainly, one of the biggest concerns that we do have is that when you're trying to build health care transformation, the best way to do this is through a bottom-up approach so that stakeholders feel ownership of the transformation rather than buy-in. By concentrating a great deal of the power with the Minister of Health and with the LHINs, certainly this looks more like a top-down approach, where they're going to be trying to elicit buy-in. We know from a variety of leadership models, whether it's quality improvement, whether it's health care transformation, that top-down approaches don't work. We need bottom-up. Unfortunately, this bill is a very top-heavy bill.

Mr. Jeff Yurek: Do you feel this bill is going to improve the care palliative patients receive in this province, or perhaps be a hindrance or just stay the same?

Dr. Darren Cargill: I certainly am very worried that the increase in bureaucracy that is suggested through this bill, the creation of sub-LHINs—we know that right now, health care dollars are at a premium and that they have to be spent very wisely. I'm not sure spending the next health care dollar on hiring additional bureaucracy is what's necessary. We need to be directing this money more towards front-line care, whether that be doctors, nurses, personal support workers and so forth. We don't need to be expanding our health care bureaucracy at this time. Unfortunately, I feel that that is what Bill 41 is going to accomplish.

The Chair (Mr. Monte McNaughton): Dr. Cargill, we have to move to questioning now from the third party and Madame Gélinas.

Dr. Darren Cargill: No problem. Thank you.

M^me^ France Gélinas: Thank you, Dr. Cargill. I want to thank you for the good work that you do, and that you have chosen to work with some of the most vulnerable people in Ontario, people needing palliative care. I thank you for the care that you provide.

I also want to thank you for the very good work you've done with the MPP from Windsor-Essex, my colleague Lisa Gretzky, in support of Bill 54, Dan's Law, to make sure that home care and palliative care are not denied to Canadians who need it. Your advocacy is much, much appreciated.

Dr. Darren Cargill: Thank you.

M^me^ France Gélinas: My question will focus on—we have a bill in front of us. I'm trying to quantify how important it is to you that consultations, meaningful consultations—what you call transformations from the bottom up—take place before we move ahead with the idea of getting rid of the boards and the CEOs of the CCACs and putting all that under the LHINs.

1340

Dr. Darren Cargill: Thank you very much for the question. I think it's incredibly important. I'm not sure I can quantify how important because, unfortunately, most people view that lack of consultation as being a non-starter for this bill.

The physicians in Ontario are committed to participating in the kind of health care transformation that is going to improve care not only for palliative care patients but patients throughout Ontario. But unfortunately, it's a fatal flaw in this bill. If it proceeds in its current form, I think, unfortunately, it will have the exact opposite effect. It will end up bogging down front-line care rather than releasing them to do the work they need to do.

M^me^ France Gélinas: Thank you.

The Chair (Mr. Monte McNaughton): Thank you, Dr. Cargill, for your presentation today.

Dr. Darren Cargill: Thank you very much.

MR. TED BALL

The Chair (Mr. Monte McNaughton): I'd now like to call upon Ted Ball, our next presenter. Mr. Ball, if you could state your name for Hansard. You have nine minutes for your presentation, and questions will begin with the official opposition.

Mr. Ted Ball: Thank you. As you just gave my name, my name is Ted Ball. I'm a health care consultant with Quantum Transformation Technologies.

I've given a statement out, but I'm going to try and summarize it very quickly.

I'm reluctant to call myself an expert—that gives me a bit of an odd feeling, trying to label myself as an expert—but I've spent the last 25 years studying complex system design, the art and science of complex system design. In the 1990s, I spent quite a bit of time, about 10 years, with Herbert Wong in Austin, Texas, as a group of R&D folks were pulled together to invent systems-thinking-based tools for doing organizational and system alignment. We created 23 health IDSs, integrated delivery systems, across the United States. Out of that emerged some important lessons learned about what works and what doesn't work in complex system design.

I'm here today to expose some really serious design flaws in this bill and in the consequences of very flawed and tragic design, because there is no real science to anything that's being done here. It's a raw statement of power.

I've also served as chief of staff to Ministers of Health in the province of Ontario under Bill Davis, so I'm back in my old territory again.

I also did speeches for Ministers of Health from all three political parties, so I really regard much of what I'm going to say to be completely non-partisan, although it might sound a bit harsh on the government side today.

There are two fundamental, key approaches to design. Basically, they are the top-down, command-and-control, micromanagement design, which has really been the chosen design of health care in Ontario for most of our practice since the establishment of the Ministry of Health until, of course, 2003, when the Liberals were elected and the McGuinty government came in and quite correctly looked at history and said, "This does not work.

It's a lousy way to do it. We're going to move to the second model," which is the community empowerment or devolution model.

What that legislation did, when they created the LHINs, was create a community-based board of nine members, and they were given the power to do two things: (1) oversee the planning of local health systems, and (2) allocate resources to meet their plan.

Unfortunately, they never got the devolution. No one ever devolved authority. Devolving authority would have cost about 50% of the jobs at the Ministry of Health and Long-Term Care, and the public servants went diligently to successive ministers—to Minister Caplan, to Minister Matthews and to Minister Hoskins—saying, "You don't need to implement this law. We should keep control here at Queen's Park, here with the bureaucracy and here with the minister." Those three ministers have agreed. So this law, Bill 41, is actually here to reverse what the same government did 12 years ago. It's a complete reversal of what they did 12 years ago.

The assumption of that top-down, command-and-control model is that the answers to our most complex problems are at the top of the system, in a hierarchy among public servants in Toronto. The assumption of the community-based empowerment model and devolution is that the answers to our most complex problems are as close to the front line as you can get. They're with patients; they're with families; they're with front-line workers; they're with managers locally; they're with LHINs locally. Those are two very different assumptions. Bill 41 is going back to the good old days of command-and-control being the key.

While the community empowerment version was passed back in 2004, it was never implemented and devolution at that time was expected to reduce the number of people at the ministry by at least 50%. In those days, 2003-04, we had five ADMs. Today, 12 years later, there are 20, so we didn't reduce the size of the ministry. It expanded massively.

This is a question I think you should be asking to the public servants at the Ministry of Health: How many more public servants at Queen's Park and in the LHINs is it going to take to now manage under the new Bill 41? What is the expectation? They will of course know the answer; I'm not sure that they're prepared to share it before this act passes or even before the next election just 18 months from now.

Let me deal with another issue, which is the merger of the LHIN and the CCAC as another example of "worst practice" design. When you ask the Ministry of Health, "Why did you do this?"—this is a real botch, this merger leading to conflict of interest and all kinds of other problems from a design point of view—they say they had to be in compliance with the collective agreements, which most people say is simply not true.

Let me take you to Henry Mintzberg, who is the god of strategy organizational design on our planet. Henry Mintzberg was the dean of the school of business at McGill University. He talked about helper organizations and doer organizations. A helper organization, Mintzberg says, is like the LHIN. It's a helper because it just does planning, funding, oversight and accountability. Those are the helping things. In contrast, the CCAC is a doer organization because it has a really important function providing a service called care coordination and case management. So it's a doer organization.

What Mintzberg advised the world is never, ever under any circumstances would you ever merge a helper organization and a doer organization because that would be like cross-breeding an elephant and a pig. It would be a very ineloquent design and it's a crime against nature and it doesn't work; it's dysfunctional and it's not going to happen. So here we are, we're doing it anyway, and when you ask them why, they say it's in the collective agreement, but many experts say there are other ways to deal with that. The fix is probably to change case management. Care coordination should be governed and managed by the places where they're going go, which is the family health teams, the CHCs and the hospitals where they're located.

Let me say something about the sub-LHINs, because I just heard the gentleman from the OMA say there's no evidence for that. That's not true. The sub-LHINs are probably the very best thing about this act. This is exactly what we should be doing, having these sub-LHINs. Stephen Shortell, back in the 1990s, wrote about IDS, the integrated delivery systems. Those are exactly what a sub-LHIN region is. There's the potential that they're going to get this right. However, if you listen carefully to what the ministry is saying, it's probably going to get really badly screwed up because in best practices in the IDS, the integrated delivery system that Shortell wrote about—best practices include focusing around a shared vision, focusing around a system scorecard, collaborative governance and the integration of IT, finance and HR for a system of services.

That's not where the ministry is heading. The ministry is heading into yet another command-and-control—let's wipe out all the boards, let's have a super-system board for the system and let's have a system CEO for the entire system, who should be the hospital CEO and just automatically declare that they're the ones to be in charge. So those are real flaws in the design.

The flawed design of Bill 41: I think that Bill 41 is basically answering the question of who's going to be the boss, who's going to be in compliance, and I think you should count the number of times you read the word "compliance" compared to the number of times you read the words "collaboration," "co-operation," "coordination" or that kind of thing.

If we had to call legislation after the outcome that is produced, this act should be called the community disempowerment act. What it does is it reverses what McGuinty did in 2004. It says, no, the local community nine-member board is not in charge anymore. It's been branded and marketed as putting patients first. You should ask Patients Canada why in fact they're so skeptical about this act, because Patients Canada, the

voice of patients in this province, says that they're not in favour of Bill 41, that they don't see how any—

The Chair (Mr. Monte McNaughton): Thank you very much, Mr. Ball. I have to cut you off.

The questioning will begin with Mr. Yurek.

1350

Mr. Jeff Yurek: Thanks for coming in today. I have just a couple of quick questions. In debate, the government talks about how they're actually empowering the local community. Can you speak to that, about the power structure with Bill 41? We feel that it's more power for the Ministry of Health through the LHINs, taken away from actual local voices.

Mr. Ted Ball: If you go back to the paper, Patients First, you will find at the back a section called the appendix. The appendix contains the most important proposal. Hidden in the appendix is the proposal that says that from here on in, the Ministry of Health is going to be in charge of the LHIN. So it absolutely is exactly what you're saying. This is an act that puts the ministry in charge of the LHIN and the LHIN in charge of a bunch of other things that the ministry can now control. This is really about the re-empowerment of the Ministry of Health.

In fairness, they never gave up that power, right? It's true that we did pass that other act, but it was disregarded by the ministry and all the ministers I just named. They never implemented the act.

So I think you're quite correct that this is about the empowerment of the ministry.

Mr. Jeff Yurek: And where does the patient sit in this bill? It's coined the Patients First Act, but I haven't seen anything that's empowering or helping the patient.

Mr. Ted Ball: No. I work quite a bit with the folks at Patients Canada. I don't know if they're appearing before you, but if you read their press release, they're extremely skeptical that any of these changes in bureaucratic authorities are going to have any beneficial impact for patients. I agree with that position completely.

In complex system design, if you focus on designing for outcomes for patients, you end up with a completely different focus on what you would do. This is a design that says who's going to be the boss, who's going to be the big boss and who's going to be in compliance, and then compliance is essentially the focus.

The Chair (Mr. Monte McNaughton): Thank you, Mr. Ball. Madame Gélinas?

M^me^ France Gélinas: I'm pleased to see you again. I have heard many of your talks before, and I appreciate your insight into the design of our health care system.

Try to explain to me: The minister is the minister; he is already in charge. He can already command whatever he wants within the Ministry of Health. Why do we bother with all of this?

Mr. Ted Ball: This is not for the minister; this is for the ministry. The minister, as you know—in the act, I think it says something like "The minister can do anything he or she wants, any time they want, nyah-nyah nyah-nyah nyah-nyah."

M^me^ France Gélinas: Pretty much.

Mr. Ted Ball: So the minister has the authority to do anything, any time. What this is doing is it's saying, "The ministry is in charge." Even though I think it's unnecessary, because the ministry is in charge anyway, many of the public servants found the act under Mr. Smitherman to be offensive because it stripped them of their power and handed the power to community boards of nine people. That was a huge insult. This is getting back.

The Liberal Party has agreed to pass this act. I assume there's going to be an election in 18 months. There isn't enough runway room left to implement this act in those 18 months, so I assume this will be a matter of debate for the upcoming election.

We know where the Liberals stand on this: They are in favour of the re-empowerment of the ministry, and command and control. We don't know where the opposition parties are. I'm going to assume that they're going to be in favour of community empowerment and devolution of authority.

M^me^ France Gélinas: Would making the boards of the LHINs elected boards help in any way?

Mr. Ted Ball: No, I don't think so.

M^me^ France Gélinas: Because of the design?

Mr. Ted Ball: Because of—

M^me^ France Gélinas: Because of the power that the ministry will have over them anyway?

Mr. Ted Ball: First of all, I have a huge respect for governance. If you read the Patients First Act, you can't find any reference to the word "governance." So imagine doing a system design and never even—

The Chair (Mr. Monte McNaughton): Mr. Ball—sorry. We have to move now to the government. Ms. Kiwala.

Ms. Sophie Kiwala: Thank you so much, Mr. Ball, for being here today. I do want to acknowledge you for your long-standing contribution to the medical field, despite some of the things that you've said. Certainly, somebody who has had such an outstanding career—I wasn't exactly anticipating hearing you say "nyah-nyah nyah-nyah nyah-nyah," so there you go. I just wanted to add that.

I would also like to add a few positive things that I think are going to be good things in Bill 41. If it's passed, it would give the LHINs the tools, the oversight and the accountability they need to align and integrate local health care services. Under the Patients First Act, the LHINs would take on responsibility for home care, primary care planning and performance, better positioning them to coordinate care. This is something we have heard from our communities.

There has been quite a bit of discussion about consultation. I personally hosted a consultation in Kingston and the Islands with many different stakeholders from the medical community. I know that the LHINs held consultations as well.

Through the process of developing the Patients First Act, the Ministry of Health actively engaged thousands of Ontarians. Over the course of two months, approxi-

mately 6,000 individuals and organizations were consulted through six ministry-led round tables, 247 LHIN-led sessions and hundreds of additional meetings. In addition to health service providers that were consulted, many of those who were consulted were patients and caregivers.

A criticism that we've heard from patients and their families is that patients often experience difficulties when accessing or connecting to various—

The Chair (Mr. Monte McNaughton): Ms. Kiwala? Sorry, we're at the time allocated.

Ms. Sophie Kiwala: Are you kidding?

The Chair (Mr. Monte McNaughton): If you want to get to questions, you have to get to questions.

Thank you very much, Mr. Ball.

Mr. Ted Ball: Was that a question?

Ms. Sophie Kiwala: We didn't get there.

The Chair (Mr. Monte McNaughton): More of a statement.

Ms. Sophie Kiwala: Thank you for joining us.

Mr. Ted Ball: Thank you.

The Chair (Mr. Monte McNaughton): Our next presenter cancelled, the 2 o'clock one, but the 2:15 presenter is here. But I understand that Madame Gélinas has a motion.

M^me^ France Gélinas: I take it that you've all received a copy of the motion that I would like to read into the record?

The Chair (Mr. Monte McNaughton): They're being distributed now.

M^me^ France Gélinas: Oh, I take it that you are about to receive it, but it's very short and really easy.

I move that the committee authorize the Clerk to attempt to schedule witnesses for this evening's meeting from the remaining requests to appear that were received as of the request deadline.

You remember that we got 67 names that we had to prioritize. All I'm saying is, given that we have some empty spots, let's use our time wisely. The Clerk will fill the spots with whoever they can reach. We're not going to prioritize or anything. Can I count on your support?

The Chair (Mr. Monte McNaughton): Any discussion on the motion? Any discussion? Shall the motion carry? Carried.

ASSOCIATION OF LOCAL PUBLIC HEALTH AGENCIES

The Chair (Mr. Monte McNaughton): We'll now call upon the Association of Local Public Health Agencies. Thank you very much and thanks for coming early today. You'll have nine minutes for your presentation. If you'd just state your name for Hansard, please, and begin.

Dr. Valerie Jaeger: Thank you, Mr. Chair. Through you to the members of the committee, good afternoon. My name is Valerie Jaeger. I am a family physician in public health and also currently the president of the Association of Local Public Health Agencies, or ALPHA.

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

Dr. Valerie Jaeger: I am pleased to appear before the committee today on behalf of our member medical offices of health, local boards of health and affiliate public health professional organizations to provide comments on Bill 41.

As public health professionals, we are very supportive of those measures proposed in this bill that aim to bring disease prevention and health promotion principles to local health system planning in Ontario. We strongly believe that the best way to guarantee improvements in the quality of patient-centric care and truly put patients first is to prevent Ontarians from becoming patients for as long as possible.

ALPHA sees Bill 41's formalized linkages between local medical offices of health and the local health integration networks as an important and welcome step towards reorienting health care services toward prevention of illness and promotion of health, and to health equity in all our populations.

Reorienting the health care system towards illness prevention and health promotion is one of the five pillars of the 1986 Ottawa Charter for Health Promotion, which celebrates its 30th anniversary this month. This international agreement has guided public health's efforts to improve population health worldwide ever since. The other four pillars are healthy public policy, creating supportive environments, strengthening community actions, and developing personal skills.

1400

Local Public Health is therefore delighted by the opportunity to help this move forward in Ontario with our LHIN partners by sharing our expertise in population health and health equity to strengthen the health care system's contributions to the health of the population overall. The success of this will, of course, depend on the capacity and willingness of the respective partners to carry it through. It will be very important to remember that our respective approaches or lenses to health are very different. The system governed by the LHINs exists primarily to treat illnesses in individuals through medical, technological and other therapeutic interventions. Local Public Health seeks to improve health throughout populations by tackling the underlying social, environmental and economic conditions that influence it. It will therefore be of critical importance, once we have a legislated relationship, to ensure that "putting patients first" does not interfere with Local Public Health's requirement to put healthy people first.

This brings us to the other four pillars of the Ottawa charter that I mentioned. These are intentionally broad and demonstrate that access to health care on its own has a relatively minor impact—about 25%—on the overall health of a population. We therefore need to ensure that whatever contributions Local Public Health makes to strengthening the fifth pillar of the charter, they do not come at the expense of our existing work on the other four.

Notwithstanding our support for the public-health-related elements of Bill 41, we have several concerns about the potential demands of our proposed new roles under the broader Patients First initiative, especially given the capacity and resource issues that Local Public Health is already dealing with. I have already alluded to the different mandates of Local Public Health units and LHINs. We must ensure that the application of public health expertise and resources remain focused on a common understanding of a population health approach—from CIHI: "an approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups." Translating population health information into planning, funding and delivery decisions for acute care is not currently within the scope of Local Public Health.

Effective public health is all about partnerships, whether legislated or not. We feel it is important to stress that while a legislated relationship between Local Public Health and LHINs is fine in principle, we view our relationships with other sectors, such as education, primary care, municipalities, planners and community organizations, as equally, if not more, central to our mandate. We would welcome assurances that the new legislative weight of our partnership with LHINs will not erode our existing essential ones. We also acknowledge the key role played by our most valuable partners in primary care in such key areas of health promotion and disease prevention as patient education, screening and vaccination.

Finally, we are also uneasy about the imposition of a significant new set of obligations on Local Public Health in an ongoing climate of austerity. New resources and funding will obviously be required for Local Public Health to effectively engage in this work, but these cannot be viewed in isolation. Local Public Health, especially in some areas, is already struggling with capacity issues owing to austerity measures that have imposed budgets within which we are increasingly unable to meet our already existing mandates.

A properly resourced, well-supported and effective public health system which has the capacity to work effectively on its existing mandates as well as the new Patients First obligations will be critical to the success of the partnership that Bill 41 seeks to create. This partnership will not succeed if the other facets of an adequately funded, robust and complete public health system are ignored.

I will take this opportunity to reiterate that we were very pleased that the transfer of public health funding and accountability agreements that were initially proposed in the Patients First discussion paper have not been included in Bill 41. Our firm position remains that such structural and administrative integration is not required for, and may indeed be detrimental to, a fruitful relationship.

By mandating a relationship between Local Public Health and LHINs, Bill 41 creates an important avenue for incorporating population health and health equity principles into health system planning. We are in support of this, as we agree that it will contribute to improved health outcomes and patient experience as long as investments in keeping people healthy remain a cornerstone of the system as a whole.

I thank you very much for the opportunity to appear before you today, and I welcome your questions.

The Chair (Mr. Monte McNaughton): Thank you very much. Madame Gélinas?

M^me^ France Gélinas: Just a quick question: Has the government started its review of Ontario Public Health Standards? Is ALPHA being fully involved in this? What's the status of the review?

Dr. Valerie Jaeger: Through you, Mr. Chair, I can share what I can share. Certainly, the government has started the review of the standards. Different partners, including ALPHA, have been involved in this process. Our understanding is that we are getting close to receiving a draft.

M^me^ France Gélinas: Okay, thank you. You made allusion—and you're very polite, but I won't be quite as polite. There has been a funding freeze on public health units. Some of them are struggling to the point where nurse practitioners were laid off from the health unit in Muskoka. What is this funding constraint going to mean with the new bill? How are you going to be able to do more when your budget is frozen or being cut back?

Dr. Valerie Jaeger: Thank you very much for the question. I think the funding freeze, the 0%, is not for all health units, but it is for the majority of them. The effect will vary from health unit to health unit.

It's definitely an issue of capacity. I know this whole issue of capacity is one that is being looked at by the ministry and also by ALPHA.

M^me^ France Gélinas: Are you hopeful that your budget may actually go up—and not have the 0% overall for health units?

Dr. Valerie Jaeger: Madame Gélinas, I am always hopeful.

M^me^ France Gélinas: Good answer.

You talk about the risk that we now have legislated this relationship with the LHINs that may come at the expense of other important pillars.

Dr. Valerie Jaeger: I think this is always the caveat—the "watch out"—for public health, in that the demands of the acute-care system are acute and almost infinite. We are very concerned that our primary public health work, which we are the only ones really mandated to do—

The Chair (Mr. Monte McNaughton): Thank you very much. We have to move to the government for questions. Ms. Wong.

Ms. Soo Wong: Thank you very much for your presentation. I'm very pleased that you're able to join us today.

There's a perception from the opposition that we haven't consulted on Bill 41. Can you share with the committee how much consultation our government has done, in terms of Bill 41, with your organization?

Dr. Valerie Jaeger: I can share with the committee the discussions that ALPHA has had. I think we should

be clear that Bill 41 was preceded by a differently named bill, which was also preceded by the Patients First discussion paper.

ALPHA's interaction with the government started following the Patients First discussion paper.

Ms. Soo Wong: So there has been much conversation with your organization. Am I correct?

Dr. Valerie Jaeger: There has been conversation with our organization, although the major tenets of both bills were already in place in the Patients First discussion paper.

Ms. Soo Wong: The other question I wanted to ask you: Part of ALPHA is the medical officers of health as well as board members—because I used to sit on ALPHA. How will the medical officers of health from different regions be improving public health but also the whole issue of population health planning? Because this in the past was very much in silos. How will Bill 41 help to improve the population planning, in your opinion?

Dr. Valerie Jaeger: I think you can improve it on multiple levels. Public health has access to epidemiologists. We have local health data. We also work closely with our community and social service agencies. For example, in Niagara, we do a lot of GIS over-mapping, overlaying, of where services are, where they're not, where the needs are. I think it can certainly contribute to geographic placement.

We also do local studies of what are the acute health care needs—in Niagara, for example, we prioritize those—and this can help lead the LHIN into which areas should get special attention.

Ms. Soo Wong: So in your opinion, Bill 41 will help to improve coordination, and potentially population-based in terms of identifying the needs—

The Chair (Mr. Monte McNaughton): Ms. Wong? Sorry, we're out of time.

Mr. James J. Bradley: It was just getting good.

The Chair (Mr. Monte McNaughton): The official opposition: Mr. Yurek.

Mr. Jeff Yurek: It is getting good. I'm up now.

Thanks for being here today. I noticed you mentioned about health promotion being very important. It's important to us as well. We've seen, over the years, that it has moved from a Minister of Health Promotion to a bottom line item on the organizational chart. Are you concerned that health promotion isn't enough of a focus heading into the creation of the mega super-LHINs?

Dr. Valerie Jaeger: That actually has not been one of our concerns or a concern raised by ALPHA. I think it's one of the successes, in a sense, of public health, and the health care system in general, that health promotion is now something which is recognized at all levels, whether you're a primary care practitioner, an acute-care hospital or Cancer Care Ontario. Everybody is speaking about health promotion. They may mean slightly different things, but overall this is a good thing.

1410

Mr. Jeff Yurek: The other point that maybe you can comment on: I spoke with a member of a health unit—I won't give names. He had spoken to his LHIN, and the LHIN's response was, "We'll gladly have you on one of our committees."

Is this what you're seeing as a partnership between public health and LHINs, having maybe a member sitting on a committee? Or do you see a more wholesome discussion on planning?

Dr. Valerie Jaeger: I anticipate a more wholesome discussion. I think that the legislation's intent is that it occurs at the highest level between the Medical Officer of Health and the LHIN's senior leadership. I think the opportunity exists for multi-level co-operation.

Mr. Jeff Yurek: Do you see anything in this bill that will ensure that occurs?

Dr. Valerie Jaeger: The multi-level? No.

Mr. Jeff Yurek: Okay. Thank you.

The Chair (Mr. Monte McNaughton): Excellent. Thanks for presenting today.

HEALTH QUALITY ONTARIO

The Chair (Mr. Monte McNaughton): We'll now call upon Health Quality Ontario. I understand that they're here. Perfect.

Good afternoon. Thanks for coming early. If you'd just state your name for Hansard, you have nine minutes for your presentation.

Dr. Joshua Tepper: Great. Thank you very much. My name is Dr. Joshua Tepper. I'm a family doctor, and president and CEO of Health Quality Ontario. I appreciate the time today.

Bill 41, I think, represents a potential and an opportunity to improve the quality of care in the province. It can improve safety, timeliness, efficiency, equity and patient-centredness. I think that we all want to believe that health care is unanimous for everybody who lives in this province; in fact, it isn't. Your colour, your age, where you live—north versus south—matters tremendously. Rural versus urban matters tremendously.

A few stats:

We know that people who live in the North West LHIN are seven times as likely to have an amputation related to diabetes than those in the Central LHIN.

C-section rates for women across the roughly 120 hospitals for uncomplicated pregnancies—routine—varies anywhere from 4.5% to almost 40%;

Opioids, of which we know so much and about the harm they do, county by county across the province of Ontario—a tenfold variation.

These differences in care, person by person, community by community, have a tremendous impact and undermine the quality of what we believe every Ontarian should deliver. Our hope, therefore, is that, as the provincial agency on quality, we have the opportunity, through Bill 41 and other measures, to help improve the quality of care and to reduce these variations.

One of the important opportunities that comes through this bill is the development of clinical standards—standards that can help tell us when the evidence is strong for

what care should like and not look like; standards that would be developed not just for clinicians but for system leaders, and not just for system leaders but, most importantly, for patients. Each of our standards about specific areas of care will articulate, in plain, clear language accessible to all, what good care means, regardless of who you are and where you live.

We need, finally, to make a sustained effort to face this problem of variation. We need, ultimately, to have one health care system that will be substantively the same for everybody. This doesn't mean that we don't recognize the differences in care. I want to be absolutely clear that standards are not an opportunity to eliminate patient-centredness; they are actually to guide patient-centredness. It is an opportunity to bring evidence to the bedside in a consistent manner, regardless if you're home care, primary care, hospital or acute care.

Therefore, what we want to see is the rollout of standards, the elimination of variation and the engagement of patients. Our standards, developed with patients, will also involve front-line physicians, physician experts, nurses and other health care providers, as well as caregivers and family members.

We look forward to this bill, and we look forward to our role in bringing it forward. I stand open for questions.

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

We'll move the government. Ms. Kiwala.

Ms. Sophie Kiwala: Thank you very much for being here today, and thank you very much for your deputation, Dr. Tepper. It's a great opportunity to be able to hear about perspectives from across the health care spectrum. I certainly appreciated your focus on standards.

As you know, if passed, the Patients First Act would establish an integrated clinical care council to develop and make recommendations to the minister on clinical standards in priority areas such as home care and primary care. I'm wondering if you can add a little bit of emphasis on how it will benefit patients.

Dr. Joshua Tepper: What this actually is about is less, in my mind, about recommendations to the minister, to be honest and respectful; it's actually about how we help front-line clinicians and patients at the front lines of care get more consistent care. The problem we see around the world—literally around the world—is that standards or guidelines get developed but there's no way of really embedding them, and they get left on shelves.

The integrated clinical council, which you mentioned, is an opportunity to bring in expertise from across the province to say, "How do we bring these to life? How do we actually bring these documents into the front lines of your home care, your primary care, your hospital so that in fact care begins to change?" Some of these dramatic differences, in the prescribing of anti-psychotic medications, the prescribing of opioids, the use of diagnostic imaging and radiation technologies—how do these some tenfold, twentyfold variations start to eliminate through a simple set of 12 to 15 statements? This council will be an integral part of the implementation part, and that's why it's so important.

Ms. Sophie Kiwala: Excellent. That's fantastic. I think that one of the primary focuses that we do have is to better integrate the care, and I think that—

The Chair (Mr. Monte McNaughton): Ms. Kiwala, we have to move to the opposition, and Mr. Yurek.

Mr. Jeff Yurek: Thanks, Chair.

It's good to see you again.

Dr. Joshua Tepper: It's nice to see you, Mr. Yurek.

Mr. Jeff Yurek: Just a few questions with regard to the standards that are being created. You're going to have to, obviously, get the feedback, which you mentioned. What type of reporting structure are you going to have the front-line health care professionals perform, and have you worked in how much time that will take away from patient care?

Dr. Joshua Tepper: First of all, the standards are all developed with front-line physicians and nurses in the development. So as we create each statement, as we create each standard, they're thinking through this question and helping us solve it. In fact, I think what we see, actually, is the opportunity for more efficient care. What we actually see is less redundancy, less repetition, less unnecessary testing and, in fact, when people know what the evidence dictates, you actually see more efficient care, which is one of the definitions or the dimensions of quality.

Again, our process is fully transparent. Not only do we openly solicit for anybody to sit on our committees, once we have a draft it gets pushed out widely for open comment. All those open comments go back to the committee for input, so it's a completely involved, transparent process with heavy, heavy engagement of those, as you say, on the front lines who will have the opportunity to live them.

Mr. Jeff Yurek: The LHINs are going to want to collect some of this data. Are you ensuring that that's taken into account too, because the concern I'm hearing from health care professionals is, "It's going to create more reporting for me, more paperwork I've got to fill out and submit"?

Dr. Joshua Tepper: I think in some cases a lot of the data exists. I threw a lot of statistics out. I drew those out not from additional reporting but from reporting that's already done through the administrative system. I think we're also very clear that, in some places, the standard may be great and they won't need to change. What we know about that variation is that some places actually perform very well. They'll take a look at the standard and say, "You know what? We're good there." Other places might say, "You know what? Actually, when we take a look, we're not performing where we should be, and so we're going to invest a little energy to data-collect to get better." Other places won't need it, and in a lot of places—

The Chair (Mr. Monte McNaughton): Thank you very much. We have—

Dr. Joshua Tepper: Oh, sorry. My apologies.

The Chair (Mr. Monte McNaughton): We have to move to Madame Gélinas.

M^me^ France Gélinas: I'm pleased to see you, Dr. Tepper.

Dr. Joshua Tepper: It's nice to see you.

M^me^ France Gélinas: It's always nice to see the reports that Health Quality Ontario does. I still read them from cover to cover, and I still enjoy them.

Dr. Joshua Tepper: Thank you.

M^me^ France Gélinas: What can we say to clinicians who come forward and have serious concerns about clinical standards? They come forward and say, "This is going to be used to ration care so people don't get the best care." They often put forward the example of the PET scan, that the way we went at it in Ontario meant that we had the most restrictive access of all other provinces, and they link that back to clinical standards. How can you reassure us?

Dr. Joshua Tepper: I guess what I can offer is that it's certainly not our intent at all to use the standards in that way. It's why we develop them with health care professionals, with physicians and others. It's also why they're very clinically oriented to the front lines of care as well. I think we have seen other jurisdictions around the world use standards, the NHS, perhaps, being the best example. I don't believe the evidence suggests—I don't believe so—that it has in fact been used to restrict care. I think it's something we should be cautious of. This bill needs to work for patients but it also has to work for providers, and literally the hundreds of thousands across the system. If this is our part, we need to make sure that that's the case.

M^me^ France Gélinas: We have long wait-lists to get into our long-term care. Your report showed a 280% increase in wait times for people from 2004 to 2013. Would it make any difference if the case coordinator is at the CCAC rather than the LHINs, to get in quicker?

Dr. Joshua Tepper: I probably don't have the depth of knowledge in that specific area to comment helpfully. I apologize. I'm not trying to duck the question; I just don't think I know enough about that specific question to put the evidence behind my answer.

M^me^ France Gélinas: Okay. Let's go to same-day appointments. In your report—

Dr. Joshua Tepper: Same-day and next-day?

M^me^ France Gélinas: Yes, same-day and next-day appointments. Do you see anything in this bill that will help—

The Chair (Mr. Monte McNaughton): Madame Gélinas, that's the time.

Thank you very much for your presentation today.

Dr. Joshua Tepper: Thank you.

The Chair (Mr. Monte McNaughton): We're moving along quickly today. I just wonder if the Ontario Health Coalition is here. Not yet? For the 3 p.m. presenter, I understand we're just waiting for interpreters to come down and to reach him on the telephone.

Interjection.

The Chair (Mr. Monte McNaughton): I guess we'll break, but stay close by so that we can resume as quickly as possible.

The committee recessed from 1420 to 1421.

ONTARIO HEALTH COALITION

The Chair (Mr. Monte McNaughton): Welcome back. That was a short recess. I see the Ontario Health Coalition is here. Come on up, Natalie. If you'd just state your name for the record—I know you've done this a few times before. You have nine minutes for your presentation, followed by two minutes of questioning from each party.

Ms. Natalie Mehra: I'm Natalie Mehra, and I'm the executive director of the Ontario Health Coalition. Thank you very much for hearing from us today.

The Patients First Act is really a misnomer. This act has precious little to do with improving health care for patients, but it is a technocratic bill, primarily aimed at expanding the powers of the local health integration networks. The primary function of the bill is to transfer the community care access centres over to the local health integration networks, and to amend that legislation in order to allow them to provide the direct services that the CCACs currently provide. But it also provides new powers to the LHINs to step over local boards of directors for health service providers to appoint investigators and supervisors.

Then there are just some additional somewhat bizarre inclusions in the act; for example, the exclusion of the public from LHIN meetings. The primary problem with the LHINs is hardly that they're too democratic or that the public is going to too many of their meetings—quite the opposite, in fact. What is of concern to us in this is that this bill in no way actually improves home care services, and that in fact most of the problems that we saw in the CCACs are also evident in the LHINs.

In very blunt terms, for a great deal of money, we think that there will be no savings here, no improvement in access to care and, in fact, an expansion of the powers of the LHINs, to what end we're not really sure. So part of our concern about this act is not just what's in this act, but what it sets the stage for and what may be coming next.

There never was a LHIN review, which was in the LHIN legislation, which the government is required to do by its own legislation. Prior to an election, the government amended the legislation to delay that LHIN review until after the next election, started the LHIN review and never completed the LHIN review. So there never really has been a proper opportunity for the LHINs themselves to be evaluated.

The bottom line is that the Ontario Health Coalition has worked extensively on health restructuring that has happened under the powers of the local health integration networks, and it has been deeply problematic. Just a few weeks ago, the Central East LHIN put up a notice on its website at 11 a.m. for a board meeting that it was holding at 2 p.m. The notice was only by website. It was for a motion that the LHIN was making regarding the integration or the merger of hospitals covering a million people from Scarborough to Durham. It's an outrageous abuse of process.

But the LHIN legislation actually has very few procedural safeguards, and enormous powers for endless health care restructuring. In fact, the LHIN legislation was set up to force the restructuring of the health care system. It has done that, and it has created a context of continual instability, continual centralization of services, continual movement of services. The public has no real ability to access documentation regarding this, the plans are not made public—none of the norms of procedural safeguards that are used in other jurisdictions regarding restructuring.

When the last round of restructuring happened in the 1990s, I can remind you that comparable legislation set up the health restructuring commission. It had a two- or three-year mandate. There was a sunset clause. There were clear powers it had. It had to report to the public. There were procedures. Everything was documented. The public had access to documentation. There was recourse to the courts. There were actual procedures and so on. None of that exists in the LHIN legislation, so they are not democratic in any way. The normal democratic procedures and safeguards don't exist in them.

They are often extremely elitist. They have precious little understanding of democracy. They have not improved access to care. The fundamental job of a public health care system is to plan and meet population need for care. They do not do that in any way at all, and yet they have enormous powers to restructure.

We worry about what it means to move the home care system over to the LHINs. At this point, there are hundreds of provider companies in home care, all of which have duplicate administrations. The problem of duplication and redundancy is not solved by simply transferring the CCACs to the local health integration networks.

In addition, the fundamental job of public health care, to plan for and try to meet the public's need for care, is not being done, and there is nothing in this bill that's going to help it get done.

That's it.

The Chair (Mr. Monte McNaughton): Great. Thank you very much. We'll begin with the official opposition. Mr. Yurek.

Mr. Jeff Yurek: Thanks for coming in today.

Ms. Natalie Mehra: Thanks.

Mr. Jeff Yurek: You mentioned the fact that the LHIN review never took place, and now we're giving them more power and making them larger. The only thing we have going for us with regard to a review of any part of the LHIN is the Auditor General's report that came out last year. Do you have any comment on that report at all?

Ms. Natalie Mehra: I'm just looking at the main findings.

The problem is that the LHINs themselves have not measurably improved health care services in any way. The powers that they do have that could possibly be used to improve services—for example, they've always had the power to look at home care contracts. Up in the north, home care provider companies are being paid for contracts, but the number of missed visits—so the contract is to provide home care visits. The number of missed visits our local coalition found was astronomical. Yet the CCAC did nothing about it; the LHIN did nothing about it. There was no standard, no enforcement, no protection for people who are bedridden at home and vulnerable and for whom, repeatedly, the home visiting nurse or the home visiting personal support worker never showed up, because the company was just unable to provide the service for which it was contracted.

That is routine. That's not just up in the north; that's all across Ontario.

There are many, many, many examples. The LHINs are supposed to have a set of criteria for standards for hospitals. Most of those have nothing to do with improving patient care, but a few of them do, and they're supposed to have targets attached. I remember at one point the target was 90% of people were supposed to be able to access home care within 28 days of discharge from hospital. The LHINs never in any way enforced that standard. I mean, there's just no enforcement of any standard of care—

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

M^me^ France Gélinas: Thank you for coming, Ms. Mehra. The bill basically says we will get rid of the boards of the CCACs, get rid of their CEOs, do a vice-president of community services within the LHINs, and everything else stays the same. Could you think of other ways to improve our home care system? What would be your priority if we were serious about improving our home care system?

Ms. Natalie Mehra: Under the Canada Health Act, Canadians have the right to access care based on need, not based on wealth. That's the foundational principle of public health care in the country. That is what our provincial governments are supposed to do when they design the health care system.

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Ontario has cut more than half of its hospital bed capacity. That's acute-care beds, chronic care beds—it's total capacity. Most of that care has been moved out to home care. And yet people don't have the right to access care at all. There is no right to access care. The suffering of people not being able to access care is awful. It truly is. The government, I think, has done this because they had to do something about the mess that is home care in Ontario, but this act doesn't actually do anything about the mess that is home care in Ontario. It certainly doesn't put patients first. It expands a bureaucracy that hasn't worked so far to improve anything.

If you wanted to improve home care, you would need to restructure the home care system. We believe the best system would be a public, not-for-profit system—an integrated system that would reduce the massive duplication, take out the profit-taking, restore the ethics of a not-for-profit home care system and shunt the resources to actual care, as opposed to all of the providers whose interests dominate reform, as they have in this case, and dominate where the money goes.

M^me^ France Gélinas: Were you surprised to see—

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

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

Mr. John Fraser: Ms. Mehra, thank you very much for being here this afternoon and for your presentation. I do differ with you on the role of local health planning. I think we know that. I do appreciate your point of view. We do have challenges that exist inside the system. I hate calling it a system, but transitions are things that I think need to be addressed inside our system. I wrote a report on palliative care and how critical it is there, but it happens everywhere.

I know we differ, but I believe the way forward is local health planning that takes into account the capacities of the environment that they're in to approach problems like stewardship, like transitions. If you don't build a structure and give it some authority, I think you'll have a really hard time driving change. Driving change from the Hepburn Block is not entirely effective when it comes to a small local community.

I look at my community of Champlain. I know we have drug counselling and addictions counselling in school because we have the participation of a LHIN. We have that for suicide prevention for youth. We have a Bridges program for stepping out of hospital.

How much time do I have? I want to get—

The Chair (Mr. Monte McNaughton): About 30 seconds.

Mr. John Fraser: Okay. Just in terms of looking at problems of stewardship and transitions, what's your point of view? Because we obviously have a different—if you can answer.

Ms. Natalie Mehra: We're out of time, right?

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

Ms. Natalie Mehra: Obviously, we believe in a regionalization in the sense of regional health planning. But the LHINs don't do that. Our critique is that the mandate of the LHINs is fatally flawed. They've been given restructuring powers, but they don't actually measure and try and meet population need for health care services.

The Chair (Mr. Monte McNaughton): And with that, two minutes is up.

Ms. Natalie Mehra: Thank you.

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

Interjection.

The Chair (Mr. Monte McNaughton): You didn't get a supplementary.

HÔPITAL MONTFORT

MONTFORT HOSPITAL

The Chair (Mr. Monte McNaughton): The last presenter of this afternoon session is Montfort Hospital. I understand they're on the line now. Can you hear us? Dr. Leduc, are you on the line?

Dr. Bernard Leduc: Sorry. Yes, I am on the line.

The Chair (Mr. Monte McNaughton): Thank you very much. Doctor, you'll have nine minutes for your presentation, followed by two minutes of questioning from each party, beginning with the third party. If you could state your name for Hansard and begin your presentation.

Dr. Bernard Leduc: My name is Bernard Leduc, président-directeur général de l'Hôpital Montfort. Merci au Comité permanent de l'Assemblée législative de l'Ontario de nous recevoir, en particulier à la veille du 30^e^ anniversaire de la Loi sur les services en français de l'Ontario.

I'm going to present in French but will be happy to take questions in English.

Juste un peu d'historique sur l'Hôpital Montfort : fondé par les Filles de la Sagesse en 1953 pour subvenir aux besoins en santé de la population francophone de la région d'Ottawa, l'Hôpital Montfort a une histoire qui a été particulièrement touchée lors de la Commission de restructuration des services de santé en Ontario, qui a mené à une bataille épique avec, finalement, un jugement de la Cour d'appel contre le gouvernement de l'Ontario en 2000. Ce jugement était fondé, en fait, sur les principes non écrits des Pères fondateurs de la Confédération et faisait de la Loi sur les services en français une loi quasi constitutionnelle, basée en particulier sur le respect et la protection des minorités linguistiques au Canada.

Montfort a été, par la suite, bonifié, en fait, d'infrastructure avec un projet de construction important et une désignation universitaire par le ministère de la Santé de l'Ontario en juin 2013. À l'intérieur de son rôle d'hôpital universitaire, Montfort a un mandat provincial, entre autres, d'appuyer le gouvernement à rencontrer ses obligations vis-à-vis la Loi sur les services en français. C'est à cet égard que nous présentons humblement nos recommandations pour bonifier et améliorer le projet de loi 41, donnant la priorité aux patients.

Nous sommes particulièrement reconnaissants des modifications apportées entre le projet de loi 210 et le projet de loi 41, en particulier la précision explicite à l'article 5 que cette transformation doit respecter la Loi sur les services en français « dans le cadre de la planification, la conception, la prestation et l'évaluation des services ». Nous sommes aussi également reconnaissants que l'autorité compétente des hôpitaux a été reconnue en les excluant du pouvoir des directives spécifiques des RLISS. Nous prenons en considération, par contre, le fait que le projet pourrait être bonifié en précisant davantage les obligations directes de cette transformation du système de santé en regard de la Loi sur les services en français.

Nos recommandations sont en fait de trois ordres.

Le premier : on réfère beaucoup à la définition de « l'intérêt public ». Donc, à l'intérêt public au niveau du projet de loi 41, notre recommandation est d'inclure spécifiquement l'obligation de servir les populations

francophones en situation minoritaire à l'intérieur de la définition de « l'intérêt public ». Présentement, on parle d'équité et on parle de diversité, mais les obligations spécifiques reliées à la population francophone ne s'y retrouvent pas. Alors, ça serait notre recommandation, de préciser plus formellement cette recommandation.

L'autre élément important qui se produit avec le projet de loi 41 est, évidemment, l'intégration du rôle des centres d'accès aux services communautaires à l'intérieur même des réseaux locaux d'intégration des services de santé, reconnaissant que les réseaux locaux d'intégration des services de santé sont assujettis, par rapport à leurs interactions avec le public, aux obligations de la loi sur les services de santé en français. Les RLISS, ce qui est l'acronyme pour les « LHIN », deviennent maintenant des fournisseurs de services. Donc, leur mandat et leur rôle est élargi et dépasse de beaucoup la planification, l'évaluation de la performance et le financement, en attribuant un rôle de fournisseur de services directs aux patients.

Il est à noter que, à travers le territoire de l'Ontario, il n'y a seulement que deux centres d'accès aux services communautaires qui sont désignés selon la loi sur les services de santé en français, soit le centre d'accès aux services communautaires du Nord-Est et celui de Champlain. Il n'y a aucun RLISS aujourd'hui—réseau local d'intégration des services de santé—qui est désigné selon la loi sur les services de santé en français. Donc, notre recommandation est de définir et d'exprimer clairement l'obligation de désignation selon la Loi sur les services en français pour les RLISS qui sont dans les zones désignées. Je sais que le commissaire aux services en français suggère des modifications à apporter à la Loi sur les services en français qui demanderaient ou qui impliqueraient que la province de l'Ontario au complet soit désignée, ce qui augmenterait encore l'envergure—mais pour l'instant, à l'intérieur du corps législatif actuel, de s'assurer que les RLISS entreprennent un processus de désignation selon la Loi sur les services en français.

Afin de se conformer à ce processus de désignation, étant donné qu'il y a du langage dans le projet de loi qui modifie la composition du conseil d'administration des RLISS, que ce soit indiqué dans ces modifications proposées que le gouvernement s'assure que les RLISS respectent les exigences minimales du processus de la désignation selon la Loi sur les services en français en ce qui concerne la représentation de francophones au niveau du conseil d'administration des RLISS.

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Également, le transfert des activités des centres d'accès aux services communautaires qui donnent les services par des ententes contractuelles : la recommandation est de mettre très au clair que ces ententes contractuelles soient assujetties, elles aussi, à l'obligation de fournir des services dans les régions désignées, ou, même plus, au niveau de la loi sur les services de santé en français. Nous comprenons qu'à l'intérieur du projet de loi tel qu'il est déposé, il y a du langage qui exclut ces ententes à certaines lois. Donc, on comprend la raison de formellement expliquer que ces ententes sont exclues de ces lois-là. Nous considérons qu'il est aussi important qu'il soit spécifiquement et formellement indiqué que ces ententes-là sont par contre assujetties à la Loi sur les services de santé en français—sur les services en français.

La troisième recommandation est de rehausser le rôle des six entités de planification de services de santé en français dans l'Ontario. Le projet de loi 41 est complètement muet à cet égard. La recommandation, c'est de rehausser leur rôle afin d'aller au-delà de l'engagement communautaire et de conférer un rôle beaucoup plus actif à ces entités dans le processus décisionnel des RLISS lorsqu'on parle de planification des services de santé.

Alors, en conclusion, le projet de loi 41, Loi modifiant diverses lois dans l'intérêt des soins axés sur les patients, solidifie un système de coordination et de continuité des soins de santé pour tous les Ontariens et Ontariennes. Il doit, cependant, prendre en considération la diversité culturelle et linguistique de la population, et la planification devrait s'appuyer également sur l'apport et la représentation de la communauté francophone de l'Ontario en situation minoritaire afin de s'assurer que les décisions sont prises avec et par les personnes qui comprennent le mieux les besoins et les enjeux de leur collectivité. Nous croyons que les recommandations qu'on vous soumet aujourd'hui permettront de bonifier le projet de loi 41 et d'assurer et d'aider le gouvernement à rencontrer ses obligations vis-à-vis la loi sur les services de santé en français envers la population francophone.

Merci de votre écoute.

Le Président (M. Monte McNaughton): Merci beaucoup. M^me^ Gélinas.

M^me^ France Gélinas: Bonjour, Docteur Leduc. J'ai seulement deux minutes, et j'ai beaucoup de questions, donc je vais aller très vite.

Dans un premier temps—je commence en sens inverse—« rehausser le rôle » des entités : est-ce que vous êtes d'accord qu'elles devraient avoir pouvoir décisionnel, et ça, de façon indépendante ou au travers des RLISS?

D^r^ Bernard Leduc: La situation idéale serait, évidemment, d'avoir un pouvoir décisionnel indépendant des RLISS. Mais dans une période de transition, je pense qu'il faut aller beaucoup plus étendre leur rôle, qui est présentement l'engagement communautaire, et un rôle en fait aviseur consultatif. La difficulté avec les entités de planification, c'est aussi la relation avec l'entente de responsabilisation directe avec les RLISS, qui crée un environnement qui est un peu difficile à comprendre quand on parle de planificateur d'égal à égal.

M^me^ France Gélinas: D'accord. Quand vous parlez de respecter la représentation minimale sur les nouveaux conseils des RLISS, est-ce que vous parlez d'une personne francophone par RLISS, un minimum d'une personne, ou—le représentant dans le Nord-Est, on est 30 %—30 % des membres du RLISS devraient être bilingues ou francophones?

Dr Bernard Leduc: Je pense qu'il peut y avoir un double standard à ce niveau-là, donc une représentativité minimale, mais qui peut être proportionnelle dans les régions où il y a beaucoup plus de francophones. Je n'ai pas spécifié de termes spécifiques parce que les modalités au niveau de la désignation peuvent changer. Par contre, je pense qu'il est important d'inclure, dans le libellé de la loi, le respect en vue d'une désignation.

Mme France Gélinas: Et est-ce que vous seriez satisfait que ça soit tout simplement une définition de l'intérêt public qui donne des obligations envers les francophones, ou si vous vous attendez à le voir dans toutes les clauses du projet de loi?

Dr Bernard Leduc: Je pense qu'au niveau des définitions de restructuration du conseil d'administration, au niveau du projet de loi, c'est plus que juste l'intérêt public. Le danger de le mettre dans un principe directeur, c'est que lorsqu'on tombe dans la mise en application, évidemment, c'est souvent secondaire.

Dans la cause Montfort, l'avis d'un sociologue disait très bien que la majorité, même si bien intentionnée, peut—

The Chair (Mr. Monte McNaughton): Sorry. That's time.

We have to move to the government now. Mr. Fraser.

M. John Fraser: Bon après-midi, Docteur Leduc. Merci pour votre présentation et vos recommandations aujourd'hui. Merci pour vos efforts, les efforts pour l'Hôpital Montfort dans notre région et pour tous les Franco-Ontariens.

I will spare you the rest of my French, Bernard. Je travaille fort pour améliorer mon français.

Dr Bernard Leduc: Et c'est très apprécié. It's very appreciated.

Mr. John Fraser: In the interests of time. I want to thank you for your recommendations. Will we have a copy of your presentation as well?

Dr. Bernard Leduc: We will be submitting a memoir, yes.

Mr. John Fraser: That will be great. Thank you very much.

I do want to say that I'm particularly proud of the fact that the Montfort became an academic hospital. It was critical in the contributions to the education of health care professionals in Ontario. I was pleased to be part of that.

In saying that, in terms of your recommendation in regard to the six entities—I know that Madame Gélinas asked that question, but I didn't quite get the answer to that, on how you see those being connected, or not connected, to the LHINs.

Dr. Bernard Leduc: Presently, the « entités de planification » are actually just giving recommendations to the LHINs in terms of planning. It depends on how involved they are in all the projects of integration that are happening around the LHINs. I think there is a significant variation from LHIN to LHIN in that specific area.

I think that we need to enhance the role of the entity to not just being an entity that engages the francophone population to give advisory comments, but—

The Chair (Mr. Monte McNaughton): Sorry. We have to move to the official opposition now, and Mr. Yurek.

Mr. Jeff Yurek: Good afternoon.

Dr. Bernard Leduc: Good afternoon.

Mr. Jeff Yurek: Just a quick question regarding the power structure that's being created here: We're seeing a movement of more power going back out of the local control up into the ministry. Do you have concern that that might affect the voice of the francophone—not only in the regions that are deemed bilingual in this province, but in other regions? I'm from the London region, and we have a strong francophone community. I do have concerns that, somehow, this might be lost in the transfer.

Dr. Bernard Leduc: This is an explanation on why we feel it's more important to get all the requirements with the French Language Services Act more specifically present in the different recommendations that we're looking at.

Actually, there are eight out of 14 LHINs that are covering an area that's at least partially or totally designated under the French Language Services Act. I think we need to make sure that those LHINs, with the restructuring—especially with the fact that they're going to be providing direct services to the population—are designated with that. I think that with the designation will come more of the regional and local strengths about the implication of the francophone community with their regional authority.

The other part of our recommendations is to improve the mandate of the entity to be more than just an advisory committee or engaging the community, but to be part of the decision-making process and actually making decisions, at the end.

Mr. Jeff Yurek: Great—

Dr. Bernard Leduc: This will keep the local or regional strengths of the system, instead of centralizing.

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

Dr. Bernard Leduc: Merci beaucoup, and good success in your work. Thank you.

The Chair (Mr. Monte McNaughton): This committee stands recessed until 6 p.m. tonight.

The committee recessed from 1450 to 1803.

The Acting Chair (Mr. Robert Bailey): Thank you, ladies and gentlemen. I'd like to welcome you here for our evening sitting.

FÉDÉRATION DES AÎNÉS ET DES RETRAITÉS FRANCOPHONES DE L'ONTARIO

The Acting Chair (Mr. Robert Bailey): Our first presenter is with the federation of the francophonie Ontario. Would you please come forward and identify yourselves for the record?

You'll have nine minutes for your presentation, and then at that time, we'll start with two minutes of questions, starting with the official opposition.

Like I say, welcome, and if you'd introduce yourselves, then you can start your nine minutes.

M^me^ Élizabeth Allard: Je suis Élizabeth Allard, présidente de la Fédération des aînés et des retraités francophones de l'Ontario. Nous sommes situés à Ottawa.

M^me^ Denise Lemire: Denise Lemire. Je suis directrice générale de la Fédération des aînés et des retraités francophones de l'Ontario. Ça me fait plaisir d'être ici.

The Acting Chair (Mr. Robert Bailey): Thank you. Begin with your presentations—nine minutes.

M^me^ Élizabeth Allard: Monsieur le Président, au nom de la Fédération des aînés et des retraités francophones de l'Ontario, je vous remercie grandement pour nous avoir donné l'occasion de participer à l'étude du Comité permanent de l'Assemblée législative sur le projet de loi 41.

Nous sommes particulièrement encouragés de voir Qualité des services de santé Ontario inclure un volet sur l'équité dans leur plan d'amélioration de la qualité.

Je serai brève dans ma présentation. Nous avons su ce midi seulement que nous pouvions présenter, alors je n'ai pas de mémoire avec moi, mes nous pouvons l'envoyer subséquemment.

L'offre des services en français dans le milieu de la santé est une grande préoccupation chez nous, les aînés franco-ontariens et franco-ontariennes. D'ailleurs, le vieillissement de la population a été identifié comme le troisième plus grand défi de la communauté francophone au cours des cinq à 10 prochaines années lors d'un sondage qu'a fait l'Assemblée de la francophonie de l'Ontario, l'AFO.

La FARFO apporte aujourd'hui les considérations et les recommandations suivantes quant au cadre en matière des niveaux de soins.

Compte tenu que :

—les Franco-Ontariens et Franco-Ontariennes ont un accès inégal aux services de santé dans leur langue;

—la sécurité d'une personne est à risque lorsque celle-ci ne peut communiquer clairement avec un professionnel ou une professionnelle;

—les barrières linguistiques causent évidemment des incompréhensions, de mauvais diagnostics et des erreurs de médication et de traitement;

—un fait très important : la population francophone est vieillissante, et ce, dans toutes les régions de l'Ontario;

—les outils d'évaluation des résidents permettant de recueillir les renseignements sur les besoins de la clientèle et de leurs personnes soignantes sont manquant;

Le facteur linguistique fait donc partie de l'expérience de la clientèle.

Nos recommandations :

—que les services de santé en français soient disponibles partout en Ontario, y compris dans les foyer de soins de longue durée. C'est une préoccupation primordiale pour nous, la fédération des aînés;

—que le ministère mette en place un programme global d'offre active de services de santé en français;

—que l'on établisse—et ce, encore, est un fait très important—clairement que les tierces parties mandatées par les RLISS pour l'offre de services de santé soient aussi assujetties aux dispositions de la Loi sur les services en français.

En bref, ce sont nos préoccupations et nos défis. Comme j'ai dit, nous pouvons faire suivre le tout par un mémoire avant le 23 novembre, je crois. Merci.

The Acting Chair (Mr. Robert Bailey): Is that your presentation?

Ms. Élizabeth Allard: Yes. It was good?

The Acting Chair (Mr. Robert Bailey): Official opposition, two minutes.

Mr. Jeff Yurek: Thanks very much for being here. I'm okay speaking English?

Ms. Élizabeth Allard: Sure. I'll answer you in English; don't worry.

M. Jeff Yurek: Je parle français un peu, mais—anyway.

You mentioned French services across the entire province. I know that's not happening now, the availability of it. And you mentioned especially long-term care. You didn't mention anything about hospitals. Is this a concern as well, that hospitals should also—

Ms. Élizabeth Allard: It is as well.

Mr. Jeff Yurek: And, in fact, the third parties. So you're talking about the nursing agencies that go into your home, making sure they have access to French-language services.

We had somebody speaking earlier, before our break. Their concern also was French-language services, but they were more focused on the areas that are highly francophone areas. The whole province, though, is your—

Ms. Élizabeth Allard: Yes, designated regions.

Mr. Jeff Yurek: They also mentioned about board makeup at the LHIN levels. Do you think there should be a minimum of francophonie on the board or should it reflect the population—like have a minimum of one or two on the board, whereas for northern Ontario maybe have half or three quarters of the board?

Ms. Élizabeth Allard: It should reflect the population, because only one sometimes is not enough, because it's too limited. It should reflect the regions.

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Mr. Jeff Yurek: Thanks for your comments. I look forward to your full dissertation.

Ms. Élizabeth Allard: Thank you very much.

The Acting Chair (Mr. Robert Bailey): Madame Gélinas.

M^me^ France Gélinas: Bonjour. Ça me fait bien plaisir de vous souhaiter la bienvenue à Queen's Park. J'ai deux minutes, donc des petites questions bien serrées.

La première, c'est lorsqu'on parle des tierces parties, la Loi sur les services en français ne s'applique pas. Pour

vous, comment important—j'aimerais que vous me donniez la valeur de l'importance que les tierces parties qui offrent des soins à domicile soient assujetties à la Loi sur les services en français : peu, beaucoup, extrêmement?

M^me^ Élizabeth Allard: Beaucoup, et beaucoup plus, sans dire extrêmement. C'est primordial parce qu'ils arrivent au front, vraiment, et ils donnent les premiers services aux personnes âgées. Comme je disais, nos personnes âgées sont vulnérables. Souvent, elles perdent leur deuxième langue, alors c'est extrêmement important.

M^me^ France Gélinas: Merci. Du côté de l'offre active en français, ce serait pour tous les services de santé. Est-ce que vous voyez le besoin d'offre active au niveau du RLISS également lui-même?

M^me^ Élizabeth Allard: Oui, absolument, madame.

M^me^ France Gélinas: Absolument?

M^me^ Élizabeth Allard: Oui.

M^me^ France Gélinas: OK. Et du côté des foyers de soins de longue durée, est-ce que vous aimeriez que tous les foyers de soins de longue durée aient une aile francophone, ou est-ce que vous préférez une maison désignée francophone par région?

M^me^ Élizabeth Allard: Mais c'est ça. L'idéal serait une maison désignée francophone par région, là où c'est faisable, mais on sait qu'il y a des régions de l'Ontario qui sont un peu isolées. Oui, on pourrait les concentrer. Ça sauverait évidemment de l'énergie et des ressources.

Maintenant, dans les régions très, très populeuses, bien, on peut avoir une aile francophone, absolument—mais s'assurer qu'ils sont servis en français aussi.

M^me^ France Gélinas: En ce moment, les lits désignés francophones ou les ailes désignées francophones—

The Acting Chair (Mr. Robert Bailey): Okay. Sorry, the two minutes are up.

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

M. John Fraser: Bonsoir, madame Allard et madame Lemire. Merci pour votre présentation et vos recommandations ce soir, et merci pour votre appui pour les personnes retraitées et les personnes âgées, les plus vulnérables, pour qui la première langue est le français, les Franco-Ontariens.

Mon mandat, comme assistant parlementaire du ministre de la Santé et des Soins de longue durée, est dans les soins palliatifs et la fin de vie. Vos points sur l'importance de langue pour les personnes qui souffrent de démence ou qui sont en fin de vie—vos recommandations sont très importantes parce que dans les consultations l'année passée—la première langue est très importante pour la sécurité et la qualité des services pour les personnes plus vulnérables qui souffrent de démence ou sont en fin de vie.

M^me^ Élizabeth Allard: Absolument, c'est très important, et je vous remercie parce que vous comprenez le problème. Vous avez exposé le problème tel qu'il est. Ce sont des aînés vulnérables. La démence, c'est un gros problème. Il faut qu'ils aient les services adéquats dans leur langue.

The Acting Chair (Mr. Robert Bailey): Sorry. Merci. The time is up.

M^me^ Élizabeth Allard: Merci.

The Acting Chair (Mr. Robert Bailey): I hate to be the bad guy.

MS. KATHY BUGEJA

The Acting Chair (Mr. Robert Bailey): Our next presenter is Kathy Bugeja. You'll have nine minutes for your presentation.

Ms. Kathy Bugeja: Thank you. Good evening, everyone. My name is Kathy Bugeja, and I am here today as a primary caregiver, providing my concerns with respect to Bill 41, the Patients First Act. I am joined by my husband, Leo, sitting behind me here, who came with me for moral support.

Over the past two decades, as a daughter, daughter-in-law and close friend, I have been entrusted with managing the care of five frail seniors, all presenting with different comorbidities: congestive heart failure, multiple stroke, advanced dementia, diabetes and associated complications—the list goes on and on.

I have experienced the urban myth first-hand, several times over, that people can be managed in the community. Too often, the province's Home First strategy has really meant "home alone," condemning the patient and their caregivers to a life of physical, social, emotional and psychological isolation. I am convinced that every complex patient who is forced to be kept at home well beyond the stage of safely being there breeds at least one other complex chronic patient in the system.

What is particularly difficult is that it is only when you reach the next crisis in care that the system offers you a crumb of additional support—maybe some extra additional home care support to deal with the very real problem of changing adult diapers for a 200-pound, aggressive, immobile adult. It takes three people to do that effectively, by the way.

So imagine my despair when I read the Patients First Act, to realize there's nothing in here about any more direct patient care services, no promises of more home care hours, no more long-term-care beds, no shorter wait times for actual surgery—nothing. The providers may be more integrated, but you still need the actual resources to deliver the care.

Instead, as a former mergers and acquisitions specialist, I see Ontario will spend millions of dollars to merge two distinct entities, CCACs and LHINs—unionized with non-unionized operations, a nightmare in and of itself. I see, as a business consultant and Ontario taxpayer, millions of dollars being spent on creating 78 mini-government offices, called sub-LHINs, staffed with hundreds of government-employed project managers, data analysts etc. Each manager on average earns $75,000. How many home care hours does that strip out of the system? Because, of course, Minister Hoskins has told us the total health care budget is not increasing. And

that budget is comprised of two parts: direct patient care and administration. So if you increase one of those components, administration, the other component, direct patient care, has to take the hit.

The ministry claims that administration and management savings accruing from merging CCACs and the LHINs will be more than offset by increased employees, and inevitably the need to house them in larger premises with the attendant leasehold improvements, new furnishings, IT systems etc. But it gets worse.

In business, it is a fundamental generally accepted accounting principle that you do not have your payables person do your receivables. That is an invitation for mismanagement and fraud, but that is exactly what the government has created for itself in this bill. The government has created a closed loop system: It creates the policy, it delivers the services, it manages the daily oversight, it audits itself, it eliminates any appeal mechanism and it has final arbitrative authority. What would ever compel government, then, to reveal if something isn't working or if they made a mistake? The public and Ontario taxpayer wouldn't know until well after the fact—maybe never. This is another financial scandal in the making.

References to a patient ombudsman in the bill are token optics. As a caregiver, one needs real-time flexibility and options. To illustrate, I was indescribably grateful to the cardiac critical care team bending the rules to allow my dying mother one extra day in the cardiac critical care unit, so she could be transferred to the palliative care unit and bypass the general ward with its screaming dementia patients. This seems small, but it's a monumental victory for a caregiver who realizes she has run out of options.

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This leads me to my last and final point: One thing that I have learned throughout all of my years as a caregiver, spending hundreds of hours in ERs, in wards, in doctors' offices and on the phone trying to arrange another crumb of care, is that if you want or need something from someone, the last thing you do is poke your finger in their eyes. But that's exactly what this government has been doing continuously to our physicians and other health care providers in the system for the past three years. Stop doing that. You're making my life infinitely harder.

People have only so much capacity to be able to continue to respond. When you treat people with disrespect, when you shackle their hands, when you "direct," "supervise," "legislate" and "investigate" them to the point where they are beleaguered or they have no more flexibility, you cripple the doctor-patient relationship. There are mechanisms in this province to bring the medical profession and government together to work on solutions that will benefit all Ontarians. Stop the pissing match, because I need these people. They're the only ones I can rely on. So tell me what you're going to do to address this problem.

Thank you for your attention.

The Acting Chair (Mr. Robert Bailey): Thank you. We'll start with the third party. Madame Gélinas, please: two minutes.

M^me^ France Gélinas: Can I call you Kathy?

Ms. Kathy Bugeja: Please do.

M^me^ France Gélinas: Thank you for your words, Kathy. I have been saying for a long time that our home care system is broken, that it fails more people than it helps and that it needs to change. You have put it in words that are way more eloquent than mine, and I thank you for coming and sharing your story with us.

Our home care system is broken. The Patients First Act takes the board of the CCAC and the executive director of the CCAC away, puts a vice-president of community services at the LHINs, and nothing else changes. That means that every time you need support, every time you beg for crumbs, that's all that will continue to be available. This is not acceptable to me.

How can you call something "Patients First" when it has nothing to do with improving patient care? Our home care system is broken, and that means that good people like you have to suffer for it. The people who you look after—your mother, the five family members you talked to us about—we failed them, and I'm sorry for failing your family. We have to do better. This bill has to do better.

I can guarantee you that I will do my best to change it so that it lives up to its name and to make sure that it puts patients at the centre. Getting rid of boards and creating a new bureaucracy is not the way to go; I agree with you. The way to go is to look at the broken system, to look at our home care system and why it is failing so many people. It's not failing so many people because we have a board of the CCAC. That has nothing to do with anything. This bill is smoke and mirrors. It's not going to help you. It's not going to help the close to a million Ontarians who depend on our home care system.

If you have anything else that you want to add on the record—

The Acting Chair (Mr. Robert Bailey): Time's up. The two minutes are up; sorry.

Government: Mr. Fraser.

Mr. John Fraser: Thanks very much, Ms. Bugeja. I want to thank you for coming and sharing your story. I have some experience with this from a family perspective, and that's why, as a parliamentary assistant, I have been doing some work in palliative and end-of-life care and other areas like scope of practice.

Although I don't agree with Madame Gélinas in her description that more people aren't getting what they need than people are getting what they need, what I do believe is that I think that we would all agree that more people than not are not getting what they need. Too many people are—not more people, but too many people.

One of the challenges in this—and I'm sure you've experienced it because I know that I have experienced it when you're transitioning from hospital to home care, or from one place to the next—is the challenge of stewardship in the system. Because I really, firmly believe that

all of us—everybody who is involved in that system, everybody who touches a patient—has a responsibility to make sure that patient gets to the next place that they need. And it doesn't happen often enough. There are some really excellent providers that are out there that do that. There are a lot of them, but it doesn't happen all of the time, to consequences like what you're describing in your family.

The system does have to be more responsive. What I want to assure you is, to do that, I really, firmly believe that what we need to do is to build structure to give local planning and decision-making more authority, more structure, more ability to adapt to local needs, because that's the only way to get down to the patient level; that's the only way to change culture. You're not going to change culture from downtown Toronto. It's not going to happen. Where we see successes—and I'll give some examples in palliative care. In Sudbury, in Windsor and in Ottawa, where communities have come—

The Acting Chair (Mr. Robert Bailey): Sorry, Mr. Fraser. The time is up.

Mr. John Fraser: Oh, jeez. Two minutes goes so fast. Thank you.

The Acting Chair (Mr. Robert Bailey): Thank you for the presentation—

Mr. Jeff Yurek: Chair?

The Acting Chair (Mr. Robert Bailey): Oh, sorry. Sorry; I was thinking we did you. All right. Mr. Yurek from the PCs.

Mr. Jeff Yurek: Thank you very much. I'm just going to say a few things and then let you have the floor to end it. I think they should pull this bill and start from scratch. Numerous people have come to this committee. Patients and caregivers were not part of this process. I think we need to develop a health care system structure around the patients and caregivers who deal with the system. Instead, we have a bill here that's creating another level of bureaucracy, the structure they want to create, which is going to take more money out of the system.

That's all I wanted to say. You have the floor here.

Ms. Kathy Bugeja: I would like this bill to not be passed yet, or at all, until this government tells the Ontario public how much it's going to cost to merge the CCACs and the LHINs. That's an expensive proposition. I believe the Ontario taxpayer has a right to know.

I would like this bill to be created with the medical profession. I do not believe that this bill has consulted with the medical profession in the venue that is created. They have a physician services agreement; they have mechanisms to do this. The white paper in December 2015 and the legislation in February were all introduced without formal consultation with the body that represents the 40,000 doctors.

Six doctors around a table are six talking heads who only speak for themselves, unless they have the broader engagement of the profession. I rely on that group to make sure there are things in the bill that work for patients first.

I'll conclude my remarks. Thank you.

The Acting Chair (Mr. Robert Bailey): Okay. Thank you for your presentation.

I'd remind all the parties that if we can keep the questions a little shorter, then we can give the presenters a little more time to comment.

THE LUNG ASSOCIATION—ONTARIO

The Acting Chair (Mr. Robert Bailey): Next, we'll have the Lung Association of Ontario with Ms. Andrea Stevens Lavigne, vice-president of provincial programs.

Ms. Andrea Stevens Lavigne: Call me Andrea.

The Acting Chair (Mr. Robert Bailey): Okay. We'll just do the drill. You've got up to nine minutes for your presentation. Then we have two minutes of questioning from each party.

Introduce yourself for the record, please.

Ms. Andrea Stevens Lavigne: I shall. Thank you very much. My name is Andrea Stevens Lavigne and I am the vice-president of programs at The Lung Association—Ontario. I'm delighted to be here this evening to speak in response to the Patients First Act. I'm especially delighted to see some lung health champions in the room.

The Lung Association does support the overall goal of this legislation; that is, to put patients first and to ensure that their needs are met at a local level. We feel that's particularly important for the 2.8 million Ontarians who suffer with lung disease.

This number has in fact continued to grow since we first released our report several years ago: Your Lungs, Your Life. Just this week, we released new data from the Institute for Clinical Evaluative Sciences, which obviously are based on our own Ontario OHIP data, that show that almost 900,000 people in this province have chronic obstructive pulmonary disease. It also indicates more than two million with asthma; one in four children have asthma. Obstructive sleep apnea is another growing concern, with approximately 300,000 individuals.

COPD in particular is responsible for 24% of all hospitalizations in this province and for the highest rate of readmission. It's no surprise that COPD and lung disease overall place a huge burden on our health care system.

Respiratory disease also affects a number of underprivileged segments of our population, including indigenous peoples and foreign-born Canadians. We believe that this legislation could potentially provide that opportunity to help these people with lung disease and provide an opportunity to not only improve care, but to reduce health care costs.

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At the same time, our primary caution is that we put a strong provincial framework in place. We need to ensure that evidence-based guidelines and tools are in fact integrated and incorporated at the local level. We don't want to reinvent the wheel in a number of different regions and sub-regions. We have, in fact, worked over the last two or three years to develop an Ontario Lung Health Action Plan with more than 60 stakeholders

across the province. That action plan does provide those overall measures and standards and tools that are evidence-based and have research behind them.

One of the recommendations in particular, related to that plan, is the addition of certified respiratory educators across existing health care infrastructure. Our research shows that investing $200 per patient will yield a savings of $1,000. Certified respiratory educators are highly trained professionals that come from a variety of different disciplines, but they have special training to become CREs and to work with patients to help them manage their lung disease. In fact, research has shown that it reduces health care costs. I'll come back to the CREs in a moment.

I'm not going to go through all of the recommendations that we provided in our submission, which we provided to the government a few months ago, but, basically, just to highlight, there are many areas of the legislation where we feel there are opportunities to strengthen. Certainly, we agree with the importance of seamless links between primary care and other services, accessible home and community care, which has already been spoken about so eloquently, and, finally, stronger links between public health and other health services. Lung health, for example, does in fact cross the entire continuum: We're concerned about prevention, early intervention, identification, treatment and, of course, research.

Let me come back, just for a moment, to the certified respiratory educators and what they can do and some of the evidence that we have. The Lung Association has in fact been managing the Primary Care Asthma Program, which is a program of the government of Ontario, for more than 10 years. It was evaluated 10 years ago, and it demonstrated that, in fact, by including certified respiratory educators in a multidisciplinary team, we could not only improve patient care, but we could reduce health care costs. We reduce significantly the number of visits to emergency rooms by both children and adults, which obviously decreases cost. That program has been replicated in many different communities across the province. Just recently, there has been new research to show that a similar model related to COPD will have the same effect. In short, we have the solutions. We know where the burden of care is; we know that these diseases are continuing to rise and the health care cost is continuing to rise, but the good news is that we do have solutions. We have evidence-based tools.

In conclusion, I'd like to just reiterate that the Lung Association does support the overall goal of the legislation to put patients first and to integrate care at the local level. But we hope that the involvement of stakeholders will be an integral part of the implementation process, and we believe that there are opportunities to strengthen the implementation by the inclusion of these types of recommendations that will finally address the burden of lung disease.

The Acting Chair (Mr. Robert Bailey): Thank you very much. We will start with the government for two minutes. Mr. Fraser?

Mr. John Fraser: Thank you very much for your presentation and for being here today. Thank you for your submission and your work, especially on the asthma program.

I was saying a little bit earlier, in terms of building seamless access and connections between primary care and, actually, public health and those who have chronic conditions like lung diseases—many of them are; most of them are. What do you see evolving? For instance, in your association, what are the things that you want to see that could be made stronger through local decision-making that is based on the capacities that exist inside the community?

Ms. Andrea Stevens Lavigne: Great. Well, as I said earlier, we do have evidence-based tools. So, in an ideal world, we would see every local planning region use the same type of evidence-based tools to integrate, to work with, to make those linkages between primary care—not only multidisciplinary teams, but sole practitioners—with the hospitals to ensure there's that seamless link after discharge.

The reality is, the majority of people with lung disease are in fact treated in primary care, so it's really important that we have those links between the hospital and acute services.

I'll just put in a word around sole practitioners. Again, there's lots of evidence to show the benefit of multidisciplinary teams, but unfortunately, only 25% of patients in the province have access to those teams. In an ideal world, we'd love to see these types of additional resources—the certified respiratory educators—being mobile, being accessible to sole practitioners, to any clinic. The beauty of our suggestion, our recommendation, is that it doesn't require new infrastructure. It's a modest investment. We can use existing clinics, whether they be hospital-based or community-based—

The Acting Chair (Mr. Robert Bailey): Okay. Sorry, Ms. Lavigne.

Ms. Andrea Stevens Lavigne: No problem.

The Acting Chair (Mr. Robert Bailey): We'll go to the Conservatives, the PCs, please. Mr. Yurek.

Mr. Jeff Yurek: Thanks for coming in and speaking. It's great. Again, thanks for the support from the Lung Association with Ryan's Law. I know we have quite a bit of support for that bill, and we're going to start pushing the government again to help push that through the school boards. It seems they hit a roadblock somewhere along the time, but we'll get back to that.

I noticed you mentioned certified respiratory educators, and you listed a number of health care professionals. I'm thankful you put pharmacists there.

Ms. Andrea Stevens Lavigne: Yes.

Mr. Jeff Yurek: Sometimes they're left out of the picture, but they're key.

The bill allows for the creation of a patient health council, which doesn't really have much teeth, but at least they're created. But it's optional for health care professionals. So I could see LHINs not wanting to go down that avenue. What are your thoughts? Should that

be mandated, that we should have health care professionals? Because we want to bring in our educators.

Ms. Andrea Stevens Lavigne: Yes, absolutely. I feel, in terms of any kind of council of that nature, that it's again that interdisciplinary nature. It's also that link between patients and health care providers that's critically important.

We have done a lot of work with patient engagement. As mentioned earlier, the voice of the patient is incredibly important. We do represent people across the province, and we'd love to see an integrated model.

Mr. Jeff Yurek: Okay. Thanks.

The Acting Chair (Mr. Robert Bailey): We'll start now with Ms. Gélinas, from the NDP.

M^me^ France Gélinas: Thank you for coming, Andrea. By the way, I love the new logo, "Breathe."

Ms. Andrea Stevens Lavigne: Oh, good. I'll pass that along.

M^me^ France Gélinas: Yes, I really like it.

Ms. Andrea Stevens Lavigne: Thank you.

M^me^ France Gélinas: I'll start with this: Quite a few agencies have talked about equity, and they want to see a new definition of "equity" included in the bill. Has your organization given that any thought? What would you like to see if we are to put a new definition of "equity" in that bill?

Ms. Andrea Stevens Lavigne: To be honest, I haven't paid too much attention to that, although, obviously, in terms of what our concept is, certainly we believe that it is incredibly important. We talk about the communities and the councils having to represent the local communities. Again, I think that's really important. However, I would also indicate that, unfortunately, especially with people with lung disease, there are certainly a large number in marginalized communities. I think when we look through the equity lens, we have to be really careful and look for new strategies to be inclusive.

M^me^ France Gélinas: You talked about seamless links. There are some organizations that want to see the care coordinator integrated into primary care rather than transferred to the LHINs. Right now, the case coordinators are with the CCACs. They would move to the LHINs. Some want them in primary care. Do your organizations have any opinion?

Ms. Andrea Stevens Lavigne: We've actually seen different models—that's a very good question—where the case manager, who can be a certified respiratory educator—we've seen it work at the hospital level, and we've also seen it work directly in primary care. I feel that it is possible that it could work. Again, our major issue would be access to care. There are multiple doors for people to access the system. I'd like to see case managers in more than one place.

M^me^ France Gélinas: Would you support that the bundles of care be defined—

The Acting Chair (Mr. Robert Bailey): Sorry, the time is up. I apologize. Thank you very much for your presentation today.

Ms. Andrea Stevens Lavigne: Thank you.

MS. MAUREEN TAYLOR

The Acting Chair (Mr. Robert Bailey): We'll call the next delegation. Maureen Taylor.

I feel like the heavy here today.

Ms. Maureen Taylor: Hi.

The Acting Chair (Mr. Robert Bailey): Your name—identify yourself—

Ms. Maureen Taylor: My name is Maureen Taylor. I'm appearing before you as just Maureen Taylor, but I was the co-chair of the provincial-territorial expert advisory panel on physician-assisted dying, which was actually set up by the Ontario government.

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I will not be speaking for that entire panel, but I can certainly refer to our recommendations. Also, my late husband was Dr. Donald Low, who died of a brain tumour a little more than three years ago, 10 days after expressing his wish for an assisted death. So I'm an advocate for assisted death and I'm going to confine my remarks on the bill to the clause—I'm sorry; I had two hours' notice and I don't have it in front of me, but the one that says that the health minister will not—I guess, for lack of a better word—force a religious institution to provide a procedure that does not jibe with that religion's conscientious beliefs.

This is problematic not only for assisted dying, but for a lot of other issues in health care. I'm thinking here about a woman's right to birth control, to access abortion and perhaps LGBT rights. I'm not sure that our Premier understands the legacy that she may leave if she allows these rights to be compromised. But I'm going to talk about assisted dying.

I work as a physician assistant in Michael Garron Hospital, which is a community hospital in the east end of Toronto, so let's use this as an example. I may see a patient with terminal cancer who has tried everything, and the last chemo doesn't work. They come into a hospital very sick, maybe febrile, with an infection. It used to be that they had three choices: They could continue to receive medical therapy and stay in hospital, they could opt for palliative care and try to go home into the community, if possible—that's an issue; other people will speak better to whether that's possible—or we could try to get them into our palliative care unit that we have in our hospital.

Now they have a fourth option. They can ask for an assisted death. If they meet the criteria, in our hospital, we will entertain that request.

If that patient, that very same patient, were at St. Joseph's hospital or St. Michael's Hospital or the Pembroke hospital, not only would they not be able to exercise that option, they may not even be able to have that discussion about whether they qualify with their physician.

The way that we practise health care in this province, we cannot allow those types of religious beliefs to get in the way of what is a legal right for people now, in this country. You also know that the idea of, "Oh, well, we'll transfer you out to another institution that will give it to

you"—where are these ambulances that have nothing better to do but to transfer people around from one institution to another? If they're in Pembroke, are we really going to, as taxpayers, fund them to get in an ambulance and go to Ottawa just to have the discussion?

I will leave it there, but I'm begging you, please. I understand; I was raised a Catholic. My children are baptized Catholics. But in this day and age, these are publicly funded institutions, and everyone does not get to choose the hospital they end up in. If you want to call this the Patients First Act, this clause adds something that absolutely does not put patients first. It puts a bunch of bishops first.

The Acting Chair (Mr. Robert Bailey): Thank you, Ms. Taylor, for your presentation.

We'll start with the official opposition. Two minutes. Mr. Yurek?

Mr. Jeff Yurek: Thanks for coming in, and for your words. Thanks for contributing that to committee. It's something that probably wouldn't have come up or been thought of at that point, so it's something to take back and discuss.

Since you brought up medically assisted dying, yesterday we had nurse practitioners here, and their big comment was that they're allowed to inject the medications or deliver the medications, but they can't—

Ms. Maureen Taylor: Prescribe them, yes.

Mr. Jeff Yurek: —prescribe the medications. Do you think that is more of an emergent issue to fix than—because this bill is going to take a lot of—

Ms. Maureen Taylor: I don't think it has to be an either/or. I mean, nurse practitioners have been accepted in this province for a long time. If we're going to give them a scope of practice that includes end-of-life care, I think they should be able to provide that. I don't think it has to be either/or.

I want to stress, too, that I totally support the rights of individual health care practitioners not to participate in assisted death if that goes against their conscience. But I don't think institutions should have that right. There's a difference. It's a balance, but I think we can find it, and I think we did in our recommendations from the EAG. But the government is not following them in this clause.

Mr. Jeff Yurek: Thanks for adding that second part.

The Acting Chair (Mr. Robert Bailey): I guess I'll go to the NDP.

M^me^ France Gélinas: I thank you so much for coming. I'm sorry for your loss of your husband.

Ms. Maureen Taylor: Thank you.

M^me^ France Gélinas: I admire the work that you have done. It's the first time that it hit my radar, and it should have hit my radar sooner, so I'm glad you came.

Have you looked at other provinces that do have Catholic hospitals? How do they handle it?

Ms. Maureen Taylor: It's not going well. We know that in Vancouver, a gentleman was in a Catholic hospital at the very end of his life and he asked for an assisted death. They did put him in an ambulance to transfer him across town. He was in excruciating pain, because of course the paramedics are not allowed to keep up his opioids as he goes across the city. It's not going well.

Catholic bishops in Alberta have told all their priests not to give Catholics who get an assisted death a Catholic burial or funeral. I mean, that doesn't have anything to do with this, but I think there's a reassertion of these very antiquated notions of what people should and shouldn't be allowed to get, and I'm not willing as a woman to let these men tell me what my reproductive rights are. As someone who may one day be in the position where I'd want an assisted death, they don't get to tell me where I get it.

M^me^ France Gélinas: Because you have the expertise: In my riding right now, I had a family reach out to me where we were not able to even identify a physician able to help. Would you have suggestions so that those become more accessible to people who want them?

Ms. Maureen Taylor: It was there in our recommendations. We anticipated that access would be a problem, especially in rural areas. We anticipated that. We feel that the province needs to have a coordinated effort of physicians who may be willing even to be flown into a remote community to provide it.

Over telemedicine, we can assess patients for their capacity. We can look at all their medical records and see if they fit the criteria. But even we felt RNs—

The Acting Chair (Mr. Robert Bailey): Thank you—

Ms. Maureen Taylor: —in those communities should be able to provide it under a directive.

The Acting Chair (Mr. Robert Bailey): Thank you, Ms. Taylor. I apologize for the interruption.

We'll go to the government now, please.

Mr. John Fraser: Thank you very much, Ms. Taylor. It's good to see you again. We had a chance to share a panel about a year or so ago, and I want to thank you for your work on the panel and for your advocacy.

As you know, my work is in palliative and end-of-life care, and I believe that's a thing we should be focusing on, simply because the decision is about choice, and right now not all the people have all the choices that they need.

Having said that, my mom is Catholic as well, but I don't think this is about Catholics—because I've spoken to a lot of physicians and people. I see it as a right of conscience. You're looking at a right of access, which is important, and a right of conscience, and you've got to find a way to balance those.

I said to my mom, "Mom, do you think that you could participate?" My mom said, "No, I don't believe I could do that, because this is what I believe."

Ms. Maureen Taylor: She won't be compelled to.

Mr. John Fraser: And then she said, "But there are extreme circumstances." So what that said to me—she's very wise. She said, "You're asking me a question to which I have no proximity. You have proximity to that question. You've seen that." So I think as we move forward with this thing that's not new to the world but new to us, we have to find a way to come through it together.

I'm saying this respectfully, and this is me speaking: I think there's a risk that if we take hardened positions on either side, we run the risk of not coming through this together. That's my personal opinion. I do believe that the decision was right and that people need access; I think we need to balance conscience too, and it's a difficult thing to do. I think we need time.

Ms. Maureen Taylor: Again, conscience of individuals is not in dispute. But with respect, John, if the government had taken the lead on this to ensure access for Ontarians, so that what France was describing wasn't happening, maybe we wouldn't have to be so adamant about slipping this clause in—which was, by the way, slipped in just a couple of weeks ago. It wasn't in the original bill in June.

The Acting Chair (Mr. Robert Bailey): The time's up. Thank you. I appreciate your presentation today, and I appreciate the patience of the people that are—it's a short time, and I appreciate that.

THE NEIGHBOURHOOD GROUP
ST. STEPHEN'S COMMUNITY HOUSE

The Acting Chair (Mr. Robert Bailey): The next group is The Neighbourhood Group: Mr. Bill Sinclair, executive director. You know the drill: Introduce yourself, please, for the record, and once you start you have nine minutes. Then the parties will have two minutes each for questioning, starting with the NDP.

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Mr. Bill Sinclair: Hello, Mr. Chair and members of the committee. I am Bill Sinclair, and I'm actually the executive director of St. Stephen's Community House. I'm speaking today on behalf of the Neighbourhood Group and St. Stephen's Community House, which are two organizations providing community support services and mental health and addiction services directly to the public in downtown Toronto.

We're both community-based, multi-service agencies that work in partnership with all three levels of government, with United Way and with the community to deliver a wide range of programs and services to vulnerable individuals and families. The Neighbourhood Group has existed for 105 years, and St. Stephen's for 52 years. Many of the community health services that are referenced in the Patients First Act are not only delivered by organizations like ours but were originally created and promoted by our organizations and organizations like ours long before there was government funding for help for vulnerable seniors and people living with disabilities. We are full partners in creating healthier communities, not just delivery agents.

As a result of our key role in community health, we're deeply concerned about section 21 in the proposed Bill 41. Specifically, we believe that this section of the act, as currently constructed, is inappropriate and unethical by providing unrestricted powers to the LHIN—the local health integration network—to appoint a supervisor who would replace the legal rights and responsibilities of a duly elected community board of directors for our organizations.

At St. Stephen's Community House, funding from the LHIN accounts for approximately 17% of our annual total revenue, yet this proposed legislation would allow a LHIN-appointed supervisor the ability to remove our board of directors and take full control over 100% of our revenue and assets. This is contrary to our status as a non-profit corporation under provincial legislation and as a charity under federal legislation. It would also be a major concern for our other funding partners, such as other levels of government and the United Way, and would place our organization in default with these partners.

Further, from a very practical, community and client perspective, it's almost certain that a LHIN-appointed supervisor would be unqualified to operate our non-LHIN-funded services: our licensed child care centres; our Ontario Ministry of Advanced Education and Skills Development-funded employment services; our Ontario Ministry of Children and Youth Services-funded youth justice services; our federal Immigration, Refugees and Citizenship Canada-funded settlement services; and more. These have nothing to do with the LHIN and should not be taken over by a LHIN-appointed supervisor.

The Ministry of Health and Long-Term Care press release about the bill proposes to "increase access to care with better coordination and continuity." The Neighbourhood Group and St. Stephen's Community House strongly support these objectives, but we strongly maintain that in achieving these goals, this legislation is flawed and needs to be amended before third reading to take into account specific changes to section 21, which would threaten our future programs and services and our legal and charitable rights as organizations.

We feel that this section should be changed to only apply to the appointment of "program supervisors"—supervisors appointed to direct a LHIN-funded program where the LHIN can find no other solution to resolve a compliance issue. Of course, there should be other steps to try and resolve a compliance issue before appointing a supervisor. But, as previously mentioned, it is wrong to appoint an organization supervisor to replace an elected community board of directors for a multi-service and multi-funded organization.

Further, some specific changes: In section 21.2, we would like to see specific guidelines or regulations and conditions under which it is in the public interest for the LHIN to appoint a program supervisor.

Also in section 21.2, it would be good to include a requirement for ministerial and cabinet approval before the LHIN appoints a program supervisor. It shouldn't be entirely up to the local health integration network to do that.

Also in section 21.2, include a mechanism for a community-governed non-profit to request a review or an appeal of the appointment of a program supervisor.

Finally, in section 21.2, define more specifically, through guidelines or regulations, the conditions under which, and the extent to which, a program supervisor may be empowered to govern the health services of a

provider that has multiple funding sources. For instance, it should specify that the LHIN-appointed supervisor is empowered only to direct those resources and programs that are LHIN-funded.

We also support specific changes to the act that would ensure that LHIN-funded programming is directed within the non-profit sector, the non-profit sphere, and not leading to funding for for-profit providers for health care.

We encourage the standing committee to recognize the critical and ongoing role that Ontario's non-profit and charitable sector has played to ensure that the legislation creates a supportive environment for non-profits and charities to continue to serve our communities.

Thank you for this opportunity.

The Acting Chair (Mr. Robert Bailey): Thank you, Mr. Sinclair, for your presentation.

We'll now go to the NDP for two minutes.

M^me^ France Gélinas: Thank you so much. You made it crystal clear as to why this provision of the bill is wrong and needs to be changed. I guarantee you that you will have my support to try to change this to the best of our ability. You cannot have an unelected, unaccountable board of a LHIN decide to run an agency like yours that has been existing for 105 years, serving us top-quality service in everything that you do. Yet, it's in the bill. We will try really hard to change it. I fully understand how important it is for your organization.

The second part is just as important. You realize that with the CCAC rules going over to the LHINs, the LHINs' definition of "agency" used to be a not-for-profit agency. It will now be the new definition, because the CCAC comes over; it will mean for-profit. How important is it for you that the definition of "agency" remains a not-for-profit agency?

Mr. Bill Sinclair: For my organization, it's more of a philosophical issue. We believe that we have competed with 100 years of quality service and can compete with the private sector to deliver quality services, but that philosophically it's a mistake, under international trade rules and other reasons, to start to move the things such as Meals on Wheels and community services and addictions services into the private sector sphere. That could have long-term damaging impacts, beyond our ability to compete—because I feel we could compete. But I think across the province and the nation, it's a philosophically bad direction to go.

M^me^ France Gélinas: Great. Thank you.

The Acting Chair (Mr. Robert Bailey): Now we'll go to Ms. Wong from the government side. Two minutes.

Ms. Soo Wong: Thank you very much, Mr. Sinclair. I'm quite familiar with St. Stephen's. Your previous executive director and I go back many, many years. So thank you for all the good work between St. Stephen's and the Neighbourhood Group.

I hear your comments, on page—to the bottom—that you fully support the objectives of the proposed bill in terms of coordination, and through coordination and continuity of care, especially in your area; there are a lot of frail seniors. The objective of the bill is to improve that coordination, as well as communication.

So I'm going to ask you, as an NGO, a non-profit organization: How do you see your role in terms of a future part of offering more health care services? We have heard consistently from the Auditor General about the CCACs, the ineffectiveness. What can we do to work together better? Because we've got to get this right. Whatever it looks like, we've got to get it right in terms of coordination and communication. How can you share with us, from your organization—from both your organizations, not just one—in terms of better providing options for the constituents, your residents?

Mr. Bill Sinclair: We're active in our local health integration network and the sub-regions on the health links that have been created in recent years, working to develop care plans for vulnerable, complex-care seniors, but also adults with mental health and addictions issues. In each case, the decision—you pull together a care team. It's family members, the doctor, the nurse, the community services that deliver the services right in people's homes, and you try to determine who is going to be the team leader or who is going to be the case manager to make sure that the vulnerable patient makes their appointments, has coordinated care and has their treatment. In some cases, it's a family doctor; in some cases, it's a nurse of a group practice; and in some cases, it's a social worker set in the community, based on each individual assessment.

We have done thousands of care plans for seniors in our community and we will continue to do so to make sure that no one falls through the cracks, that the right person is paying attention, is keeping all the people informed, bringing them around a table, when needed, or a virtual table sometimes, and that the people are getting the care they require to stay at home as long as possible and to have improved health.

The Acting Chair (Mr. Robert Bailey): Okay, Mr. Sinclair. Thank you. The government time is up.

We'll go to Mr. Yurek from the PCs.

Mr. Jeff Yurek: Thank you, Chair.

Thanks for coming in. Yes, I'm quite concerned with section 21, the fact that they only provide 17% of your funding and have the potential to take over your organization and your board of directors. I'm assuming you do quite a bit of fundraising and such to maintain part of your funding.

Mr. Bill Sinclair: That's right, almost $1 million a year.

Mr. Jeff Yurek: So you would be expecting the LHIN board, once they take you over, to do the fundraising for you, is that it?

Mr. Bill Sinclair: Exactly. Or that our donors would maybe not trust us with their dollars if they weren't sure that—if our board is not in charge.

Mr. Jeff Yurek: So you're proposing either to just add a program supervisor or that we scratch that part of the bill altogether?

Mr. Bill Sinclair: That would be terrific, but I understand that the LHIN may need some powers to work with organizations where they are not compliant. So I would certainly accept a program-level supervisor to make sure

the supervisor was meeting all the standards of the LHIN. But to take over the organization and replace the board of directors is completely unethical to me.

Mr. Jeff Yurek: Okay. Well, we're going to try to make changes to that when we come to amendments.

Mr. Bill Sinclair: Okay. Thank you.

The Acting Chair (Mr. Robert Bailey): Okay. Thank you for the presentations today. Thank you, Mr. Sinclair, for your presentation.

The time allotted for the committee this evening is up, so we're going to adjourn until Monday, November 21 at 9 a.m.

Interjection.

Oh, sorry. Madame Gélinas?

M^me^ France Gélinas: Chair, before you hit that big hammer, could somebody refresh my memory as to what are the times left for meetings?

The Acting Chair (Mr. Robert Bailey): I'll refer to the Clerk.

The Clerk of the Committee (Mr. Trevor Day): Are you saying open slots, or just the time that we are still going to be meeting on this bill?

M^me^ France Gélinas: The full time that we are still going to be meeting on this bill.

The Clerk of the Committee (Mr. Trevor Day): Monday, November 21, from 9 a.m. to 10:15; then, we start again at 6 p.m. until 8 p.m. On Wednesday, November 23, from 1 o'clock till 3:45 p.m.

M^me^ France Gélinas: Thank you.

The Acting Chair (Mr. Robert Bailey): Thank you again, and thank you to the members for their courtesy to be here this evening. We are adjourned, like I said, until Monday, November 21 at 9 a.m.

The committee adjourned at 1902.

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