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Lundi 18 novembre 2013

Standing Committee on Social Policy

Local Health System Integration Act review

Comité permanent de la politique sociale

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

Chair: Ernie Hardeman
Clerk: Valerie Quioc Lim

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Monday 18 November 2013

Lundi 18 novembre 2013

The committee met at 1401 in committee room 1.

LOCAL HEALTH SYSTEM INTEGRATION ACT REVIEW

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

SUBCOMMITTEE REPORT

The Chair (Mr. Ernie Hardeman): The first item of business: Obviously we are here and directed by the Legislative Assembly to be here, and a programming motion was passed for us. Your subcommittee has met in order to set up the meeting for today, and we have Ms. Jaczek to bring in the report of the subcommittee.

Ms. Helena Jaczek: Thank you, Chair. Your subcommittee met on Tuesday, November 12, 2013, to consider the method of proceeding on the order of the House dated November 7, 2013, in relation to the review of the Local Health System Integration Act and the regulations made under it, as provided for in section 39 of that act, and recommends the following:

(1) That the committee meet on Monday, November 18, 2013, to receive a technical briefing from staff of the Ministry of Health and Long-Term Care, pursuant to the order of the House dated November 7, 2013.

(2) That the committee Clerk invite the deputy minister, along with other staff responsible, to provide the briefing and answer questions from committee members (up to one hour for a statement and the remaining time for questions).

(3) That ministry legal staff be offered one hour to provide an explanation of the act and answer questions from committee members during the briefing (up to 20 minutes for a statement and 40 minutes for questions).

(4) That the committee meet on Monday, November 25, 2013, to continue the review.

(5) That the subcommittee or full committee meet at future dates to further discuss how to proceed on the review.

The Chair (Mr. Ernie Hardeman): You've heard the report of the subcommittee. Discussion?

For clarification, I would point out that item number 2 in the subcommittee report should be number 3 and item number 3 should be number 2. To make sure that we have the appropriate item: Item 2 suggests that the remaining time should be allotted for questions. If you leave it at number 2 and do that first, that would not give you the opportunity necessarily to do number 3. So they should be turned around within the report. There's nothing wrong with the words—just make sure we all understand the direction there.

No further discussion on the report?

If we could just suggest that the cameras can't take pictures of the thing on the desk. If you would stay behind the chairs where the presenters are. If that's not adhered to, then you have to stay outside the door.

With that, if there's no further discussion, all those in favour of accepting the subcommittee report? Opposed, if any? The motion is carried. That is accepted, then—the subcommittee report.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Chair (Mr. Ernie Hardeman): As related in the subcommittee report, our first delegation will be the Ministry of Health and Long-Term Care: Robert Maisey, legal counsel group leader; and Kathryn McCulloch, director, LHIN liaison branch, health systems accountability and performance division. If you will take your seat there—thank you very much.

As to the report, your presentation will be an hour. We'll have approximately 20 minutes for you to make the presentation, and then the other 40 minutes will be divided equally among the parties for questions of your presentation.

With that, we thank you very much for coming in today, and we will turn the meeting over to you to make your presentation.

Mr. Robert Maisey: Thank you very much, Mr. Chair and members of the committee.

My name is Robert Maisey, and I'm legal counsel with the Ministry of Health and Long-Term Care. With me is Kathryn McCulloch, director of the LHIN liaison branch at the Ministry of Health. We are pleased to provide the committee with a technical briefing of the Local Health System Integration Act, 2006, which I will refer to simply by the acronym LHSIA, or "the act."

You should have, Mr. Chair, a copy of the presentation that I was going to speak to, which I hope has been handed out.

I'm getting a lot of echoing in my ears from the microphone.

Interjection: It's the camera.

Mr. Robert Maisey: Oh, it's the camera. Okay. Maybe if I sit back a little it'll go away.

The Chair (Mr. Ernie Hardeman): I think it's the camera broadcasting, or taping—are you taping the sound?

Interjection.

The Chair (Mr. Ernie Hardeman): Well then you'll have to stand back because there's too much echoing in our sound system.

We'll try it again.

Mr. Robert Maisey: All right. Thank you very much. I'll start at slide 3, if I may, which is the background of the legislation.

LHINs were incorporated first in June 2005, under the Corporations Act, as not-for-profit corporations. On November 24, 2005, the government introduced Bill 36, as it was then called, the Local Health System Integration Act. The Standing Committee on Social Policy conducted a clause-by-clause review and a number of public hearings, including amendments being passed which were recommended to the Legislative Assembly. On March 28, 2006, the Local Health System Integration Act was passed and received royal assent.

Slide 4 lays out at a very high level the structure of the legislation. There is a preamble, which I'll speak to in a minute. Part I lays out an interpretive section and some definitions. Part II deals with the local health integration networks as corporations. Part III speaks to functions about planning and community engagement. Part IV deals with funding and accountability within the local health system. Part V deals with integration and devolution. Part VI contains some general provisions.

In addition, there have been regulations made under the legislation dealing with committees of the board—that's the board of the local health integration networks—engagement with francophone communities, exemptions from the legislation, the French Language Health Services Advisory Council, and there's also a general regulation. This presentation will touch on each of those regulations, and it will touch on each section within the statute without necessarily going into significant detail.

I can take you, then, to slide 5. Slide 5 deals with the preamble and one of the key clauses in part I of the act, which is the purpose clause. The preamble lays out a number of principles about the health care system, including principles related to the Canada Health Act, promoting the delivery of the health system by non-profit organizations and achieving an integrated health system.

The purpose of the statute is set out in section 1. I've quoted from it there. It is "to provide for an integrated health system to improve the health of Ontarians through better access to high quality health services, co-ordinated health care in local health systems and across the province and effective and efficient management of the health system at the local level by local health integration networks."

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If I can move to the next slide, slide number 6, one of the key defined terms in the statute is set out in section 2, and that is the term "health service provider." This is a key term because it lists the types of health service providers that are most affected by the statute. Health service providers for LHSIA are: hospitals, both public and private hospitals; long-term-care homes; community care access centres; community service providers; community health centres; and community mental health and addiction service providers.

One of the subsections in section 2—subsection 2(3)—provides that physicians, podiatrists, dentists and optometrists are not health service providers when they offer those professional services to individuals. This has the effect of taking the ministry's Ontario Health Insurance Plan outside of the LHIN system, so that payments to physicians are not within the jurisdiction of LHINs. This point will come up a couple of other times in the statute, so that's why I've highlighted that for you.

Moving to slide 7, we get into part II of the act, which is about local health integration networks as corporations, as government agencies. LHINs were first incorporated in 2005, and section 3 of the statute continues those corporations under LHSIA.

Section 4 goes on to provide that LHINs are crown agencies. The purposes or the objects of the LHINs are set out in section 5, and those are listed in an appendix to this presentation for ease of reference.

Section 6 deals with the corporate powers of LHINs, and it provides that LHINs have the capacity to function as a natural person, which means that they can contract as any other person can, but it then places some restrictions on LHINs. Those restrictions are set out on slide number 7.

The first five bullet points under that provision on slide 7 are about financial restrictions on LHINs: the inability of LHINs to buy and dispose of real estate; to lend; to invest money; and to indemnify people without cabinet approval. The last bullet deals with: LHINs are not permitted, without cabinet approval, to provide direct health services to people.

Moving to slide 8, I've tried to summarize some of the provisions related to the corporate structure of LHINs. Each LHIN has a board of directors that is appointed by cabinet, each member for up to three years, and for no more than one term renewal; that means, no more than six years. Then there are provisions around the board's structure, around remuneration, quorum, and the appointment of chairs and vice-chairs. The statute puts the affairs under the control of the board of directors. It requires board meetings to be open to the public, with some exceptions, as set out in section 9. The statute also permits the board to employ a chief executive officer and other employees, and for the minister to fix salary ranges for the CEO. Each LHIN is required to have an annual audit and to submit an annual report to the minister, and

the statute also provides that the Auditor General may audit a LHIN.

Moving to slide 9, this takes us into the subject of planning and community engagement within the statute. Section 14 of LHSIA provides that there are some obligations on the minister: to develop a provincial strategic plan; to establish some councils related to aboriginal and First Nations people and francophone Ontarians; and to seek advice from mandated province-wide planning organizations in developing the provincial plan.

Slide 10 discusses some of the obligations on LHINs with respect to integrated health service plans. Each LHIN is required to develop an integrated health service plan for its geographic area. Section 15 also describes some of the content of an integrated health service plan, or an IHSP, as it's called in short. It must include a vision, priorities and strategic directions for the health service, the local health system. It has to be consistent with the provincial strategic plan and the funding for LHINs. This legislation has been implemented so that each IHSP of a LHIN is for three years, and the current plans are from 2013 to 2016.

On slide 11, this describes some further obligations related to community engagement. A LHIN must engage on an ongoing basis with its community about the needs and priorities of the local health system, including with patients, health service providers and employees. Community engagement can include community meetings, focus group meetings or establishing advisory committees.

Each LHIN is required to engage with the aboriginal and First Nations health planning entity and French-language health planning entity that is prescribed for the LHIN. Each LHIN must also establish a Health Professionals Advisory Committee, to act in an advisory capacity, from members prescribed in the regulation.

In addition, on page 11, the last bullet deals with an obligation on health service providers. Health service providers are required to engage the community when they develop plans and set priorities for the delivery of health services in the local health system.

Moving on to slide 12, we change subjects and get into part IV of the statute, dealing with funding and accountability. Section 17 is the provision that permits the minister to provide funding to LHINs. It also permits the minister to adjust the funding of a LHIN to take into account a portion of any savings that a LHIN generates through efficiencies in the local health system.

When the minister provides funding to a LHIN, the minister and the LHIN are required by section 18 to enter into an accountability agreement. The statute sets out some of the required content for an accountability agreement. This includes performance goals and objectives of a LHIN; performance standards, targets and measures; reporting by a LHIN; the spending plan; and a progressive performance management process.

Section 19 provides the authority for a LHIN to provide funding to a health service provider. That funding has to be provided in accordance with the agreement that a LHIN has with the Ministry of Health under section 18.

The section also goes on to provide that LHINs have to enter into accountability agreements, called service accountability agreements, with health service providers. The process for that is set out in a different statute, which is part III of the Commitment to the Future of Medicare Act, 2004. In appendix E of this presentation, I provide some additional information around that statute.

On slide 13, there are some additional provisions around accountability, auditing and information. Accountability agreements between the ministry and LHINs, and service accountability agreements between LHINs and health service providers, must be made public. The agreement between the ministry and health service providers can be assigned to LHINs under section 19. That was a transition provision to allow the ministry to move funding agreements from the ministry to LHINs, as LHINs have taken on funding authority over the last seven and a half years.

LHINs are not permitted, by section 20, to enter into any agreement that would limit a patient from receiving health care in the LHIN geographic area. There is an exception to that, which is around CCAC services. The intention with that provision is to permit patients to receive services from any health service provider, regardless of which LHIN the patient resides in. The exception to that is CCAC services for home care.

LHINs can audit health service providers that they fund, and they can require information from them. They cannot require personal health information to be provided. LHINs can also share information—financial information or performance information, for example—that they receive from health service providers with one another, with the ministry and also with the Ontario Health Quality Council.

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Moving to slide 14, here we get into part V of the statute on integration and devolution. This part is more complex than the other parts. In previous sections, we typically were dealing with only one subject, and they were relatively self-contained. In this part, a number of the provisions work together with one another, and there are quite a few cross-references.

LHINs and service providers are required to develop integration strategies to better coordinate health care services and use health resources more efficiently. The term "integrate" is defined in section 2—so that's part I of the act—to include:

—the coordination of services and interactions between persons and entities;

—the partnering with another person or entity in providing services;

—the transfer or merging or the amalgamation of operations or health service providers;

—to start or cease providing services; and

—to cease operating or to dissolve or to wind up the operations of a person.

Section 25 sets out a number of different things that are important to deal with in integration, and it's a somewhat complex section. At a high level, it does two things. It first describes the way in which LHINs can integrate within the health care system. It also describes certain requirements for LHIN integration and what has to be included in a LHIN integration decision.

In terms of the description of the ways that LHINs can integrate, section 25, subsection 1, sets out three ways: one is through funding, which is section 19; the second is the facilitation and negotiation of integration with health service providers, and that's section 25. Then, LHINs can also order integration under section 26, or they can stop integration under section 27.

As I mentioned, the balance of section 25 goes on to describe what has to be included in a LHIN integration decision in terms of things like effective dates, the requirement to give notice to the parties and the requirement to make integration decisions public.

Slide 15 deals with section 26 of LHSIA, and this is a LHIN-ordered integration, an integration which occurs without the consent of the provider. A LHIN is permitted to require a health service provider to do certain kinds of integrations. This would include providing a service, to cease providing a service, to provide a service to a certain level, to transfer a service from one location to another, to transfer all or part of a service from one person to another person, and then, generally, to make orders to give effect to any of the above.

Section 26, however, sets out a number of restrictions on the ability of a LHIN to order integration under this section. First, only health service providers that receive funding from the LHIN can be required to integrate services under section 26, and only then in relation to those services that are funded by a LHIN.

The LHIN cannot require health service providers to make corporate or governance changes under this section, and they cannot require a health service provider to completely stop all of its operations. A LHIN cannot unjustifiably require a health service provider that is a religious organization to provide a service that is contrary to that religion. Also, LHINs cannot require the transfer of charitable property to a provider that is not a charity under this section.

On slide 16, the first bullet deals with section 27. Health service providers can initiate their own types of integration activities without permission—or I should say without being required to do so by a LHIN. If they do so, however, they have to first provide notice to the LHIN that they receive funding from. The LHIN can propose to stop the integration. The LHIN has to make that decision public and the LHIN has to invite submissions about why the integration should proceed or why it should not proceed.

Section 28 goes on to provide certain powers to the minister. On the advice of a LHIN, the minister can require a health service provider to cease operating, to amalgamate with another health service provider or to transfer its operations to another entity. There are certain restrictions on the authority of the minister under section 28 related to municipal governments and long-term-care homes, and the minister cannot order a not-for-profit health service provider to amalgamate or transfer assets to a for-profit health service provider. I should also point out that section 25, related to the content of what has to be in a minister's order, also applies to section 28.

On slide 17 there is a description of the process by which the LHIN or the minister can issue an order under section 26 or section 28, and these are the provisions where one would assume that the decisions are being made without the consent of the health service provider. In those circumstances, there's a 30-day prior notice process. There's a process for submissions to be made on a proposed decision or order and a requirement for the LHIN or the minister to consider those decisions before a final decision or order is made.

If we move to slide 18, the first four bullets deal with the implementation of LHIN integration decisions and ministerial orders on integration. The first bullet is about section 29, which is a requirement that health service providers comply with LHIN and minister integration decisions.

Section 30 deals with charitable property. If a property held for a charitable purpose has to be transferred, then the charitable purpose of the property is deemed to transfer to the entity receiving the property.

Section 31 deals with compensation. The person from whom property is transferred is not entitled to compensation except in accordance with regulations and then only for the value of the property that was not acquired from government funding.

The next bullet deals with labour relations consequences of an integration where there is an integration about the transfer of a service, or all or substantially all of the operations of a health service provider, or the amalgamation of employers—that the Public Sector Labour Relations Transition Act of 1997 applies to that integration.

Section 33 deals with the regulation-making power. Cabinet may order one or more persons who operate a public hospital and the University of Ottawa Heart Institute to cease providing a non-clinical service and to integrate the service by transferring it to a person named in a regulation.

On slide 19 we deal with the issue of devolution. This provision allows cabinet, by regulation, to devolve any power, duty or function of the minister or a person appointed by the minister or cabinet to a LHIN. This power does not apply with respect to funding related to physicians and other certain health providers. For example, it would not allow the transfer of functions under the Ontario Health Insurance Plan away from the Ministry of Health to a LHIN.

Slide 20 deals with part VI of the act, which is the general provision.

1430

Section 35 provides immunity from civil proceedings, except for judicial review, against a LHIN, the minister,

and their staff for decisions that were taken under the statute in good faith.

Section 36 goes on to provide a number of documents that are referred to in the act that must be posted on the websites of the minister or each LHIN.

Section 37 sets out regulation-making authority for cabinet.

Section 38 provides that before a regulation is made, public consultation must occur.

Then section 39, as you know, provides for the review of this legislation.

Mr. Chair, I'm conscious that I have already used up my 20 minutes, I think, and I haven't touched on the regulations, so—

The Chair (Mr. Ernie Hardeman): I was just going to say that we thank you very much for the thorough report, and I thought rather than cut it off at the 20 minutes, the committee would be very appreciative of hearing the whole report.

We will now start with the discussion, and I'm sure the rest of the information that we would like will come out in the discussion. We will still have the 40 minutes that we will divide equally among the three parties, so the whole process will last just a little bit longer. I think we'll start with the official opposition in questioning, and it will be approximately 13 minutes for each caucus. The Clerk will keep track of the time exactly.

With that, Mrs. McKenna?

Mrs. Jane McKenna: Thank you so much, Mr. Maisey, for your presentation. I have a few questions for you.

Right in the start-off, on page 5, you have in there "to provide for an integrated health system to improve the health of Ontarians through better access to high-quality health services." My first question is, what are you measuring that against? Where are the evidence-based outcomes that you're actually doing that?

Mr. Robert Maisey: I think the answer to that is that this is supposed to be set out in the accountability agreement between the minister and the LHIN, which would be section 18. Then the LHIN, when it enters into service accountability agreements with health service providers, would have those kinds of indicators. Those would be set out in the funding agreement between the LHIN and the health service provider.

Mrs. Jane McKenna: I guess, if you have this act in 2006 stating that you're going to offer a high-quality service, you must be measuring it against something else. I hear what you're saying, that it's in section 18, but is that not an easy question to answer, what they're measuring themselves against?

Ms. Kathryn McCulloch: To Robert's comment, we do have performance agreements that list a number of indicators. There are 15 indicators in the current ministry-LHIN performance agreement.

We established baselines for those at the time that the LHINs came into power or took their authority, and we have been tracking against those baselines to determine the improvement or performance towards achieving improvement on those indicators.

Mrs. Jane McKenna: So can we see those?

Ms. Kathryn McCulloch: Certainly.

Mrs. Jane McKenna: Okay, and how are they doing? As far as performance measures, which LHINs would be doing better than others, and where is the improvement on the performance of one to the next?

Ms. Kathryn McCulloch: Provincially, we have improved performance, and these are posted. These are one of the documents that are required to be posted publicly on the LHIN's website. You can look at each individual LHIN's accountability agreement to see where they're at. We do have the wait time indicators that are publicly posted as well. We have been tracking those since the initial, first agreement for the LHINs. Those are wait times for hip, knee, cataract surgeries etc.

From a provincial perspective, we have improved. There is varying performance and varying improvement, but we have improved on all of those.

LHIN by LHIN, that does vary. One of the things you have to realize is that when the LHINs took their authority, they were at different places at that point in time. Some of them would have been fairly close to meeting the provincial targets that we had established, and others were considerably farther away, depending on a lot of historic factors: capacity in their system etc. So you're right: There is variation or variability across LHINs as to the performance on the various indicators.

Mrs. Jane McKenna: So what happens? Let's say one LHIN—

Interruption.

Mrs. Jane McKenna: Why are we echoing like crazy?

Interjection.

Mrs. Jane McKenna: Let's say that one LHIN wasn't performing as well as the next LHIN. Clearly, you must have something for them to follow so they know what their job description is and what your expectations of them are, or how would they measure that? But let's say one isn't performing to the standards, because you just mentioned that each one was at a different level. What happens in the case that their performance level isn't matched? What do you do there?

Ms. Kathryn McCulloch: As I said, when they first took authority and we established the targets, the targets were very individual for each LHIN. We have a provincial target on many of the indicators, but each LHIN would have been, in varying degrees, closer or further away from that provincial target. We would have established individual LHIN targets for them. If a LHIN was considerably higher on one, we may not have set the provincial target for that LHIN to hit initially. We have continued to set targets, every agreement, year over year, to try to achieve better performance.

We meet quarterly with all of the LHINs around their performance, and we have discussions with each LHIN around their individual performance: what they're doing; the challenges that they're having; and where we, the ministry, can support them, if there is something that the ministry can do. It's just to understand what their particu-

lar issues are. There are obviously, as I say, varying issues across the different LHINs, so we have those quarterly discussions and try to move performance with the LHINs. We do monitor quarterly; they do submit their quarterly reports to us. Then the following year, when we come to their performance agreement, again we would look at where they've come and have that discussion once again around performance, where we want them to go and how to move that target.

It's a very evolutionary, iterative kind of conversation and process.

Mrs. Jane McKenna: Let's say they don't meet the targets that you have. Where I find it confusing is, if they're all supposed to be at one level, first of all, how do you know, then, to micromanage and to know what targets each one is doing? That's confusing to me. If everybody's supposed to be at this level, and you've gone in and micromanaged because this one wasn't doing as well as this one, and now you're setting the targets for this one because it's not doing as well—my point is that they should all be at the same level. We shouldn't be giving compensation because one is different than the other.

I guess my question is, if their targets are not met, and you've gone and talked to them again, what happens then?

Ms. Kathryn McCulloch: As I said, it's an iterative process. The targets are—not aspirational. The targets are to be worked upon, to achieve those targets. If a provincial target is 182 days in 2006, when the LHINs assumed their authority—in 2007, they assumed their funding authority—some LHINs would have been considerably further away from that target. They may have been at 250 days—

Mrs. Jane McKenna: Why?

Ms. Kathryn McCulloch: Because that is where the performance was provincially at that time, for a number of factors: availability of surgeons, demand—I mean, there's a whole variety of factors that may come into play in terms of why a LHIN's performance would have been higher at the time. That was the purpose of setting targets.

I think we have moved from 2006, when those provincial targets were first established, and continue to work with the LHINs. It's not a matter of hit-or-miss; it's how do we continue to allow them and support them in moving towards achieving the target that we want provincially across all LHINs.

Mrs. Jane McKenna: Okay, so correct me if I'm wrong: We're seven years into this now. We're still having the same issues of still massaging people in a position where they've been for seven years? I would love to have this with me, if seven years later, as the MPP for Burlington, I'm still having targets that I should have been meeting back on day one.

How long are you going to—I guess where I'm confused is, it's seven years. When is the cap of when enough is enough? When are they all going to be at the same peak? That's a heck of a long time to give somebody to get up to snuff.

Ms. Kathryn McCulloch: I really don't know if that's a long time or not. I think it really depends on the issues and the factors that they are dealing with. If it's an issue of finding appropriate surgeons to perform—so wait-time surgery. There are lots of issues that the LHINs per se do not have complete control over in terms of those targets, and that's where the ministry also plays a role in supporting them: What kinds of policies and what kinds of actions do we have to take provincially to be able to also help move that marker as well?

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Mrs. Jane McKenna: So after all this time, seven years of doing that, you haven't been able to solidify that?

Ms. Kathryn McCulloch: I think we've made progress. If you look at the provincial picture, we have made progress on all of the indicators.

Mrs. Jane McKenna: So we're able to see all of this information, right?

Ms. Kathryn McCulloch: Yes.

Mrs. Jane McKenna: From each LHIN to the next, what their targets are, what the expectations are and where they've gone in seven years? From year to year, we're able to see that?

Ms. Kathryn McCulloch: Yes.

Mrs. Jane McKenna: Okay. And, for example, if you come back after a year and you say, "Okay, here we are with this LHIN. This is where we're at. We're basically at the same place we were," who actually rewrites the targets for them and gives them a goal to get to the next level? I guess that's my question.

Ms. Kathryn McCulloch: It's a process whereby a group of individuals across the ministry would meet with the LHINs—CEOs and chairs. There's a joint committee that meets to talk about the indicators generally, and then we have individual discussions with each LHIN's CEO and their senior staff, as well as ministry senior staff, around the targets.

Mrs. Jane McKenna: So is it the same people always setting the targets?

Ms. Kathryn McCulloch: It's the same positions—CEOs and senior directors from the LHINs—and generally within the ministry it's the same groups. From my branch, which is the LHIN liaison branch—we have the direct relationship—it's my ADM, as well as people from branches that have worked on wait times, which is a provincial strategy. There are a number of individuals across the ministry who would meet and discuss the targets with the LHINs.

Mrs. Jane McKenna: So I guess that if you're having the same people do the same targets and the same questioning for each LHIN and which ones are more micromanaged than the others, wouldn't somebody say at some point that the definition of insanity is doing the same thing over and over again? At what point do we bring someone else in here, to shake this up and get this to where we need to go?

Ms. Kathryn McCulloch: I don't know if the conversation around target-setting is where you can actually get

the improvement. You can set a more difficult target; that doesn't get you to the improvement. We meet with them to try and identify where the challenges are and where the opportunities are.

Mrs. Jane McKenna: So how do you get to that improvement, then? If after seven years you've been looking at what specifically can get them to the next place, what are the improvements that they need? It just seems so complex. We're making this more difficult than it actually is.

Ms. Kathryn McCulloch: I think it is complex. Each individual indicator may have a series of reasons or factors behind that particular performance. Provincially, we've done well. Each LHIN will have areas where they have done well and their performance has improved, and they may have areas where they continue to be challenged. It varies across LHINs. You're right; it is complex, and I don't think it is just setting a target. There is more behind it: to understand the reasons why the targets may or may not be achieved in a particular area in a particular period and what other factors are contributing.

Mrs. Jane McKenna: Okay. So, for me, I'd really like to see exactly what those challenges are for myself, so I'm going to look at that.

My next question is: How many LHINs have had to revise targets, and how many times have they had to be revised?

Ms. Kathryn McCulloch: We visit the targets on a yearly basis. Each year we are looking at trying to move the performance marker. We have provincial targets, and once we hit the provincial targets—I think that's agreed—the provincial targets have been set—

Mrs. Jane McKenna: But how many?

Ms. Kathryn McCulloch: How many?

Mrs. Jane McKenna: How many have actually had to have been revised? How many LHINs have had to have their targets revised?

Ms. Kathryn McCulloch: We revise the individual LHIN targets on a yearly basis. The provincial targets have not been revised.

Mrs. Jane McKenna: So how many have actually met the targets?

Ms. Kathryn McCulloch: It really is individual. I'll go through some of them. Central LHIN was at or below or within 10% of the LHIN target on all 15 of their indicators—there are 15 current indicators. Central East was at or below their LHIN performance targets for 10 of their 14 indicators. For 12 of 15 indicators, the majority of LHINS were at or below or within 10% of LHIN targets. So it varies, and it varies by target. For the 12 of 15 indicators that they were at or below, the ones that have particular issues are around knee replacements, and that's often an issue around surgeon availability, and repeat unscheduled emergency visits. However, we have continued to see the LHINs perform year over year or improve year over year.

The Chair (Mr. Ernie Hardeman): Okay. Thank you very much. That concludes the time.

Ms. Gélinas.

M^me^ France Gélinas: Just a few questions on the presentation that you did. The first one is on the slide on page 6.

Good afternoon, Deputy.

Mr. Saäd Rafi: Good afternoon.

M^me^ France Gélinas: It has to do with the last bullet, that physicians, podiatrists, dentists and optometrists are not considered service providers. Was this a policy decision or is there a reason within the laws that exist that those were excluded?

Mrs. Jane McKenna: Point of order, Chair.

Interjection.

M^me^ France Gélinas: He will turn it on for you eventually.

The Chair (Mr. Ernie Hardeman): It's getting rather confusing. If someone was just watching it on camera and not hearing what was happening here, all of a sudden we have four people presenting instead of two.

Mr. Saäd Rafi: My apologies, Chair.

The Chair (Mr. Ernie Hardeman): If we could clarify—

Mr. Saäd Rafi: Saäd Rafi, Deputy Minister of Health and Long-Term Care. I noted that we were into a set of questions, so I was hoping that the committee wouldn't mind us coming to the table.

The Chair (Mr. Ernie Hardeman): I would just point out that our program this afternoon was set up that for the first hour we would hear from the legal branch. We had the presentation, and we're now having the questions. We then will be hearing from the ministry.

Mr. Saäd Rafi: Sure. We'll take our leave.

The Chair (Mr. Ernie Hardeman): Thank you. It was getting a little confusing—

M^me^ France Gélinas: We'll see you soon.

The Chair (Mr. Ernie Hardeman): —as we were shuffling around our presenters.

With that, we'll go back to your questions, Ms. Gélinas.

M^me^ France Gélinas: Did you hear my question?

Mr. Robert Maisey: I did hear the question. Just for the transcript, I guess, I'll repeat it. It was around subsection 2(3) and the list including podiatrists and physicians, and whether it was a policy choice or whether there was a legal reason. The answer is that it was a policy choice.

M^me^ France Gélinas: So there are no legal reasons that would prevent family health teams or individual fee-for-service physicians to be governed under the LHINs if the ministry so chose?

Mr. Robert Maisey: That's right, except this provision would have to be changed, and I'm sure there would be other provisions in the Health Insurance Act that would also have to be changed. But by statute, the Legislative Assembly could change this provision so that physicians were funded and held accountable through LHINs, yes.

M^me^ France Gélinas: Okay. My next question is on your slide deck page 9. In there, the last bullet point, you say that the minister shall "Seek advice from mandated

province-wide planning organizations"—you give the example of Cancer Care Ontario—"in developing the provincial plan" that they have to put out. Is the balance of how much comes from the ministry and how much comes from the planning organizations defined or is it really depending on how things go?

Mr. Robert Maisey: It's not defined. That provision simply requires the minister to seek advice from those organizations.

M^me^ France Gélinas: Okay. I'm on page 13. My first series of questions will just be cleanup little questions.

Part IV, funding and accountability, the last bullet point again: "LHINs can share information they receive from health service providers with each other, the minister and the Ontario Health Quality Council."

"Can share" is different from "must share." Is there any place in regulations or otherwise where it's stated what must be shared with them and what information the LHINs could choose to not share, if they see fit?

Mr. Robert Maisey: There isn't. The purpose of this section is to facilitate the sharing of information as needed; for example, where a health service provider, such as a significant hospital, provides services to residents in one or more LHINs, to allow those LHINs to share information back and forth between one another. So it's permissive rather than mandatory.

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M^me^ France Gélinas: So if the LHINs get patient-specific information, with this part of the bill, are they allowed to share patient-specific information with each other, with the minister and the Ontario Health Quality Council?

Mr. Robert Maisey: The LHINs should not be receiving patient-specific information unless the patient has consented to it. Section 22—

M^me^ France Gélinas: But it is for a patient who has consented to share; usually it has to do with complaints that they share that information with the LHIN. Then does that automatically mean that that personal information that the patient has willingly shared the LHIN becomes available to other LHINs, the minister and the Ontario Health Quality Council if that LHIN decides to share?

Mr. Robert Maisey: I don't think it would be under this section, because this section deals with information that's not personal health information. I think the way that that would be shared is either under the Freedom of Information and Protection of Privacy Act or under the Personal Health Information Protection Act. It wouldn't be this section, because this section doesn't authorize the LHIN to collect the personal health information.

M^me^ France Gélinas: All right. So, in my little brain, what you just said, does that mean that the personal health information supersedes the fact that the LHINs can share information, that if it is personal information that they have, they would not be allowed to share it, although we have written in section 22 of the bill the exact opposite?

Mr. Robert Maisey: This section deals with non-personal health information.

M^me^ France Gélinas: How do I know that?

Mr. Robert Maisey: Because section 22 speaks about, "A local health integration network may require ... any health service provider to which the network provides funding" to provide information to the network "other than personal health information."

M^me^ France Gélinas: And you're reading from?

Mr. Robert Maisey: Subsection 22(1).

M^me^ France Gélinas: You're reading from the bill, from the act?

Mr. Robert Maisey: From the act, yes. That's subsection 22(1). Your question is about subsection 22(4), and that section talks about, "A local health integration network may disclose information that it collects under this section." So "under this section" means section 22, and section 22 provides that a LHIN can collect information "other than personal health information."

M^me^ France Gélinas: Okay. That makes sense.

My question then has to do with, and I lost the page that this was on, where you talk about how the ministry—let me find it again. The ministry can issue orders. They can—

Mr. Robert Maisey: That would be section 28, is it, on page 16?

M^me^ France Gélinas: Yes, exactly. Thank you. The second bullet point: "The minister, on the advice of a LHIN, can require a health service provider to cease operating, amalgamate with another health service provider, or transfer its operations to another entity." Why couldn't the LHIN do that on its own? Why the minister?

Mr. Robert Maisey: That goes to one of the significant policy decisions that was made when this LHIN legislation was introduced, which was to separate integration of services from the integration of corporations or the integration of health service providers.

Section—no, let me speak to the policy intent without referencing the sections for a second. The policy intent was that LHINs would be able to integrate services; the minister would be able to cause amalgamations of corporations, of health service providers. So there were restrictions placed on LHIN integration, that they could only move services around without the consent of a health service provider; they were not able to, for example, require hospital corporations to amalgamate. That provision for hospital amalgamations, for example—I pick them only because that has happened—was left to the minister under section 28 in circumstances where the hospitals were not willing or were not consenting to that amalgamation.

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

Ms. Cindy Forster: Do we have some time left?

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

Ms. Cindy Forster: I have a couple of questions. At the very beginning of the document today, it talks about the principles of the health care system, including references from the Canada Health Act—promoting the

delivery of health services by non-profit organizations and achieving an integrated health system.

How are we doing with continuing to deliver services in a non-profit as opposed to for-profit way? Because it seems to me that many of the agencies that open in the province are non-profit. For example, new long-term-care beds are still being awarded to for-profit agencies over non-profit agencies. So we have this kind of guiding principle, but it seems not to be in keeping with what we're actually doing.

Mr. Robert Maisey: Well, I can speak to the technical aspects—the principle stated, as you said, in the preamble—I can't really comment, as legal counsel, on the policy choices that have been made. There are a number of other provisions in the statute that place restrictions on the ability of integration to occur when there's a transfer of service, for example, from the not-for-profit sector to the for-profit sector. That's generally not permitted without the consent of the organizations involved.

Ms. Cindy Forster: With respect to pages 15 and 16 of the document, around the integration and devolution piece, it says the LHINs "cannot require the transfer of charitable property to a provider that is not a charity." Can that voluntarily happen?

Mr. Robert Maisey: Technically, yes it could happen voluntarily. However, there would be consequences for both organizations, not under this statute but under other statutes. When you transfer charitable property from a charity to a non-charity, there are significant tax consequences for that, and there are also consequences under the Charities Accounting Act that would come into play. So, technically it would be possible, but there would be significant consequences for that.

Ms. Cindy Forster: There was some reference, as well, to municipal restrictions under section 28. Can you explain that a little more—municipal governments and long-term-care homes?

Mr. Robert Maisey: Right. I'll give you the specific section. It's subsection (3) of section 28, so 28(3).

As I was mentioning in response to a previous question, the minister is allowed to issue orders around corporate governance to amalgamate health service providers. Some health service providers, as you know, are municipal governments that operate long-term-care homes. These restrictions prevent the Minister of Health from causing the amalgamation of municipal governments, because clearly that's something that should occur under the Municipal Act. So that provision speaks here to the fact that the Minister of Health is not permitted to require municipalities to merge just because they provide a health service. Also, the minister is not permitted to close down a municipal home. That's the purpose of those provisions.

The Chair (Mr. Ernie Hardeman): One more question.

Ms. Cindy Forster: Okay. Just further to that, the minister cannot order a not-for-profit health service provider—for example, a hospital that has long-term-care beds—to transfer assets to a for-profit health service provider. However, can the non-profit voluntarily do that, and what are the implications?

Mr. Robert Maisey: That goes to the question you asked previously, which is that a not-for-profit doing that would be hit with tax consequences for that. If that's a transfer of service, then the LHIN would have to be given notice of that under section 27. So the LHIN would also be able to say yes or no to such a transfer.

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The Chair (Mr. Ernie Hardeman): Thank you. That concludes your time. The government: Ms. Jaczek.

Ms. Helena Jaczek: Thank you, Chair. I will start with slide 6, and most of my questions will be fairly technical.

You talk about health service providers and you also, of course, mention public and private hospitals. That would include the federally incorporated hospitals as well, would it? There are a few in Ontario.

Mr. Robert Maisey: Yes. Hospitals that are incorporated under the federal corporations act—

Ms. Helena Jaczek: Would also be included.

Mr. Robert Maisey: Right.

Ms. Helena Jaczek: Thank you. "Community service providers," on the same page: That strikes me as a rather broad term. How do you define community service providers? Are these services where the Ministry of Health and Long-Term Care provides funds to these agencies?

Mr. Robert Maisey: Yes, that's right, and it's defined in the definition as "a person or entity approved under the Home Care and Community Services Act." I'm afraid that in this slide deck I was trying to use fewer words than more. It would be an organization that is a community service provider or a community agency under the home care legislation.

Ms. Helena Jaczek: Okay. Thank you.

Mr. Robert Maisey: If I can just add to the previous question: You were asking about federally incorporated hospitals. Those would be federally incorporated hospitals that are public hospitals under the provincial Public Hospitals Act. I'm not sure if there are any other types of hospitals around, but there used to be hospitals that were federally incorporated and only funded by the federal government. Those would not be included under this legislation.

Ms. Helena Jaczek: I'm thinking of Collingwood. In a previous committee, we heard about that.

Mr. Robert Maisey: Right, and I was thinking of some of the hospitals that used to exist—and I know that they've been reorganized—in the Far North.

Ms. Helena Jaczek: Yes, so not those. Thank you.

Moving on to slide 7, the LHINs "are crown agencies": Are the 14 LHINs, with their boundaries, described in the act?

Mr. Robert Maisey: No. The boundaries are described in the definition of "geographic area" in section 2. What happened at the beginning when the LHINs were first created was that the boundaries were described and

set out on the ministry's website, and the statute makes reference to that. The boundaries are on the website.

Ms. Helena Jaczek: So if there was a desire to change boundaries, it would not require an amendment to the act?

Mr. Robert Maisey: That's correct.

Ms. Helena Jaczek: It would be a ministerial order or something of that nature.

Mr. Robert Maisey: It would be a regulation.

Ms. Helena Jaczek: A regulation. Okay, thank you.

On slide 8, LHIN "board meetings are open to the public," obviously with the exceptions of finance and personnel issues, etc: Are they required to advertise their meetings?

Mr. Robert Maisey: Yes. Subsection 9(3): "A LHIN shall give reasonable notice to the public of the meetings of its board of directors and its committees."

Ms. Helena Jaczek: And how are they required to do that? On their website?

Mr. Robert Maisey: That's right. The statute doesn't speak to the operationalization or how that's to be done, but my understanding is that typically, their website does have notice of the meetings.

Ms. Helena Jaczek: That's considered sufficient.

Mr. Robert Maisey: That's right. In fact, I would go further, now that you remind me. There's a provision on information to the public, which is section 36. Where a LHIN is required, under the statute, to make something public, then it's to do so on its website. That's section 36.

Ms. Helena Jaczek: If we could move on to slide 11, you make reference to a Health Professionals Advisory Committee, with members that are prescribed in regulation. Could you tell us who these people are?

Mr. Robert Maisey: Yes. I'm afraid that's a part of the presentation I didn't get to, which is on slide 25—

Ms. Helena Jaczek: Oh, okay.

Mr. Robert Maisey: —but that's fine. If we can take you to slide 25, there's a heading that talks about the Health Professionals Advisory Committee. In the second bullet, "The committee must be comprised of physicians, nurses, a dietitian, a pharmacist, an occupational therapist, a psychologist and three" other people, as decided by the LHIN. Then there are some rules in the regulation about who is not permitted to be on the committee.

Ms. Helena Jaczek: And who is not? This is, I guess, the next bullet.

Mr. Robert Maisey: Right.

Ms. Helena Jaczek: Members of a trade union?

Mr. Robert Maisey: No, it's not members of a trade union; it's board members. That would be the executive members. The intention with the Health Professionals Advisory Committee was for LHINs to receive advice on the local health system, among other things, from front-line health care workers. There is a series of people who are not permitted to be on this committee. That would include members of advocacy organizations and members of the executive of a trade union. However, people who are employed and are members of a trade union are permitted on this committee.

Ms. Helena Jaczek: And the size of this Health Professionals Advisory Committee?

Mr. Robert Maisey: The size is up to 15. That's in subsection 5 of the regulation, section 1.

Ms. Helena Jaczek: Okay. On slide 12, your second bullet: "Permits the minister to adjust a LHIN's funding to take into account a portion of any savings generated through efficiencies of the local health system." Maybe that's for Ms. McCulloch. Does this mean that funding could be removed the following year if an efficiency is found?

Mr. Robert Maisey: Actually, I'll take that one. That is directed at provisions in another statute, which is the Financial Administration Act. The Financial Administration Act largely provides that if there is funding left over by the ministry or other organizations to which that statute applies, that funding has to be returned to the Ministry of Finance. This provision enables the Ministry of Health to not do that for a LHIN, so that a LHIN can keep the benefit of efficiencies that it creates. But it is permissive, not mandatory.

Ms. Helena Jaczek: So, to Ms. McCulloch: How do you deal with those situations, when you do find funding efficiencies?

Ms. Kathryn McCulloch: That particular provision hasn't been implemented in the act to date.

Ms. Helena Jaczek: But you've observed efficiencies. Is it usually that there's another area that the funding gets put toward?

Ms. Kathryn McCulloch: There are efficiencies, but that particular provision has not been implemented, so we've never defined the various terms in that. There was some further work that needed to be done in order to actually operationalize that particular provision. Currently, we just deal with it—

Ms. Helena Jaczek: So it's sort of permissive, and it's there.

Ms. Kathryn McCulloch: Yes.

Ms. Helena Jaczek: Okay. You've talked quite a bit about the LHINs' powers and the minister's powers related to integration and devolution, but what are the requirements of the health service providers? As an example, if a health service provider decides to cease a particular service, are they required to inform the LHIN before they cease a service?

Mr. Robert Maisey: If the service is funded by a LHIN, then the service should be addressed in the accountability agreement between the LHIN and the service provider. That would, I would expect, require some kind of a discussion between the LHIN and the service provider as to an amendment to their service agreement.

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Section 24 does require each service provider, separately and in conjunction with one another, to identify opportunities for the integration of services.

To your specific example, if the ceasing of a service by one service provider is really in order to integrate it with another provider, then that would trigger section 27, which requires the health service provider to give formal

notice to the LHIN, and the LHIN has 60 days to object to that.

With your question, there are a couple of ways in which the scenario can unfold. The two ways that I'm aware of, that I've described, would require some kind of discussion with the LHIN, either towards an amendment of the service agreement that the provider has with the LHIN, or a formal notice under section 27.

Ms. Helena Jaczek: To what extent does the ministry look at the service accountability agreements that every LHIN is involved with? We know you have an agreement with the LHIN, and the LHIN has the service accountability agreement with the provider. Following up on my previous question, it sort of depends on the degree of detail that that service accountability agreement has within it. Who monitors the service accountability agreements?

Ms. Kathryn McCulloch: The LHINs monitor their own agreements with their providers. However, the ministry has been involved in the actual development of the standard accountability agreements that the LHINs enter into with their providers, so the various hospital—

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time for this delegation.

This also provides me with the opportunity to say thank you and to apologize for my previous ruling, on account of I noticed that both of the presenters presently are going to be part of our next panel, too. We were just trying to start the next panel sooner.

With that, we invite the rest of the panel to come up. I would just inform the committee that, obviously, any further questions we have for the first part, which has been the legal part of the actual bill—it would be quite in order to continue asking in that same vein in this one.

We will now hear from the deputy minister and Catherine Brown, the assistant deputy minister, health system accountability and performance division, and of course, the present two who were before us.

With that, we will provide you with an opportunity first to make your presentation and then, when you've made your presentation, Deputy, we'll open it to questions. The questions will be just in 20-minute rotations, because it's not set for a time limit.

Having said that, we do hope that when we get to the end of our time, we will have someone be able to end on a fair basis, so I may have to make the last round a little different than the 20 minutes. But it will be 20-minute rotations, starting with the third party.

With that, Deputy, the floor is yours. Thank you very much for coming here. We will look forward to your presentation.

Mr. Saäd Rafi: Thank you, Chair, and thank you, committee. My apologies for the previous interruption.

Thank you very much for the opportunity to speak with you today about the Local Health System Integration Act, 2006, or LHSIA, which sets out the legal framework for the establishment and functioning of local health integration networks, or LHINs. The ministry welcomes the standing committee's review of LHSIA.

The province implemented this reorganized system only six years ago. The purpose of this review of the legislation is to take a closer look at how the system is working and to identify and consider areas for enhancement or improvement. This is an opportunity to retool in order to make the system more effective.

M^me^ France Gélinas: Sorry, Deputy. I was just wondering if you had copies of your presentation.

Mr. Saäd Rafi: We should.

The Chair (Mr. Ernie Hardeman): I haven't seen them.

Mr. Saäd Rafi: My apologies. We meant to distribute it prior to me speaking.

M^me^ France Gélinas: No problem. I think they're coming.

Mr. Saäd Rafi: Okay. I'll pause.

The Chair (Mr. Ernie Hardeman): Deputy, it's not that they will not be listening to you if they have the presentation, but it's a great opportunity to write down the questions as we're going through.

Mr. Saäd Rafi: Of course.

Interjections.

M^me^ France Gélinas: No, that's the legislation. No biggie. We can take notes.

Mr. Saäd Rafi: My apologies. That seems to be the only thing I'm doing.

The Chair (Mr. Ernie Hardeman): You can carry on, and when they arrive, they'll come up.

Mr. Saäd Rafi: Thank you.

I'll just pick up. The purpose of this review of the legislation is to take a closer look at how the system is working and to identify and consider areas for enhancement or improvement. This is an opportunity to retool in order to make the system more effective.

Let me now provide you with a description of Ontario's health care system that existed before LHSIA came into force on March 28, 2006. In 2004, when the ministry was directed to draft the legislation, the province had 154 hospitals, 581 long-term-care facilities, seven ministry regional offices, 16 district health councils, 42 community care access centres, five health intelligence units, 37 local boards of public health, 55 community health centres, five academic health science centres, and more than 350 mental health programs. All these entities had differing geographic areas, funding flows and overlapping accountabilities. In addition, there was a variety of different not-for-profit community agencies that also planned services on a geographic basis and operated without broader system planning guidance.

District health councils had no funding authority. Their role was to provide advice to the ministry. The ministry planned and administered health care across the province, taking into account the DHCs' advice, along with the information provided by regional offices with respect to local and regional needs.

Looking at the Canadian context, by 2004, nine other provinces had implemented regionalization. Regionalization of health care entailed more than the devolution and decentralization of services from provincial govern-

ments to regional authorities. It included consolidation of authority from local boards and agencies, and some centralization of services. Regionalization was the remedy proposed for the diagnosis of fragmentation and incoherence made by commissions across the country in the late 1980s.

In most provinces, authorities are corporate entities unique from pre-existing provider organizations, some created through enactment of specific legislation. The relationship between government and the governance of authorities varies, but most jurisdictions appoint at least some portion of authority boards. The scope of responsibilities varies but generally includes a resource allocation role. The scope of health sector devolvement varies but mostly includes hospitals linking to community-based and long-term care. Primary care and drugs have not been included.

Let me now turn to a few examples of regionalization in other provinces.

In 2001, British Columbia consolidated 52 regional agencies consisting of 11 regional health boards, 34 community health councils and seven community health service societies into five health authorities and one provincial health services authority that manages provincial programs and eight provincial services. A new First Nations Health Authority was announced in October 2013.

In 2004, Alberta reduced 17 regional health authorities, or RHAs, to nine, with cancer and mental health and addiction boards continuing. In 2008, Alberta dissolved its RHA system, creating in its place a superboard called Alberta Health Services, AHS, incorporating the nine previous RHAs, or regional health authorities. I would note that they are now into another round of potential changes to governance, if not the structure, of the Alberta health system.

In Quebec, 18 regional boards were transformed into 18 health and social service agencies in 2003.

I provide these examples to demonstrate that in Canada, regionalization has taken many different paths in different jurisdictions. There is no common definition of a health region, no uniform understanding of what services should be regionalized and no consensus on the nature of governance.

It should be noted that in an effort at continuous improvement, most provinces have modified their initial reforms, some more than once. It takes time to get it right, and they have been at it longer than we have in Ontario. The development of LHSIA needs to be viewed in that context as well as the context of the province's fiscal situation at the time.

During the previous two decades, health care costs had risen substantially. Between 2001 and 2005, health care spending rose by an average of 8.2% annually. By 2005-06, health care consumed nearly $33 billion, or 46% of total program spending. Predicted costs continued to exceed predicted revenues, and spending was expected to continue to increase, due in part to the cost of new technologies, new pharmaceutical products and an aging population with a higher prevalence of chronic illnesses.

Increased spending on health services had not necessarily resulted in better population health outcomes: Cancer mortality and obesity rates were higher in Canada at that time than in most OECD countries.

The public continued to raise questions about the sustainability of the health care system. Demographic changes, including an older population and an aging health workforce, along with the fiscal challenges, pointed to the need to transform the system.

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The sustainability of the health care system was seen as dependent upon reducing the rate of growth in health care expenditure. At the same time, the government directed that costs be reduced through efficiency and elimination of redundancy rather than through reductions in service. A new model of system management was called for.

The model under which we now operate is led by local health integration networks, 14 geographically-based organizations that are responsible for planning, funding and integrating services at the local level, as you've heard. LHINs were founded on the principle that community-based care is best planned and coordinated within the local geographic community.

In developing the legislation, the ministry sought input from hundreds of people across the province, including patient advocacy and community groups, labour organizations, health care providers and health-related associations. Since 2006, when LHSIA was proclaimed, LHINs have had the responsibility to plan, fund and integrate local health services, including hospitals; community care access centres, or CCACs; community support services; long-term care, mental health and addictions services; and community health centres. The number of CCACs across the province was reduced from 42 to 14 to align with the new LHIN boundaries.

LHINs are responsible for allocating more than $24 billion in health care funding. The total funding for LHIN operations is approximately $90 million, which represents 0.4% of the total ministry funding they receive. In 2012, the provincial budget reduced the LHINs' administrative budget by 5%.

LHSIA contains the legislative elements of the LHINs' accountability as it relates to governance, including annual and financial reporting requirements; reporting relationships and oversight structures and mechanisms; planning, system integration and performance management frameworks; community engagement; accountability and compliance mechanisms; and approaches to funding and allocation.

Several regulations have also been developed under LHSIA to facilitate the implementation of the legislation. The relationship between the ministry and LHINs, including specific accountability structures, is governed by LHSIA, the ministry-LHIN performance agreement, an MOU, management board directives and other applicable government policies.

As you've heard from my colleagues, each LHIN is required to enter into an accountability agreement with

the ministry—the ministry-LHIN performance agreement, or MLPA, as we call it—which sets out the key funding and operational expectations of the LHINs and the ministry. The MLPA reflects the government's role in setting priorities for the province's health care system while acknowledging the LHINs' role in identifying local priorities, as established in their integrated health services plans. The agreement reflects that Ontario has a single system with 14 networks that facilitate the coordination of care delivery among the regions. The MLPA also articulates the ministry's performance expectations of the LHINs, as you've heard.

Finally, the agreement sets out the ministry's and the LHIN's understanding of their respective performance obligations and identifies the scope of decision-making responsibility of the LHIN and the ministry for specified programs and services.

The current MLPA includes 15 LHIN performance indicators and associated targets, as well as the funding that each LHIN receives. LHINs report quarterly to the ministry on the MLPA performance indicators, such as wait times and ALC rates, as well as the financial health of the sector and of the LHIN itself.

The ministry has an MOU with the LHINs that sets out the relationship between the ministry and the LHINs. LHSIA sets out the roles of a LHIN, which include helping to develop and implement the provincial strategic plan and provincial priorities and services; working with others to improve patient care and access to high-quality health services, as well as continuity of care; disseminating information on best practices; improving the efficiency of health service delivery and the sustainability of the health system; allocating and providing funding; setting performance standards with funded health service providers and ensuring that they are achieved; being accountable for the effective and efficient management of the LHIN's human, material and financial resources; and carrying out any other objects the minister specifies by regulation.

LHINs have an obligation to monitor local health system performance and report on health outcomes by entering into service accountability agreements with health service providers they fund to establish and ensure the achievement of performance standards. They can compel health service providers to provide plans, reports, financial statements and other information that the LHIN needs to carry out its duties.

A key provision of LHSIA is to require LHINs to develop IHSPs, or integrated health services plans, every three years. The current plans run from 2013 to 2016. Essentially, the IHSP is a road map which guides health system improvements over the following three years. It sets the vision and identifies the integration priorities and initiatives to be delivered within available health system resources.

The IHSP demonstrates a devolved and local approach to integrated planning by reflecting ministry priorities. For example, in the current IHSPs, the LHINs have identified activities that they will undertake over the next three years to support better care for seniors, people with chronic conditions and mental health, among some of the priorities.

To better assess their needs, LHINs must engage on an ongoing basis with their community, which includes patients, health service providers and employees who may be impacted by planning decisions. They also consult across their community about the needs and priorities of the local health system to seek the input that reflects the needs of their diverse populations, including the francophone community and aboriginal and First Nations peoples.

Beyond planning, funding and integrating local health care services, LHINs are now playing a role in the province's community health links announced by the minister nearly a year ago. Health links are intended to address the complex health care needs of about 5% of Ontario patients who consume two thirds, or 66%, of the health care budget.

Health links are accountable to the LHINs. Their leadership, governance and degree of integration are flexible and based on local needs, and LHINs are identifying where complex patients are within their region for health links. LHINs are also partnering with the ministry in the implementation of community-based specialty clinics.

As part of its action plan for health care, the government wants to shift procedures that don't require hospital stays into non-profit community clinics because it's a more appropriate and efficient way to ensure that Ontarians get the right care, at the right time, in the right place.

Hospital outpatient clinics and independent health facilities have long been a part of the provincial health care system. The ministry is working with the LHINs to transfer routine cataract procedures from hospitals to non-profit clinics covered by OHIP.

A major element of reforming the way services are delivered is reforming how they are funded. Funding reform started in 2012-13 and will be phased in over four years. We're now in the second year of health system funding reform.

Ontario is shifting the focus of its health care system away from one that has primarily been provider-focused to one that revolves around the person and the patient. The ministry is working hand in hand with health care experts, senior leaders, front-line providers and the LHINs to move from global funding towards a more transparent, evidenced-based model, where funding is tied more directly to the quality of care that is needed and will be provided.

Treating patients with the right care at the right time and in the right place will improve the health of the people of Ontario, which will reduce costs and preserve our health care system for generations to come. Funding reform is a key component to delivering better quality care and maintaining the sustainability of Ontario's universal public health care system.

An evidence-based system organized around the health care needs of a community will result in greater

access to care, better quality and value for their tax dollars by:

—funding hospital, long-term-care and community care providers based on how many patients they look after, the services they deliver and the specific needs of the population they serve;

—using the best available evidence and proven best practices to provide care that works best for the patient and for the system;

—incenting efficient and high-quality service delivery.

In the past, health service providers could choose to implement service changes in order to balance their budget. Now the ministry is moving to a system where funding is tied more directly to the care being provided to ensure that the people of Ontario get the health care that they need. The changes that are taking place have been informed by world-class providers, system leaders and stakeholders who treat the people of Ontario every day. The ministry is working with the health sector as partners to create a health care system that puts people first.

The ministry has many strategies in place to help providers make the transition to the new funding model. These will help to ensure that patient care is the top priority and health care spending is used to improve quality in a cost-effective manner.

Building on the work of our world-class health care providers and researchers, funding reform will give Ontario's leading providers the tools and a forum to establish best practices based on the best available evidence and world-leading innovations.

The people of Ontario will now receive care that is more focused on the entire patient journey. This shift in focus will encourage better value for money in the health system by spreading best practice, improving quality and lowering costs.

The government has made a conscious decision to focus on care in the community so that there are more options available to help older people stay at home longer. Care in the community is more affordable than care in hospitals or long-term-care homes, and home is where people typically want to be for as long as possible.

LHINs are closely involved in funding reform, given that it affects health service providers like hospitals and CCACs that fall under their jurisdiction.

Let me close by saying that now that the province is engaged in health system transformation, this is an opportune time in the evolution of the province's health care system to revisit LHSIA and see where we can strengthen and improve it.

We look forward to the feedback the committee provides us on how to strengthen the role of LHINs so that they can continue to drive transformation across our health care system, thereby ensuring it will remain sustainable for the future.

Thank you, and we'd be now pleased to answer your questions.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It's much appreciated.

We'll start the 20 minutes, but with the indulgence of the committee, I have a question from the Chair. It's a simple one. I was just wondering, from the legal branch, in your presentation, you pointed out that the LHINs must meet in public other than for finance, personnel, legal advice. In the presentation of what the LHINs are supposed to do, I have concern that it would be very difficult to find anything that didn't somehow touch legal, finance and personnel issues because of their responsibility, and when their structure is to pay out money, decide who gets it and how much they get, and personalities and fighting about that. In the end, how is there anything—I wondered if we could get a written response for the committee as to defining what part of their business would be in public and what part wouldn't?

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I know that the committee, in the period that's coming, is going to find a lot of discussion about whether in fact they are as open to the public as necessary. So I wondered if we could get, from the legal branch, a written interpretation of that section of your report.

Mr. Robert Maisey: Certainly, but perhaps I could try to answer the question now. Would that be all right?

The Chair (Mr. Ernie Hardeman): That would be fine with me. I don't have the right to ask questions now—just to ask for reports back.

Mr. Robert Maisey: What would you—

The Chair (Mr. Ernie Hardeman): If you could answer now, that would be super.

Mr. Robert Maisey: Let me give a try. The challenge with writing a PowerPoint presentation is that one crushes together a whole series of words. It may have given the suggestion that the exceptions were broader than they are. In subsection 9(5), for example, "personnel matters"—it's not just any personnel matter; it's a personnel matter that involves an identifiable individual. General, non-identifiable individuals: That wouldn't be in camera; that wouldn't be in private.

The legal matters would be litigation or labour relations negotiations or solicitor-client information. Financial, personnel or other matters: That subsection relates to things that would be disclosed that are of such a nature that the desirability of avoiding public disclosure of them in the interests of the person affected or in the public interest outweighs the desirability of having the meetings held in public. So there's a fairly significant restriction there around the information being in the interests of the person affected.

I don't know if that helps or not, but I do believe that financial information is frequently discussed in public by LHINs.

The Chair (Mr. Ernie Hardeman): Okay. Thank you. Yes, Deputy?

Mr. Saäd Rafi: Just before questions, I was remiss in not introducing my colleague—second from my left—Catherine Brown, who's the assistant deputy minister who has responsibility for the work with the LHINs.

The Chair (Mr. Ernie Hardeman): Okay. Thank you. With that, we will start the rotation with the third party. Ms. Gélinas, we'll start your 20 minutes.

M^me^ France Gélinas: I still have two little loose ends before I get into the questions for the deputy. The first one is that—just refresh my memory. Because they are a crown agency, that means they're under the Ombudsman. Am I right?

Mr. Robert Maisey: That's right.

M^me^ France Gélinas: They are. Okay. And the second is—actually MPP Jaczek asked a question and it became more blurry than clear to me. On page 12, "Funding and Accountability:" Under section 17, "permits the minister to adjust a LHIN's funding to take into account a portion of any savings generated through efficiencies in the local health system." I take it that the regulations for that part of the bill have not been done.

Mr. Robert Maisey: I'm sorry that my answer made it more confusing. There are no regulations for this provision. It's simply a permission for the minister to not take back money when efficiencies are created. Instead of having a requirement at the end of the year that unspent monies come back to the Consolidated Revenue Fund, it's a permission for the minister to leave some of the funding with the LHIN where the LHIN has unspent funding because of efficiencies.

M^me^ France Gélinas: All right. At the end of the fiscal year, if the LHIN's budget is not fully spent, they write a cheque to treasury just like everybody else?

Mr. Robert Maisey: That's right; it comes back. They don't even write a cheque.

M^me^ France Gélinas: They just—

Mr. Robert Maisey: It comes back. That's right.

M^me^ France Gélinas: Okay. It comes back. But if this clause was ever acted upon—and I think, Kathryn, you told us—sorry; I should call you Ms. McCulloch. You told us that it was never enacted, as in, they were never allowed to keep any?

Ms. Kathryn McCulloch: We don't allow them to keep it, but the particular provision was never operationalized, so what percentage was never determined. We just haven't operationalized that particular provision.

M^me^ France Gélinas: I don't know what "operationalizing" means.

Ms. Kathryn McCulloch: If you look at the words, it's a per cent of that. Well, we've never determined what percentage we would allow and—

Interjection: The criteria.

Ms. Kathryn McCulloch: Exactly—the criteria that we would actually implement that and allow the LHINs to be able to keep that money.

M^me^ France Gélinas: So right now, if there's any money unspent, it gets taken back, just like everybody else. If we were to work on this, then there's a clause that allows for some money to stay year over year or from one fiscal year to the next, but you've never used it.

Ms. Kathryn McCulloch: It's efficiencies too. It's not just underspending. It's not just, "We didn't spend our money," so you get to keep it next year. It's that you found some savings through something that you implemented. So there are a few pieces that criteria would need to be established about what—

M^me^ France Gélinas: Okay. Deputy, you talked about engagement with the First Nations and engagement with francophones through the entity process, and you spent quite a bit of time explaining how the LHINs set their priorities. I wanted to better understand: How does the priority that those entities, whether it would be First Nations, aboriginal or francophone, how do those two—what happens when they don't line up?

Mr. Saäd Rafi: Well, the idea is for them to line up. There is an advisory council, as you know, for those entities. They are really just reaching a midpoint in their mandate, and they would use the same guides that we would talk with the LHIN about, in terms of the forward-looking document—the IHSP—the relationship they have in terms of accountability agreements, as well as their own assessment of the needs within those six entities.

If there is a challenge to that, then there is a dispute resolution process that LHINs have within their accountability agreements, for example, that I believe would also exist, in that there's a process of discussion, of joint resolution and then escalation through there. I would imagine that that could ultimately lead to a removal of funds. We have not seen a circumstance where that has arisen, I do not believe.

M^me^ France Gélinas: All right. I'm not familiar with the resolution process that you're talking about, so I'll give you a real life example. The francophone entity identified the need for a new community health centre in a francophone community. It makes this as a recommendation to their LHIN as the number one priority for the francophone entity for that region—a francophone community health centre. The LHIN's response: "Community health centres are not a priority. Here's our list of priorities. CHCs are not on it. Thanks for your advice, but go away."

So there's a process—explain that to me again. And where do those regulations or whatever—how come I don't know about that?

Mr. Saäd Rafi: One, I would hope they weren't that dismissive, but just suffice to say that was shorthand for the response. I don't believe this is something that's captured in regulation as it is in the, sort of, cut and thrust of how one does planning. That specific example of a community health centre would be more than just operating funding, potentially. It may require capital funds. I would like to have hoped the LHIN didn't simply say, "It's not our priority; go away, we have other priorities," but rather that it may not have been a priority at that time within that catchment area, and/or they would also have to consult with us, because they're not making capital decisions independent of the ministry.

It's hard to image that there is a very short conversation about something that is prepared and produced by community organizations, be they the entities or be they the LHINs, that look at the needs. However, having said that, not all needs can be met and not all priorities always align. I think that's just a fact of practical implementation and financial resource availability etc.

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M^me^ France Gélinas: I'm aware of this. I'm more interested in what is in place to settle those differences. The example is not that far away—sure, it took longer than my 30-second explanation to get to it, but at the end of the day, the LHINs do not see expansion of primary care as one of their priorities, but the francophone entity does. The LHIN says, "You have to make recommendations that fall within our priorities." The francophone entity is saying, "Well, your list of priorities is not what our community is telling us is their list of priorities." So what exists when priorities don't line up? You went through a resolution process that is foreign to me and that I didn't follow.

Mr. Saäd Rafi: Maybe I'll address the last part secondly. The entities are structured to provide advice on the needs of their catchment area and community, and it is just that; it's advice. Advice is not always taken—can't always be afforded. The LHINs actually don't control primary care.

I probably misspoke in terms of—I was identifying their accountability agreements as an example of, in those accountability agreements, mostly with health service providers as distinct from these entities—but with a health service provider, the LHIN would have a dispute resolution process within the accountability—

M^me^ France Gélinas: Yes, but they're not a service provider; they're an entity.

Mr. Saäd Rafi: Right. I said I misspoke on that.

M^me^ France Gélinas: Oh, okay.

Mr. Saäd Rafi: That was probably not the right example to provide.

M^me^ France Gélinas: Okay. So for an entity, whether it be aboriginal First Nations or francophone, there are no dispute resolution mechanisms? The LHINs always win; the entity always loses?

Mr. Saäd Rafi: I guess if you want to characterize it that way; it's not necessarily a won-lost scenario that we would provide. But the entities are there to provide their advice. The LHINs are there to undertake planning and accountability within the means and resources that they have. So, ultimately, the LHINs have to make that decision, yes.

M^me^ France Gélinas: Any other comments as to how it gets settled or anything like this?

Mr. Saäd Rafi: I'm not sure that I would characterize it as something that has a settlement. A settlement implies to me that there's a contractual obligation or a contractual relationship that says, "I tell you to do X spending on Y activity. You will spend it. If you don't agree with me, then we have a process to resolve our dispute." As I said, I muddied the explanation by getting into the accountability agreements, but they are advice-providers. Someone has to decide whether that advice is something that can be afforded or implemented at that time. In this case, it would be the LHINs in concert with the ministry.

M^me^ France Gélinas: At the beginning, it was actually my colleagues from the PCs who talked a lot about accountability and meeting—you talked to us about a set of 15 quality indicators. I don't think you called it "quality indicators," but indicators—

Ms. Lisa M. Thompson: Performance indicators.

M^me^ France Gélinas: Performance indicators—thank you. I know they're available on their website. Not all of them are up to date, and they're not always that easy to follow. Could you provide us with a one-table summary as to what those 15 indicators are—

Mr. Saäd Rafi: Sure.

M^me^ France Gélinas: —how the 14 LHINs are doing, as well as over time, if you have them over time, when were those indicators put into place, and when was the last time they were updated?

Mr. Saäd Rafi: Yes, we can get you that, because I think, as Kathryn McCulloch was saying, some indicators have come on at different times. I didn't catch all of that conversation back and forth, but maybe one point would be to mention that when we say the performance in a LHIN is at or below—and maybe this is obvious—we mean it has met or exceeded. I think that "at or below" terminology may suggest "below" meaning subpar performance. If the objective is X number of days in order to get cataract surgery, and they're at it, then they're right at that number of days. If they're below it, then they're exceeding.

So again, not trying to be trite about it, but the nomenclature may not be the best that we're using. But we'll get you the chart against the 15 indicators and the 14 LHINs.

M^me^ France Gélinas: How long ago were the current 15 put into place? When was the last time you made a change?

Mr. Saäd Rafi: We added, I think, four or five—or maybe "adjusted," perhaps, is a better term to say—in fiscal 2011-12. The most recent data that would be there, since we're annually assessing, would be, I think, 2012-13, because we're in the 2013-14 year.

M^me^ France Gélinas: Do you assess quarterly or yearly?

Ms. Kathryn McCulloch: We revise them yearly, or we talk to the LHINs about the targets against the indicators yearly. They submit their performance reports against that. The indicators, we look at on a yearly basis. We may, to the deputy's comment, change some of those indicators—add some—but the targets are also adjusted on a yearly basis.

M^me^ France Gélinas: Okay. Do you want to—

Ms. Cindy Forster: Sure. Thanks.

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

Ms. Cindy Forster: You talked about the total LHINs' operation having a $90-million budget, representing 0.4% of the total ministry funding that they receive. That 0.4% is their administrative costs. Is that what you're talking about?

Mr. Saäd Rafi: Yes. Sorry, I'm being perhaps a little overly technical about it. That 0.4%, or about $90 million, represents the salary, wages, benefits, overhead

expenses and administrative costs for the employees of the LHINs.

Ms. Cindy Forster: How is the actual funding to the LHINs—what criteria are used to determine how that money is divided up amongst the various regions that the LHINs represent? Certainly, we find, in other ministries—community and social services, education—that some areas are underfunded and other areas are receiving substantially more funding. How does that all play out in the process of deciding who's getting what?

Mr. Saäd Rafi: I think it's a long answer, but one of the things that you would look at would be everything from the catchment area: the density; the referral patterns to a hospital; and the nature of cases dealt with in that geographic entity. In some cases, the LHINs may be helping to administer incentives for services that would be harder to provide in a certain community versus other communities. Yes, that does potentially create inequities—sometimes more money in a particular area than you would ideally have or be able to look at in a very detailed manner.

One of the reasons we started the funding reform: to take a look, starting with hospitals, which represent about $17.3 billion of the over $24 billion that the LHINs administer, and then moving to community care access centres and then long-term care, to be able to pay for patient volume and acuity and put a price on those types of services, and recognize that that can only be done, in our view, up to about—the government decided to only go forward with 70% of that total budget.

Over time—this will take four or five years, perhaps, to do all those three areas—long-term care, CCACs and hospitals—we'll have a better ability to transfer funds where funds are needed, based on patient volume. For example, if there's a particularly heavy draw on funds in a region that is seeing referrals of complex patients, then that facility—be it a CCAC, be it a hospital—should be funded for that, and not have money left in that other area where those funds maybe were assigned in the first place. With the increased acuity and demographics of Ontario's population, I think this is a move that needs to happen and needs to happen on the pace that it is, if not maybe faster, and will allow us to address the types of concerns.

I think everybody would rather have more money in their community than they currently have. I think that's a human-nature response, because we want to be able to provide all the services possible to all the people in a community. That's just exceedingly difficult to do, for all manner of reasons of supply and demand. So it's a work in progress.

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Part of the fundamental role of the LHINs is to do the planning for that. For example, before they create their accountability agreements, they do a bottom-up approach, especially with hospitals, by asking them what their volumes were last year and what their projected volumes are for the next fiscal year, and then they take an assessment of those volumes to determine what will be the funding elements to that hospital, what will be the elements in the accountability agreement. They work with us in that regard on quite a regular basis to then build this budget from the bottom up, because we do zero-based budgeting, as you know.

Ms. Cindy Forster: Do the LHINs work with each other when there are those kinds of disparities?

Mr. Saäd Rafi: They do. Whether it's a new initiative, whether it's an initiative that is evolving or requires some mid-course correction, they would strike their own working group within and among the LHINs. They have a collaborative that looks at some of these issues, which is managed by the Toronto Central LHIN.

I and my management team meet with them every month for a full day, and we go over emerging and existing issues. And they have several working groups and working tables that allow them to not only work this way within their organization and their community, but across all LHINs.

That has taken some time to evolve, because their first priority was to understand their geographic catchment area and serve the planning and accountability needs of that geographic area. Now they're looking up and out as well.

M^me^ France Gélinas: In line with what she was just asking, has the ministry ever done some reallocations between LHINs since they were put in place? Could you give me an example?

Ms. Kathryn McCulloch: The LHINs have actually reached out to us at times. I think in the Waterloo-Wellington area, between the Waterloo-Wellington LHIN and the Mississauga-Halton LHIN, they transferred funding for some community service providers that the LHIN identified they were serving population that was greater in the Waterloo-Wellington LHIN, so they did transfer funds between themselves. There are those kinds of negotiations that go on.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes that time. We'll get back around to you.

Ms. Jaczek.

Ms. Helena Jaczek: Thank you, Deputy, for your overview. I'm very pleased to see on the first page that you recognize that this is an opportunity to re-tool in order to make the system more effective. I think all of us here looked at this, and most of us were talking about regionalization of health care services for the last couple of decades. This was obviously Ontario's first crack at it, and as you've noted, there were a number of changes in other provinces as time went on. I welcome the fact that you're open in that regard.

Just picking up a little bit in terms of the administrative costs that were mentioned, I seem to recall that one of the motivators for creating LHINs was that there might be some administrative savings. As you mentioned, there were seven regional offices, there were district health councils, and so on. Did you at any time compare what has occurred with the creation of LHINs in relation to administrative costs?

Mr. Saäd Rafi: Sorry. Just to clarify: comparative with?

Ms. Helena Jaczek: The previous regime with all the regional offices and the district health councils compared to the current structure.

Mr. Saäd Rafi: Well, I would say that the costs today are probably at par with what they were when the ministry had 42 CCACs, 16 or 18 DHCs and seven regional offices. Given the amount of spending and the increase in complexity, I haven't done a full cost-benefit analysis, but I would say that that's my understanding of it. We have not sat down to do the sort of full economic benefit. I think that's really what's at the root of your question.

Ms. Helena Jaczek: But proportionately, seven years later, you're saying on par in terms of costs?

Mr. Saäd Rafi: Yes.

Ms. Helena Jaczek: So as a percentage of the total budget, it would be less?

Mr. Saäd Rafi: Yes, indeed.

Ms. Helena Jaczek: I think that's important to recognize.

Obviously, we've heard that there are certain health service providers included under the authority of the LHINs. Why were those particular areas considered for inclusion to start off with?

Mr. Saäd Rafi: I wasn't there at the time of drafting, so that's why I'm looking at Robert or Kathryn.

Mr. Robert Maisey: Okay, sure; I'll try to answer that. My microphone's on.

It was a policy choice that was made at the time, and other regional models across the country have typically included hospitals, long-term care and home care services and have excluded drugs and physicians.

Ms. Helena Jaczek: So it was based on other jurisdictions' experience that this was where to start?

Mr. Robert Maisey: I think that's fair, yes.

Ms. Helena Jaczek: Is there any thought in terms of increasing the scope of responsibilities in terms of other inclusions?

Mr. Saäd Rafi: There's no current work under way.

Ms. Helena Jaczek: There's not? So it's a question of trying to maximize the integration between the current service providers?

Mr. Saäd Rafi: Yes. I think that oftentimes, especially these days, one rushes to evaluate and assess. I think they need to continue to deliver on the remit that they have before adding additional elements. Where we have primary care as part of health links, individuals are relating to the LHINs, but we are in the process of examining changes to the legislative authority of the LHINs.

Ms. Helena Jaczek: With my background in public health, I feel sure there must be some opportunities for integration. Are those being explored on an informal basis, where the local committees and so on make suggestions?

Mr. Saäd Rafi: Yes. I would say that collaboration, co-operation and working in partnership to deliver information on vaccines, public health issues and preparedness—Dr. King, the Chief Medical Officer of Health, also participates monthly with the LHIN executives, and beyond that when committee opportunities arise. There is a better connection with public health units than there was at the outset.

Interjection.

Mr. Saäd Rafi: Robert has just corrected me on something that I neglected to mention: The government has proposed, through regulatory amendment, to add independent health facilities, that the LHINs would be able to fund independent health facilities. Those might be diagnostic imaging and the like, so I stand corrected.

Ms. Helena Jaczek: And would Robert be able to hazard a guess as to why that regulatory amendment has been proposed?

Mr. Robert Maisey: Yes. It has been proposed. I don't think it's been filed, and I can't comment on whether it will be filed, but the proposal has been made to add independent health facilities. It's in connection with the community-based specialty clinic initiative of the Ministry of Health to move low-risk hospital services from hospitals to community clinics.

Ms. Helena Jaczek: So, then, as I understand it, you have the current health service providers, you're monitoring through the accountability agreement in terms of these 15 indicators that we'll see, and you want to get everybody as up to speed as possible and then gradually, potentially with new initiatives, look at further integration? I know the ministry is involved in long-range planning and so on, so can you give us any idea about what might come down? Just any ideas that you may have?

Mr. Saäd Rafi: They're undertaking integration activities at various levels within each LHIN, and varying amongst LHINs all the time. It isn't restricted to having to hit a certain milestone. We could talk about some examples that have taken place, but just down the street, we have a couple of examples where there's voluntary merger activity taking place—UHN with the Toronto Rehabilitation Institute. We've had some examples in the Sault Ste. Marie area, where the Sault-area hospital's regional district facility has provided other services. In the mental health field, we've seen integration for the purposes of greater efficiency amongst the myriad of mental health agencies that may exist. Integration activities will continue and have continued. There are some 250 examples across the 14 of them over the last several years.

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Ms. Helena Jaczek: So you would feel that the LHINs are working as they were intended to. Would you say that we're achieving success?

Mr. Saäd Rafi: I think the performance of the LHINs has demonstrated that they're meeting, to a great extent, the requirements of them. The interaction with their health service providers has suggested that they have tried to move the yardstick in certain areas. I think what was discussed earlier in the legal aspect of your discussion was that they're not meeting all of their requirements for a myriad of different reasons. I think that's an aspect of continuous improvement that every system is grappling with across the country.

Ms. Helena Jaczek: How much longer do I have?

The Chair (Mr. Ernie Hardeman): You have 12 more minutes.

Ms. Helena Jaczek: Oh, good. Okay. I want to return to my issue around boundaries. I think most of us in this room know that we get a lot of constituents calling into our offices very often concerned about home care and community care access centre services, especially as they seem to vary—or at least to our constituents, they seem to vary—depending on which LHIN you live in. We've determined that LHIN boundaries were established under regulation, but CCACs have been established on a specific geographic area. Are those geographic boundaries of CCACs also established in the statute or by regulation?

Mr. Robert Maisey: I don't think they are in the statute. The LHIN boundaries, just for clarification, are referred to in the statute, but they're published on the website. They're not set out in a regulation. To change the boundaries, a regulation would need to be made.

My recollection is that CCACs are not set out in statute, but I may need to get back to you on that if I'm wrong.

Ms. Helena Jaczek: I would really like to know that, because certainly many of my constituents who are referred to hospitals in Toronto are having considerable difficulty accessing the CCAC services back in the Central LHIN. So that extra step of communication from a Toronto-based hospital in the Toronto Central LHIN with a patient returning home to Central LHIN has been an ongoing issue for certainly my constituency office. I'd like to have that, Chair—make sure we get the boundaries of CCACs.

Are there any unforeseen consequences from the perspective of the ministry in terms of the creation of LHINs? Is there anything that perhaps was specified in the legislation that has been found to be a barrier to moving forward in terms of transforming health care?

Mr. Saäd Rafi: I'm not offering a personal opinion, but I think it's difficult to enshrine something in legislation and accurately foresee what would be necessary even three or five years out. So if that's true—I'm sure that could be debated, too—then I'm sure there's always going to be areas of improvement to legislation that would allow any entity to do more and do better and provide better value.

I don't know of specific examples that I would point to and say, "Section X could have been written differently." That, to me, is less the point than: Are governments able to create and Legislatures able to pass legislation that will stand the test of time in what is now a rapidly changing environment due to technology and the impact of persistent chronic illness that perhaps we didn't foresee well enough in the time that it took to draft and establish these entities?

Ms. Helena Jaczek: I'm wondering, though—thank you for that—whether, in some of these quarterly meetings—Ms. McCulloch, you were referring to them with the LHINs—do you ever hear of any impediments in terms of the legislation? Fundamentally, we're looking at the legislation here. Is there anything that's holding LHINs back, or do they come up with any suggestions at any times in terms of any additional responsibilities, or is there anything within the legislation that is holding them back from their intended goals?

Ms. Kathryn McCulloch: I don't think the legislation does. Obviously, there's a list of health service providers, which we discussed already. It's currently what it is. But I think the legislation was enabling legislation. It's not really prescriptive, as some pieces of legislation can be. It really is enabling. We've been able to work with the LHINs and work within our system. I'll go back to something that the deputy commented on around the primary care piece. The LHINs don't have authority for primary care, but we have, through health links, strengthened that relationship and strengthened that connection. So I think we've been able to actually—sorry for the use of the word; it's bureaucracy—operationalize the legislation, or, in enacting it, we have been able to work through any challenges that may have been identified. But we don't hear that from the LHINs on a quarterly basis, no.

Ms. Helena Jaczek: When you have a particular LHIN that has had great success in meeting their 15 indicators, how is that information shared about those best practices with the other LHINs?

Ms. Catherine Brown: As the deputy mentioned, we meet with the LHINs on a monthly basis, with the senior management team. They share with each other and with us some of those best practices and learnings. They also meet with each other and work very collaboratively on sharing that information. In the meetings that Kathryn McCulloch spoke of, the quarterly meetings that we have, where one will say, "We've had some success in this area by doing this," we indicate, "Did you know that this one was struggling with that same problem? Have you been in touch?" We put them in touch with each other if they haven't already been. They're very good at sharing their best practices across the 14, particularly where they have similar populations or similar problems.

Ms. Helena Jaczek: You made reference, Mr. Maisey, in terms of the minister's powers on the advice of a LHIN in terms of integration. Has the minister ever invoked that power?

Mr. Robert Maisey: That's a section 28 order. No, that power has not been used since this legislation was enacted. It was modelled on a provision that used to exist under the Public Hospitals Act and previous ministers had used, but not under this legislation.

Ms. Helena Jaczek: So when the deputy is talking about some of these examples, basically it's the parties coming together and voluntarily agreeing in terms of, "This makes sense for our community," and so on.

Mr. Saäd Rafi: They would have facilitated that.

Ms. Helena Jaczek: Yes. Could you maybe give us some more examples of those successes?

Mr. Saäd Rafi: Certainly. Erie-St. Clair: They've had some combination of, for example, integration. The Brain Injury Association of Chatham-Kent has gotten together with the Sarnia-Lambton Stroke Recovery Association

and they've created one corporate entity, which has really helped to provide better coordination for brain injury and stroke services in Sarnia-Lambton overall, plus reduce administrative costs through back office integration.

Huron-Perth in the southwest: Huron Perth Healthcare Alliance and the Alexandra Marine and General Hospital in Goderich are coming together to provide obstetric services in Huron county. For the last 18 months, they have had a site, the Clinton site. The Huron Perth Healthcare Alliance was unable to get enough physician coverage and staffing coverage for obstetrical services, so they've come together and they're sharing resources so that that part of the LHIN can get services that they were having a hard time filling.

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This is a bit of response to the—sometimes you're progressing well on certain performance requirements, and you may lose a key surgeon or you may lose a key leader, and that sets you back a little bit.

Again, South West has had some breast cancer coordination work between St. Joe's and London Health Sciences Centre, in London, whereby they've had a rapid-access breast cancer diagnostic and surgery centre, which was located at St. Joe's. They amalgamated some services there for improved screening for women with potential for or high-risk of breast cancer, and mammography screening services.

I can keep going, if you like.

St. Joe's Healthcare in Hamilton—this would be in the Hamilton Niagara Haldimand Brant LHIN—with Hamilton Health Sciences Corp.: It's a transfer of mental health and addiction services to St. Joe's, and then St. Joe's transferred their pediatric services to Hamilton.

Again, this is a coalescing of services so that greater volumes make for better outcomes, and that has been a theme throughout several of the voluntary or otherwise integrated services.

Again, acute stroke service integration in Hamilton Niagara, from Norfolk General to Brant Community Healthcare: another voluntary approach to acute stroke and patient rehab at Brant. This will help to give more equitable access to the stroke recovery model that has been established as a best practice, to improve patient outcomes.

West Lincoln Memorial and the Hamilton Health Sciences Corp. have just recently announced the intention to amalgamate, whereby the 52-bed community hospital at West Lincoln will come under the aegis of Hamilton Health Sciences centre, allowing it to leverage some of the clinical care aspects of an academic health sciences centre, and perhaps Hamilton Health Sciences to take advantage of the aspects that West Lincoln provides: a high understanding of geriatric services and a high understanding of acute geriatric needs.

Trillium Health and the Mississauga hospital have come together as Trillium Health Partners in the Mississauga Halton LHIN—I think about a year ago now; time has gone by quickly.

Sunnybrook, here in the Toronto Central LHIN—Sunnybrook, up on Bayview—has had a merger with St. John's Rehab Hospital—again, a very natural patient flow for Sunnybrook, given that they have their veterans' centre and a lot of their patients go to—

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time.

If I could just take a moment again, it relates to the questions that Ms. Jaczek asked. This hearing is somewhat different to what normal hearings would be when the ministry comes in to speak to us. I just wanted to read the committee's responsibility:

"Input regarding the extent to which LHINs have fulfilled their obligations under the act, including input from, but not limited to, LHIN board members and employees, board members and employees from other health service organizations and health care policy" professionals in the health care sector.

I just wanted to point out that generally, the ministry reports and supports everything that's in it, making sure and defending that it's being operated properly. I think the committee will be well served, if not today but at some point, if we actually hear from the ministry as to her question: If you were to rewrite the act, what would you put in that would make it work better, as far as the crown corporation delivering the services that they're delivering? I think it would be quite helpful for the committee.

I'm not saying this in any contradiction to what you've done. I just think it would be very helpful, as health professionals, to tell us where some improvements could be made.

I'll just leave that with you, and we'll go to the official opposition. Ms. Thompson.

Ms. Lisa M. Thompson: Thanks very much, Chair. Welcome to the committee. I appreciate your being here.

I want to go back to the IHSP 2013 to 2016, a road map for improvements. But before we do that, I have a question to ask of you, Deputy, and it's kind of picking up from where my colleague left off. You're going to provide in your report the targets that are being met and the 15 elements, and that's going to be very interesting and useful, but today, for the purposes of this committee, if you were to rate overall the LHINs in Ontario, their performance, from one to 10, where would you place them? One being—

Mr. Saäd Rafi: Are you asking my personal opinion? Because I really don't have any.

Ms. Lisa M. Thompson: No, from the ministry.

Mr. Saäd Rafi: I don't know how to answer that. I haven't thought about it.

Ms. Lisa M. Thompson: Okay. I'll go down the line; I'll ask each and every one.

Mr. Saäd Rafi: By all means.

Ms. Catherine Brown: I think, as Kathryn McCulloch described earlier, there are 15 indicators, and every LHIN varies from time to time. Sometimes there's a health service provider shortage; sometimes there's a merger going on; sometimes there's a change. I think overall their performance is in keeping with what we would anticipate in regard to how we've set the indi-

cators. I don't think there's any, on a scale of one to 10—you know, who's at one and who's at 14. They're all performing consistent with how we've set out the expectations for them to be performing. That being said, they're at varying places along the continuum owing to local circumstances.

Ms. Lisa M. Thompson: Okay. What areas do you feel need to be improved upon? What are you hoping to see in the IHSP 2013 to 2016 being submitted from your LHINs? You must have a sense of what areas can be improved upon.

Mr. Saäd Rafi: Since the LHINs are not doing planning and accountability for the entire system, there would be areas—and we are looking at this when we look at our health system funding reform—of appropriateness. Let's say that you establish a target for cataract surgeries. One thing that research is telling us on vision care is that if you're exceeding that target—and it's not a bunch of bureaucrats establishing that target; it's done by clinicians in the community that feel that for that type of surgery the wait times could be at this level. So if you're exceeding that by a great deal, I think the first question one has to think about is, are we doing cataract surgeries too soon, too early, too often, and so appropriateness has to be part of that assessment and that determination.

So when we look at the IHSPs for the next three calendar or fiscal years, we want to make sure, as we move to a system of activity-based funding, this health system funding reform, that we're not only looking at, of course, safety, access, which is about hitting targets, but also appropriate access to targets. I'm not suggesting that means people should wait longer, but certain procedures may not be necessary in every circumstance. The LHINs' contribution to that is not solely their responsibility, because they would have to also work with individual hospitals and those surgeons to determine. In some cases in other jurisdictions, some surgeons are recommending—I'm just going to keep picking cataract—cataract surgery that may not be necessary or as soon as it's being recommended. So we need to work with those clinicians out in the community to provide guidelines and guides for that sort of thing. That's one area.

Ms. Lisa M. Thompson: All right. In terms of road maps for improvements, have you reviewed the PC Party white paper with regards to some of our suggestions for improving the delivery of health care on the front lines?

Mr. Saäd Rafi: Briefly, yes.

Ms. Lisa M. Thompson: And what is your reaction to our concept of health hubs?

Mr. Saäd Rafi: You see, I am continually resisting because you're asking questions that sound more like opinion, and as a public servant, I'm providing advice, not opinion—well, that's my job. And so I would say that there are elements in the white paper that, if you look at the hub notion, I would equate that to health links for many reasons that have to do with where services are being delivered, how they're being delivered, who is managing that care for patients and the cohort of patients. I believe the white paper doesn't get into too much on the cohort, but it suggests that there is a need in what we would call sub-LHIN or sub-region activity.

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What we have not explored is the commissioning model that is also in the paper. That is more akin to the UK commissioning care groups led by primary care physicians. I don't have an opinion, but we just haven't examined that as a model.

But where we have health links, where there's primary care involvement—and by the way, 65% of primary care physicians must be part of a health link—one could suggest that that's getting to the types of notions that are in the white paper. That's how I would address your question.

Ms. Lisa M. Thompson: Okay. We'll leave it at that.

I also want to pick up on the line of questioning Ms. Forster was asking with regard to budgeting. It's interesting. I jotted down a few comments: Budgeting is based on demographics; supply and demand. I was getting a little nervous there because I represent a rural riding. We have hospital organizations that currently are being treated the same as one hospital under one roof. But the reality is, this one organization that has been incorporated technically has four hospitals under four separate roofs. They feel they're at a disadvantage because they're being treated as if their hospital is all aligned under one ceiling. There's just invariably expenses and operating costs that they're taking on the chin as a result. So I'm wondering if, going forward with the road map for improvements, there's going to be some consideration for these unique situations in rural Ontario. For goodness' sake, services should not be based on demographics, from my perspective.

Mr. Saäd Rafi: Yes. A couple things—may I ask, which hospital?

Ms. Lisa M. Thompson: South Bruce Grey—no, Bruce South Grey.

Mr. Saäd Rafi: I cannot remember off the top of my head if—when I said demographics, it was amongst a list of many things. We're not just looking solely at one dimension.

In the funding reform, for example, for hospitals, we have included, I think, 90 of the 154 hospitals, partly because some hospitals don't have the volume, the size, and have such a wide catchment area that it would be unfair to actually include them in a model that's a function of patient flow, price and so on. They do so many things in their community, to your point.

Ms. Lisa M. Thompson: The cookie-cutter approach right now is not working.

Mr. Saäd Rafi: Our funding reform approach—you've characterized it as cookie cutter; I'll leave that. We're trying to be sensitive to northern and rural hospitals. In addition to that, we've provided a 1% increase in a zero-increase environment to northern and rural hospitals this fiscal year.

Ms. Lisa M. Thompson: For one year only, correct?

Mr. Saäd Rafi: Well, we only do annual budgets. We don't give multi-year funding indications.

In addition to that, there's $20 million available that those hospitals, along with their LHINs, have decided how they're going to provide and use. That money has been made on a more permanent basis, not just one-time funds, to your point.

Nothing's perfect, I would grant you, but we're not trying to simply say one size fits all.

Ms. Lisa M. Thompson: Okay. Ms. Jaczek was asking specifically about the provision of dollars to independent health care providers. I heard you share an example of imaging. That might qualify for dollars from LHINs. Would you also extend that same consideration to the likes of laboratories?

Mr. Saäd Rafi: It isn't contemplated under that regulatory change. That regulatory change I believe says "may"—that LHINs may fund independent health facilities, because I believe we're contemplating the community clinics to fall under the Independent Health Facilities Act. It's a regulatory amendment to the Independent Health Facilities Act, I believe. Robert?

Mr. Robert Maisey: That's right.

Mr. Saäd Rafi: Right now, we aren't contemplating community labs in that environment. We have a community lab program, with a model that is funded through the ministry's oversight.

Ms. Lisa M. Thompson: Thank you, Deputy. Jane?

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

Mrs. Jane McKenna: Hi.

Mr. Saäd Rafi: Hello.

Mrs. Jane McKenna: Just a couple of things that I want to go through in my scribble that I have here. You had said that, ultimately, in the end, LHINs would—everyone would—like more money, but more money doesn't necessarily mean better service.

I think the first thing I want to ask you is on page 7. Ms. Forster was talking about your budgets, and you were saying that it takes four to five years for each LHIN to understand their catchment area. Is that from when you started back on—I know you're saying six years; I'm assuming it's seven years, March 28, 2013. I always thought it was seven.

Mr. Saäd Rafi: Yes.

Mrs. Jane McKenna: You said six, but we're pretty darn close to seven. Nevertheless, we won't—

Mr. Saäd Rafi: They started up in April of 2007, actually, in actual operation.

Mrs. Jane McKenna: Okay. So you're saying four to five years for them to understand their catchment area, for them to get all their information together? Is that back when you started, back in April 2007, then?

Mr. Saäd Rafi: Sorry; I'm trying to find the reference to "four to five years."

Mrs. Jane McKenna: You were talking with Ms. Forster about the monies that are allocated, right? The $90 million.

Mr. Saäd Rafi: Yes.

Mrs. Jane McKenna: You were saying that it takes four to five years—

The Chair (Mr. Ernie Hardeman): The deputy is looking for the page that we're on.

Mrs. Jane McKenna: Oh, sorry. Okay—7.

Mr. Saäd Rafi: Of my remarks, I think you mean. Is that what you're referring to?

Mrs. Jane McKenna: Oh, sorry. Yes. It's your remarks.

Mr. Saäd Rafi: Oh, I know what the problem is. Mine are formatted for my eyesight. Anyhow, I'm sorry to interrupt you. Please, continue. I'll find it while you're talking.

Mrs. Jane McKenna: I guess my question is, is that four to five years when you started back in April 2007?

Mr. Saäd Rafi: Well, I think that's a very fine gradation for me to say, "Four years is up now. You should know everything about X." My only point there, I believe, was to suggest that we've seen in other jurisdictions that it takes time to make sure that you have a model that is working in the community. We have very, very vast geographies, as we all know. You all know better than I do, because you come from such varied constituencies. There are needs in constituencies that also change quite quickly, and I think that in health, that is probably as rapid as any sector or industry, and technology is a great example of that.

My reference to that, I believe, was to try to say that we need to ensure that we're not rushing to assess, but still need to make sure that we're keeping a strong pulse and push on delivery, but it does take time. I don't know if it's four to five years; I don't know if it's two years. In some cases, you might have had a community that's very organized. In our northern LHINs, I think they're a little bit more organized. They tend to work more harmoniously together out of some sense of, I dare say, necessity and perhaps not as many players in that marketplace. That would differ dramatically from Toronto Central.

Mrs. Jane McKenna: Yes. I was just picking up with what you said, and the only reason I'm saying that is because there has got to be somewhere where there can be, in stone, some type of answer, so that somebody can actually get to that goal to figure out what that is, right?

I guess, going back to that, how are we ever going to—I respect what the Chair is saying, along with Ms. Jaczek, about legislation, because it's very difficult. Hopefully we'll all have information we can bring forth to that, because if we're not able to get the LHINs to match their targets to get to where they need to go moving forward, how are we supposed to have the proper legislation written for that? I just find all of this very confusing, and I'm hoping that, in legislation, we'll be able to actually write it down moving forward to make it better, because clearly it's not.

My next question: Again, on page 7, you have that the administration budget was cut by 5% in the 2012 budget.

Mr. Saäd Rafi: Yes.

Mrs. Jane McKenna: Why? And how did you come up with 5%?

Mr. Saäd Rafi: That was a budget item for all agencies of government to demonstrate additional savings in the area of administration, set by the Minister of Finance. They, too, were required to deliver on that requirement.

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Mrs. Jane McKenna: You've said 5%; you've come up with that number. So the evidence-based of them being cut back 5%: How are they doing with that cutback of 5%?

Mr. Saäd Rafi: I believe they met their obligation, because we would monitor their funding in that regard.

Mrs. Jane McKenna: So you would have evidence-based outcomes of that, that they're okay, they're doing fine—

Mr. Saäd Rafi: Their administrative costs, yes. And we would see a reduction in that line item in their budget.

Mrs. Jane McKenna: Okay.

Mr. Saäd Rafi: In each one of their budgets.

Mrs. Jane McKenna: So then my next question is, okay, clearly, Mr. Rafi—I'm not going to assume this; I'm going to ask you this. When they are setting the targets and trying to figure out, moving forward, how to make things better, are you part of that process?

Mr. Saäd Rafi: Yes, ultimately we are. The ministry is. I am. The ADM is. The director in the LHIN liaison branch, and the minister's office—the whole process.

Mrs. Jane McKenna: Okay. Because you're there, you're the person who obviously is the hierarchy who's looking at all the aspects of it for the last six and whatever years, what—

Mr. Saäd Rafi: Four for me.

Mrs. Jane McKenna: What improvements do you see that, just off the top—just anything that you could just say to me that's repetitive, that you see over and over again, that you would like to see fixed.

Mr. Saäd Rafi: Well, I think that one can always do more on integrating services. Of course, you can only take that to a certain point, because then you get such an amalgam that it doesn't actually make a lot of sense. You can always integrate services. The committee motion talked about Drummond. He identifies back office as a good example, and the LHINs have examples of integrating back office services. More can be done. That would be the first thing that comes to mind.

Mrs. Jane McKenna: And so when you say more can be done, specifically do you have goals set for what that actually is, the more to be done?

Mr. Saäd Rafi: That's what we examine—

Mrs. Jane McKenna: That's a big generalization.

Interjection.

Mr. Saäd Rafi: Sorry.

Mrs. Jane McKenna: Yeah. I mean, "More to be done"—

Mr. Saäd Rafi: It's all advice, by the way. It's not opinion. You may disagree, that I am offering my opinion. I would say to you quite steadfastly that this is based on what we happen to know in any inter-jurisdictional comparison we might do, and I think the assessments that we would make in working with them and reviewing their integrated health service plans, as an example, would be to determine, first, are you aligned with where government's going in the action plan? Second, if you are aligned with that, what actions and initiatives in that IHSP demonstrate that you're aligned for person-centred care on the dimensions that are in the action plan? Then third is monitoring, again, not just the performance indicators, the 15—and by the way, in the main they're doing quite well against those—but also, what are you doing to then undertake the three components: plan, fund, integrate?

You had asked a question. On that third dimension, I feel that one can always do more and better in that area.

Mrs. Jane McKenna: Okay. So then my next thing is, you brought up about seniors, and I'll just say that for my constituency office we've had nothing but panic, alarm and seniors very upset about the physiotherapy and now with the cataracts. I guess with confusion where services have been cut, many feel they're falling through the cracks. I'm just curious. What was the LHINs' role in dealing with the impact of delisting and communication with patients to help them understand the new landscape of what's going on with the physiotherapy and the cataracts?

Ms. Catherine Brown: If I could comment on that, we worked very closely with the LHINs from the time of the announcement, and prior to that. They were aware that changes were coming. So we worked with the LHINs and with health service providers, both within the LHIN boundaries, some of the private physiotherapy clinics or the—sorry, not the private. The designated physiotherapy clinics are in a different area of the ministry. So we worked across the ministry and across the province with the 14 LHINs on day-to-day implementation.

There were a number of complexities in the middle of the summer right before the implementation date of August 1, where there were some judicial decisions that complicated the August 1 implementation date. We worked with the LHINs and the CCACs each and every day to make sure they were reaching out to patients, making sure every single person who was receiving physiotherapy was contacted, that they had an assessment through the CCAC for home care, regardless of where they lived or how they were receiving services.

We worked collectively with the LHINs to make sure that exercise and falls prevention classes were undertaken and were established across their regions. We worked first to replace existing classes that were under way and that were already existing in some way, shape or form, and then are looking to expand that across the LHINs' regions now.

Last but not least, we worked with the LHINs and each of their long-term-care homes to make sure they all understood what the change was, who their providers would be, how those would be funded and how they would implement that. The goal for the LHINs and the CCACs, as well as for us, was to make sure no one was left without care.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes your time. To the third party: Ms. Gélinas.

M^me^ France Gélinas: Maybe I will continue along the same lines—maybe not.

I'm reading from the first deck that we got, that everybody knows the LHINs are there "to provide for an integrated health system to improve the health of Ontario for better access...." You should all know this by now; this is what the LHINs are there to do.

My first series of questions when I questioned the legal people was about primary care. Primary care is often the gatekeeper to access the rest of the health care system, but they're not funded by the LHINs. What was the rationale for that?

Mr. Robert Maisey: That was a policy choice that was made at the time. I think it's fair to say that no other jurisdiction in Canada has put primary care underneath their regional models.

M^me^ France Gélinas: Any more? As to, we don't do it because nobody has done it?

Ms. Kathryn McCulloch: I think that the other reality at the time—we're talking seven years ago—is that we didn't have as many group models as we have. We've rolled out 200 family health teams since then. There were a lot of individual practitioners, solo practitioners. I think there was concern around interfering with that relationship in that they bill fee-for-service, and LHINs tend to fund organizations or entities, not individuals. So I think we weren't in the same place then as we are even today around the types of group practices that we have in primary care. As the LHIN model evolved, so did our primary care model. We made advancements around some of that.

M^me^ France Gélinas: This exercise—I'm quoting your words—is to "look at how the system is working and to identify and consider areas for enhancement or improvement. This is an opportunity to retool in order to make the system more effective." Would you say that it's time to look at primary care?

Mr. Saäd Rafi: That's up to you. Again, I don't think any jurisdiction in Canada—I cannot speak for Quebec because I'm not as familiar—has decided to include that approach.

Kathryn McCulloch makes a really good point because it's really only Alberta, I believe, that has moved aggressively to group primary care physician models, and they're just now starting to do so. To add individual one-off GP relationships, I think, would be difficult from an oversight management point of view. But better integrating primary care—as you said, as the gatekeeper and sometimes as a referral partner to patients, especially complex—is really what's behind that health link model. We've tried to take a hybrid approach there, given that LHINs don't have legislative authority.

M^me^ France Gélinas: So if LHINs don't do primary care, why are community health centres funded by LHINs?

Ms. Kathryn McCulloch: Those physicians are employees of the health centre, so they're funding the health centre. The physicians are just employees under that model; they're not individual physicians who are billed on a sort of per capita basis.

M^me^ France Gélinas: Okay, then why not aboriginal health access centres or nurse practitioner-led clinics?

Mr. Saäd Rafi: Well, on the former I'm not sure. On the NPLC, the nurse practitioner-led clinic, it is the same: That came to light, after LHINs were established. It appears the decision of the government was to get that up as a group model that can be an augmentation to primary care physicians. Its oversight—it was decided to build it first.

Perhaps at some point, as you're suggesting, and maybe this committee might suggest, based on other people's input as well, who you will hear from, you may choose to bring that forward as a recommendation.

M^me^ France Gélinas: Has the fact that the community health centres have been under the LHINs brought us closer to better access to high-quality services and co-ordinated health care? Have the LHINs been able to carry out their mandate better, or should we take them back and bring them back with the ministry?

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Mr. Saäd Rafi: I don't know that we have that slice of understanding, because we don't know what would have happened had they not been in there. I think one thing for certain is that the cohort that CHCs serve is better off today for the availability of CHCs than they would otherwise be because they're oft times left behind in terms of the groups that may have the most challenging health conditions and health outcomes. I think the patient cohort is better off. Who oversees them, and is that relevant to whether the patient gets better service? I don't know, actually.

M^me^ France Gélinas: Because, Deputy, when you say things like this, it opens it up to all of the other parts of the health care system that are under the LHINs. If we're not able to say if the CHCs serve the goals of the LHINs to provide better access under the LHINs, then do the mental health agencies do better or should we bring them back to—how come we haven't got any way to tell that it was a successful endeavour to put them under the LHINs and that it has served Ontarians well in the role of better access? If we don't know for CHCs, do we know for the 340 mental health agencies that have been funded by the LHINs for the last six or seven years?

Mr. Saäd Rafi: Fair point. Our indicators would tell us that CHCs—and some, where applicable, mental health—are having an impact, because there are indicators on access and wait times etc. For the role that they fulfill, they're clearly having an impact because they're part of that success. In every LHIN it will depend on where they sit against those indicators. So we're not absent data; I'm just saying that when you asked about the dynamic—would they be better if they were outside the LHIN? We don't know that because they're not.

Are they doing a good job within the LHIN? They are. They are significant players in health links because they represent a cohort of the 5% that, in fact, many primary care physicians may not represent. I would say that they have really increased their rosters in terms of roster patients, so that's an indicator that they're doing better than when they started. There is room there. There is room in the family health teams for more roster patients.

So in the search for a definitive yes or no, in or out, to me there's too many moving parts to just say simply, "You're right on this. You caught me. They would be better out." I don't think that's a statement that we can—

M^me^ France Gélinas: I'm not there to catch you, but you also read the papers, just like everybody else. You have seen the people buying the t-shirts who want to get rid of the LHINs. We have a party that ran an election on the fact that they wanted to get rid of the LHINs. And when the deputy is here, here's your opportunity to shine and convince us that the LHINs have brought value. It makes me feel very uncomfortable to hear you say things like "What is the value added?"

Had we kept mental health directly under the ministry, had we kept the CHCs directly under the ministry and put out money for health links, the CHCs would have been partners in the health links, whether they received their funding and their planning from the LHINs or not. So why are they there?

Mr. Saäd Rafi: First off, I thought this was a briefing on matters of technical content with respect to the LHINs, as opposed to me selling you on whether the LHINs are—

M^me^ France Gélinas: No, no. You're right.

Mr. Saäd Rafi: I think that's an important distinction and that's why I have some discomfort with the opinion-based questions, to be perfectly honest. I think I've tried to express that.

The point being that I don't think you can just simply say that had we just put out money, people would have come and congregated around it. I don't think so at all. I think that the LHINs, by the nature of the work that they have done, are organizing entities to help to bring these parties together.

Health links are an excellent example. These have been driven by the LHIN's assessment, in some cases—in South East and in Toronto Central—of their LHIN by sub-LHIN areas. They have worked quite, quite tirelessly and effectively to bring together the providers, both health and social service providers, that make up the core of a health link.

M^me^ France Gélinas: But I don't want to talk about—

Mr. Saäd Rafi: So they have provided value in that regard.

M^me^ France Gélinas: I agree that the health links have value, but I'm interested in, to the LHINs.

Mr. Saäd Rafi: The LHINs have provided value in bringing those together. I don't think, absent the LHINs, we could have—and I'm actually suggesting that keeping the money within the ministry, we haven't done that since the LHINs have been established. We've been slowly increasing the transfer of funds to the LHINs because there is inherent value, and that value is demonstrated by the confidence that government has shown by giving additional funding to the LHINs, from an original, I want to say, $18 billion or $19 billion to, now, just about $25 billion. So that would be a 33% increase in that six years. That too is a demonstration, to me, of value added.

M^me^ France Gélinas: All right. For the people out there who are not happy with the LHINs—I have heard them; you have heard them. They make their voice quite loud and clear in certain parts of this province. Here's an opportunity to retool. Here's an opportunity to make improvements to the LHINs. I'm asking you for your advice. What improvements can we make that would bring those people who are really unhappy to see the value of the LHINs?

Mr. Saäd Rafi: Well, I want to go back to the example of integration, because I think that is something that could be examined by maybe a change to legislation. I'm not even sure if it requires it. I don't know if it's a regulatory fix that can do that. But we could go deeper into integration, and that's partly why I think, working together with the LHINs and ourselves, we came up with the health link notion. So I would leave it at that. I don't know if others have other opinions.

But when you look at Alberta or you look at BC, this is their third model—for Alberta, maybe their third or fourth model. They had 18 or so, or whatever number they had—13. They went to nine; they went to one. Now I imagine they are going to go to something else because they've completely changed the governance of the single model. Quebec: 18; British Columbia: arguably six plus one, seven. So what's the right number? What's the right model?

I think what is clear is that these are authorities and entities that are undertaking the type of activity that (1) is very important to every Ontarian, (2) spends a great deal of funds, and (3) is very difficult to manage on the ground—well, impossible to manage on the ground—from Toronto. I think even our regional office has demonstrated that their catchment areas were so large that it was very difficult to have a line of sight to the degree that we do.

Now, I would imagine that as a committee you are going to hear input from all manner of sources that will have all manner of opinion and suggestions. Forgive me, but I didn't come prepared to provide the committee with recommendations based on inter-jurisdictional comparisons. Perhaps that's something you'll want us to do at a later date.

M^me^ France Gélinas: Okay. Just jumping ideas completely, in the first presentation we got, it made it clear that the MOUs between the LHINs and the ministry are documents that are accessible; same thing with the accountability agreements. They are posted on the website. Are the accountability agreements between the LHINs and the service providers also available?

Ms. Kathryn McCulloch: Every LHIN site should post all of their—the health service provider should also, but every LHIN site lists all of their accountability agreements with all their providers.

M^me^ France Gélinas: Lists them, and anybody could click on them and open them—

Ms. Kathryn McCulloch: I mean, a link that you would click on and it's there.

M^me^ France Gélinas: It's not through freedom of access of information; it's information that is directly available. Okay.

Do you want—

Ms. Cindy Forster: Maybe I'll ask the question that I actually asked of Mr. Maisey that he couldn't answer because it was a policy question. It's with respect to the guiding principles of the LHINs and providing health care in this province in a non-profit way. He couldn't answer that because it's hard to just—but the question is, has the government moved from those guiding principles? Because it seems to me, and probably to others, that, for example, in the long-term-care sector, nursing home beds are, more often than not, being awarded to the private sector as opposed to the non-profit sector, even though non-profit is applying for those bed licences. So I'm just wondering if there has been a shift.

1650

Mr. Saäd Rafi: I think, if I'm not mistaken, in the example you're using, those delivery agents, the for-profit long-term-care home providers, were in place prior to the legislation. I think since this legislation was enacted, the government has reinforced its commitment to not-for-profit delivery.

For example, in the action plan for community clinics, it stipulates—and we will soon be issuing a policy guide for a three-year RFP-based approach to various types of services and ambulatory care services in the community—that it will be through not-for-profit providers, and that is defined in the policy guide.

Again, I think that's the change in approach, or maybe the refinement of the approach to the delivery in a not-for-profit model. But it's also interchangeably used as a single-payer system, whereby many systems around the globe—maybe the most venerable of all single-payer systems, the UK, has private sector deliverers, but the government is the single payer, as the government is here.

Obviously, there are private services provided in health care that are not funded through OHIP.

M^me^ France Gélinas: Do you consider a group of physicians owning a practice—do you consider a physician practice as a not-for-profit entity?

Mr. Saäd Rafi: Definitionally, do you know?

Mr. Robert Maisey: I think it depends on how they are incorporated and how they practise.

M^me^ France Gélinas: Can you give me an example?

Mr. Robert Maisey: For example, family health teams, what are called FHTs—I think those are FHTs—are typically not-for-profit corporations. But a group of physicians practising through medical professional corporations in a partnership, those would be for-profit corporations.

M^me^ France Gélinas: Okay, so, a FHT, where physicians get part of their money through capitation and part of their money through billing OHIP, is considered not-for-profit?

Mr. Robert Maisey: The billing in those cases is usually done by the physician directly, so that could either be to him or her personally or it could be to their for-profit corporation. The organizational structure that we contract with in those cases is not-for-profit.

I think I got my acronym wrong. I think the acronym should be the family health network, FHN, not FHT. I apologize.

M^me^ France Gélinas: The family health network and the family—okay. What about the FHTs? What about the family health teams? Do you consider them as not-for-profit?

Mr. Saäd Rafi: Isn't it a function of their incorporation?

Mr. Robert Maisey: Again, it depends on who the ministry is contracting with and who the ministry is paying. If the ministry is paying the physician directly or the physician's medical professional corporation, then that's for-profit. If the ministry is paying an organization that is a not-for-profit corporation—say, for administrative or overhead costs—then that's a not-for-profit organization.

Perhaps I can take a different example: a community health centre. A community health centre is a not-for-profit organization that typically employs physicians as employees. There's nothing to stop a physician having his or her own office, where he or she sees other patients. In that circumstance, the physician normally would be billing the ministry directly through OHIP, and that would be for-profit.

The Chair (Mr. Ernie Hardeman): Okay. Thank you very much. That concludes the time.

Ms. Jaczek?

Ms. Helena Jaczek: Thank you, Chair. I'll start off, and I think my colleague Mr. Colle would like to jump in as well.

Deputy, you've made a few remarks about other provinces, and overall, what I've seen from BC and Alberta is a tendency to go from more boards and regional entities to fewer. I'm reminded of the issue, particularly because we're joined by Mrs. Cansfield, who happens to have a riding where her constituents, in fact, relate to four different LHINs.

I also have had a major health service provider from the Central LHIN in my riding come and talk to me about the need for fewer LHINs. So I guess, just in principle, is there any reason why we would not potentially integrate some of these local health integration networks with each other if the boundaries seem to be problematic, especially in the GTA? Is there any—

Mr. Saäd Rafi: No reason.

Ms. Helena Jaczek: Presumably, the boundaries were chosen for some sort of reason, though they were not apparent to us in the region of York, but there's no imperative to maintain those boundaries, from the ministry's perspective.

Mr. Saäd Rafi: No. Correct.

Ms. Helena Jaczek: Thank you. Okay.

In terms of these 15 indicators that you've referred to in relation to the accountability agreement, you said that you basically assess the LHINs performance against provincial standards or provincial objectives. On what are those provincial objectives based?

Ms. Kathryn McCulloch: It's the provincial targets, and to the deputy's earlier comments, the ones where there are provincial targets largely have been developed by clinical experts, so we relied on the expertise of clinicians in the field to determine what the appropriate target should be. The wait times' ones were national targets, so it wasn't just Ontario that was involved in those discussions; it was across Canada where we have targets—

Ms. Helena Jaczek: And so how often do you look at the provincial objectives and review them to ensure they're current and appropriate?

Ms. Kathryn McCulloch: You mean the targets, you're talking about?

Ms. Helena Jaczek: Yes.

Ms. Kathryn McCulloch: We have not reviewed the wait times targets since the LHINs came into being, mainly because they are national targets. It was a commitment of the federal government, and those are posted publicly.

Some of the other indicators that we've recently added actually don't have targets yet. There is no expert opinion that we have been able to glean that provides us with an idea of what those should be. So we are monitoring some of those as they come into the agreement for the first time, for the first few years, to determine what might be appropriate in the way of a target by looking at performance and what things might influence performance. The various indicators have different ways in which targets have or have not been set.

Ms. Helena Jaczek: Okay. Now switching topic a little bit back to the service agreement with the individual agencies, so the agreement that the LHIN establishes with the various agencies that actually provide patient service. Were the LHINs provided with some sort of legal template so that we could be assured of some consistency across all these service agreements?

Ms. Kathryn McCulloch: The LHINs did assume the ministry's accountability agreements at the time that they came into being. We transferred all of our accountability agreements over, and then we worked, the ministry and LHINs, jointly to develop the first template.

There are three different accountability agreements: one for the hospital sector, one for the community sector, except for long-term care, and then there's a separate one with the long-term-care sector. Those have been developed both with the ministry and LHINs but also with the input, obviously, of the providers as well. They are standard template agreements that have been developed and negotiated between all the parties.

Ms. Helena Jaczek: If the provisions of a service agreement are not met by the provider, what power does the LHIN have to terminate the agreement, or what sort of repercussions are there in terms of non-performance?

Ms. Kathryn McCulloch: It's sort of an escalating process. Obviously the first thing would be a discussion as to why. There may be some factors why indicators aren't hit, as we said, in terms of the LHINs' targets themselves. But it goes progressively, and in the hospital sector there has been a number of hospitals where they have not been meeting their performance targets, that the LHINs have required them to do performance improvement plans. So they have to come forward to the LHIN, identify where they are going to actually be able to make improvements so that they will hit their performance targets, and it goes right up to—obviously, we have in the past, put in supervisors or investigators into some facilities where the organization has not been able to meet their obligations for a number of reasons. It's very progressive, and it really depends on the individual situation.

1700

Ms. Helena Jaczek: So in the case of a hospital, on the advice of the LHIN, the minister can appoint a supervisor?

Ms. Kathryn McCulloch: That's right.

Ms. Helena Jaczek: Can the minister appoint a supervisor in a CCAC or any of the other service providers?

Mr. Robert Maisey: Yes, with a CCAC and with long-term-care homes. It's not necessarily a supervisor, but where there are quality issues, the ministry has the power to take over the licence, appoint an operator in place of the licensee.

Ms. Helena Jaczek: And in the case of community mental health?

Mr. Robert Maisey: We don't have the power to appoint a supervisor in the case of community mental health. Typically, I think it's fair to say the progressive performance management system has the organization working with other organizations that are successful, or funding is terminated.

Ms. Helena Jaczek: The ability obviously to terminate funding on the advice of, presumably—on the LHIN for the scope—

Mr. Robert Maisey: Actually, in that case, the LHIN would be terminating the funding themselves because they hold the contract.

Ms. Helena Jaczek: Okay. I understand. Thank you.

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

Mr. Mike Colle: Thank you. I was intrigued by the deputy's comment about opinion-based questions. I think you are in a place, Mr. Deputy, of opinion-based questions. That's what we do for a living. Most of our questions are based on our opinions. I totally respect your expertise, your professionalism, but just remember that our questions come from our own experience, our own practice in our community and the people we represent, so we are guilty of having opinions. I hope you'll excuse that. I don't mean that in harm, but I just mean it as an interesting comment that you made.

What I would like to say is that I know we're looking at the technical aspects of LHINs and the infrastructure and how they work and so forth. But I think like any government structure, especially in a ministry that is as large as this—this is half of our budget. I think it's probably the largest Ministry of Health in North America. Is it?

Mr. Saäd Rafi: Well, in Canada.

Mr. Mike Colle: One of the things that I think is a bit of a disconnect is, because it is so large and because, again, we are victims of our own success because I think we offer just such a cornucopia of services in our health care system that is beyond anybody's imagination, especially if you come from south of the border or even some European countries—it's really difficult, as an MPP who has been at this for a few years and as a citizen—or a health care provider sometimes—to basically understand what questions to ask and to evaluate where the system is working well.

I think where the real gap is—and it's not because of a wilful denial of duty by anybody or people going in the wrong direction. It's just that basically, like I've said around this place for years, the trains keep taking off to a certain destination and nobody ever stops to say, "Well, before you take off, do you have enough supplies? Have you told people where you're going? Why you're going? What you're going to do?" But the trains keep taking off.

What I think would really help in terms of the accountability of the LHINs and the CCACs and others is if there would be a more conscious effort—and I know there's an effort of public outreach and there's a conscious effort of inviting us as MPPs to come, and talking about stakeholders. There's got to be, I think, a more comprehensive approach to making people better understand—I'm not just talking about the patients and the citizens that need health care, but all the different players in delivering health care, that a lot of them sometimes feel frustration in dealing with the LHIN or dealing with a hospital or dealing with a family health team, because they don't quite know who to ask or where to get answers, because it is extremely complex.

As an MPP, I just find it—the physiotherapy change is one perfect example. I've been dealing with LHINs and I've been dealing with CCACs on this for the last number of months. What would really help is if there was a concerted effort, through the LHINs perhaps, of having an information function or an information office, because a lot of people I run into don't even know that there are community health centres in their community. They have no idea unless they're referred to it by a friend or by a social worker or by an MPP. I find a lot of MPPs don't even know there are community health centres and what they do.

Or I get people coming to me and saying, "Well, I don't want to be part of this new thing called nurse practitioners. I want a real doctor." I say, "Well"—and I have to try and explain to them the value of nurse practitioners and how good they are and so forth.

So what happens is, this basically, I think, ends up costing the LHINs, in their operational budget, in terms of time and communication. It's much more fraught with controversy because the communication isn't done. The outreach, the linkage with the community, isn't done in a comprehensive way on an ongoing basis, whether it's an MPP or a city councillor or a local nurse or a local nursing home, so they can visit or interact with a place, physical or otherwise—it could be digital or virtual—where people could get some answers to get through the system. I'm saying not just patients; I'm also talking about all the agents and the individuals that deliver health care through the system, because if I'm going through the list and I'm saying—no one in my community, very few, except the people at my hospitals, know what LHINs and CCACs are. They have an idea if they get sick. Primary care physicians: "What's a primary care physician?" Family health teams: "What's a family health team?" "What's a community health centre? What's a nurse practitioner-led clinic?" It is extremely difficult to ensure that the LHINs operate properly with proper input if nobody knows how to access them and access their structures or how their structures even work, because it is extremely complicated.

So I wonder, am I missing something that I haven't found out, that there's a place where people, ordinary folks or ordinary MPPs, can go to and get some good, solid answers and information and clarity on some of these complex issues that we deal with on a regular basis?

Sorry for the long preamble, but if you can try and answer that the best you can.

Mr. Saäd Rafi: Well, first, I would say I didn't mean to imply that you shouldn't have opinions. What I was getting at is that our role is not to engage in opinions but to engage in advice based on research and evidence, so I think that's an important distinction.

With respect to communications, every LHIN should be talking about the work that it's doing in its community and communicating with every one of its MPPs, either inviting MPPs to sessions, inviting MPPs to board meetings, inviting MPPs to learn about what's happening in that LHIN. And if they're not, and if there are examples, we can certainly follow up with them and see that that's either improved or that's done.

Secondly, when it comes to the actual delivery of the service, that's predominantly in the community, either through the hospital, the CHC or the community care access centre. So there are a multitude of resources available to individuals, be they family caregivers or patients. One example would be that some hospitals, especially large hospitals, might have dozens of CCAC case managers there to work with patients prior to discharge, to work with clinicians prior to discharge, to ensure—

Ms. Helena Jaczek: Dozens?

Mr. Saäd Rafi: Yes, dozens—the services that they receive in their community.

We heard in the long-term-care public accounts that there are some hospitals in the north that might have up to some 30 CCAC case managers working out of an academic health sciences centre to make sure patients are properly placed with the services that they need.

Plus, each LHIN would have websites. They would have communiqués that go out. I think one of the toughest things to get across, in my own experience, with respect to change or to understand what's available is communications, so you've hit on a subject that is always challenging, to make sure that everybody has the same amount of information.

In addition to that, government has put in a fair amount of investment in such things as—

Ms. Kathryn McCulloch: Health care options.

Mr. Saäd Rafi: Thank you—health care options where, by entering your postal code, you can understand what services are within your catchment area, be that a family health team, a nurse practitioner-led clinic—and some people actually quite like nurse practitioner-led clinics, but you're right, others want a "real doctor," as the saying goes and as I believe you said. You can access your care in that way. You can access where community clinics are with respect to some of these ambulatory services, what hospitals are in your area. In addition to that, when there have been various vaccines available or seasonal shots such as the recent campaign for the flu shot, the government has increased the scope of practice to various providers—for example, 2,000 pharmacists now have been trained—and they communicate through their means and methods.

1710

Mr. Mike Colle: Thank you, Deputy. I agree that's happening.

The real problem is, though, that when you get into a situation where you're dealing with a CCAC resource worker at the hospital or a case management worker, you're in the system, and you're sort of caught with a crisis in your family. But I'm talking about just a better understanding, even before you get to that stage, of what's available. As I said, there's so much going on, and there's so much delivery that's manic because it's urgent care in many cases, that there isn't a real sense that there's this communication available to ordinary people.

They can invite me as an MPP all they want, and I can go to the meetings, but that doesn't help in terms of communicating with my 140,000 constituents in terms of what's available in the greater Toronto area, in the LHIN area, and I deal with two LHINs: Toronto Central and Toronto LHIN.

But anyway, I don't think that's there, and that's causing a lot of damage, I think, to information linkages, those lines of communication, because there isn't this overall understanding of what the partners are all doing. Many partners don't know what's going on.

I can just imagine different parts of Toronto that I represent—they don't know, well, St. Clair West Services for Seniors has a nurse practitioner-led clinic. People are coming to my office saying, "Where can I go to a doctor?" They don't even know that that exists in their community because St. Clair West Services for Seniors, which has been around since 1953, doesn't have the time or the resources because they're too busy dealing with bedbugs or dealing with mental health issues to reach out to people, because they're also very busy with trying to access funding programs that are out there to meet the needs that they see in the community. They're occupied.

I just think there's got to be—maybe the LHINs should do it, maybe the CCACs should do—an on-the-ground way of letting the public in all our communities, through the LHIN boundaries or whatever, know what's available in the health care system, how you access it—the options.

Again, I was just really angered when I heard these people criticizing nurse practitioners because for years, we tried to get them here. They're saying, "We don't want the nurse practitioners. We want real doctors." I said, "Well, you don't even know what a nurse practitioner is."

That's where I say we need to have maybe the LHINs looking at this in terms of—and I'm not sure this is the proper forum to say that, but I think that is something that would really help lower the level of anxiety and confusion which exists within a system that's, I think, doing a heck of a job providing health care 24/7 in every conceivable situation. I've got two perfect examples. Baycrest Hospital, Sunnybrook Hospital, St. Michael's Hospital, the work that they do and the street people that they treat and the mental health issues that they treat and the seniors who are being treated around the clock and trying to get them care at home—I mentioned the other day here the needs in the psychiatric wards in the big city. I don't know how they handle all of these things, because families can't handle them.

I just think what I see, through my years of experience, is missing is—because the trains have all taken off, and nobody's given the conductor—

The Chair (Mr. Ernie Hardeman): Thank you very much, Mr. Colle. Your time is up.

Mr. Mike Colle: You agree that you've got to slow the train down?

Interjection.

Mr. Mike Colle: See? There you go again. The train's taking off; you won't stop the train. You proved my point.

The Chair (Mr. Ernie Hardeman): Well—

Mr. Mike Colle: I was just joking. It's okay.

The Chair (Mr. Ernie Hardeman): A good point, Mr. Colle. I'm very glad to see that you recognized you were just a train going—

Laughter.

The Chair (Mr. Ernie Hardeman): The official opposition: Any further comments?

Mrs. Jane McKenna: Just so I'm not belabouring Mr. Colle, but I was very grateful that you said what you said, because, Ms. Brown, when you actually said what the LHINs were doing for the seniors, in effect to the physiotherapy or the cataracts, I wanted to say that I can only speak for my constituency office and the anxiety from the seniors. I'm not even an anxious person, and my anxiety—I have someone who has worked here for 11 years, who knows every nook and cranny, and we could not get the proper answers for these seniors. So I'm only speaking for myself; I will not speak for anybody else. We went above and beyond to help these seniors out with their fear. Why we have to instill in the most vulnerable people in society that have paid their taxes their whole life that they just couldn't get an answer—all I'm saying is that if we take away anything from today, I would have

given my right arm to have the information that you said was going out to all of our places, because I can say that mine did not. It wasn't until finally my guy, exhausting every avenue, got the answers. That's all I'm going to say about that today.

Thank you so much for coming, and we're passing. That's it for us.

The Chair (Mr. Ernie Hardeman): Okay, thank you. Ms. Gélinas?

M^me^ France Gélinas: I just want to know, Chair, are we going till 6 or do we save time on the clock to look at our calendar like we had said we would?

The Chair (Mr. Ernie Hardeman): Obviously, this part goes on until such time as we're finished talking. As to the rules of the subcommittee—as I said when we started, we started in 20-minute rotations, and as long as that goes, we can't go any further. Obviously, we don't have to adjourn the committee if the discussions are over with the delegation. But I can't stop the—so you have an opportunity to further question the delegation.

M^me^ France Gélinas: But if you're speaking in code right now, if I don't ask questions, then we will look at our calendar?

The Chair (Mr. Ernie Hardeman): That's up to the committee, but I can't forego what the rest of the committee members will do as to being finished with this debate. I don't have the power to cut it off.

M^me^ France Gélinas: I'll try one quick one.

You are all very knowledgeable about the system. We are on our first day of hearings to look at what went right, what went wrong, how do we make this better? Is there something to salvage? Do we throw it out? We're just starting.

If you were in our shoes—no, I'll phrase that otherwise. You are knowledgeable people. Give us your best advice as to what should be the way forward.

I'll start with you, Deputy. What's your best advice?

The Chair (Mr. Ernie Hardeman): Thank you very much for that. Was there a question in there?

M^me^ France Gélinas: Yes: What's his best advice?

The Chair (Mr. Ernie Hardeman): What the best advice was?

M^me^ France Gélinas: Yes.

The Chair (Mr. Ernie Hardeman): Okay. We'll leave it to the deputy.

Mr. Saäd Rafi: I don't believe I've come across anybody in the sector who has been a practising administrator/clinician or clinician or otherwise in four years who has said that there is not enough money being spent. So that means that there is an opportunity to continue to find value. To me, value is a simple formula of quality divided by cost. So some of the things that have been undertaken need to continue, which is evidentiary-based changes in areas of quality to either add emerging services, emerging technologies, or remove those that have been demonstrated, evidentiary-based, to no longer be providing positive outcomes to patients, and to continue to find efficiencies and improvements in how—again, the word integration will come up—services are delivered, planned and funded in a way that continues to squeeze out more and more services for the same amount of spend. So spend the same, spend better with better outcomes is, I think, a reasonable expectation. One response to that would be community-based clinics in terms of ambulatory care.

I think that as we grapple with the burgeoning impact of demographics, given our geography, in some cases we have very high-density locations and in other cases we don't. That impacts how services can be provided and delivered.

1720

I would say we need to continue it in that regard, and at a sub-LHIN level. Health links, to me, is that example. We can moniker it any way we want—any way one wants; pardon me—but providing care to the most vulnerable will squeeze out better outcomes. Better outcomes will bring savings. Savings will get reinvested. Ergo, there's enough money in the system.

I would say that if people don't want, like you said—both parties have suggested that there should not be LHINs. Then I think one would logically ask the question: Who will have the on-the-ground, local interaction to plan, fund, integrate, and other services that you may feel are necessary that are not being provided by the limitations of a piece of legislation that's seven years old?

I mentioned a few earlier, and I would add some of those examples now. The benefits that have been wrung from the system are as follows: You have the most efficient hospitals in the country—some have argued, in North America, but certainly in the country. You have comparisons to HMOs, the US model of HMOs, such as Kaiser Permanente. They have far fewer—they have nine million patients, so a nine-million catchment area; we have a 13.5-million catchment area. They have 37 hospitals, I think, and 17,000 physicians; we have 154 hospitals and we have 26,000 physicians. They spend $49 billion; Ontario spends $49 billion.

I think we have to look at how we deliver services, through what channel of delivery, to use a private sector phrase. I would say that access to community care and access to family physicians has also increased. Wait times have been monitored and, in the main, meet or exceed their targets.

The glass is half full in that regard, in terms of performance—that's my assessment against metrics—but more can always be done.

M^me^ France Gélinas: Anybody else? What's your best advice for us?

Ms. Catherine Brown: I would concur with what the deputy has said. I think the one piece, when I listened to the conversation today—there has been lots of commentary about boundaries and changing boundaries. There will always be a boundary, whether it's the boundaries of the province or within the province, whether it's a hospital's boundaries or a LHIN's boundaries. I think there are many things that can be done that are not necessarily related to retooling the legislation but thinking differently, based on that evidence, about what the best

way is to have those dollars follow the patient, and that's not necessarily a legislative fix. We learn about that, as the deputy pointed out, based on outcomes. We learn about the best ways to do that.

I think the other piece I would suggest is the ability to think about what variables impact things like wait times, for example. One of the examples that—as many of you know, I am relatively new back to health care—and the hip and knee piece—the wait times can vary so much, only to learn that patients defer their surgery. Patients say, "I'm waiting for Dr. Smith, and I'm going south for the winter, and I'd rather do it in the spring."

Considering what those hard-and-fast drivers may drive, that is not the intended outcome. That is not the best outcome, necessarily, to force someone to go to have surgery at a time and a place when they choose not to.

Thinking about when we set those rules, there was discussion of putting harder or faster rules into the legislation. I think, as Kathryn McCulloch pointed out, it's a permissive piece of legislation, and that was intended at its outset, to allow government the flexibility to make changes based on outcomes and evidence. I think that's a valuable aspect of how it was set up originally.

M^me^ France Gélinas: Any advice, Ms. McCulloch?

Ms. Kathryn McCulloch: I think, again, to sort of support what the deputy said, there's always going to have to be some kind of a regional, local presence. I think that's something that, clearly, from what's happening across Canada, we've all recognized what it looks like. It can ebb and flow, it can expand or shrink, but there has to be a presence on the ground that understands the local needs, particularly in Ontario, I think, because it's such a vast province with such different geography.

The other piece that, certainly, we talk about a lot within the ministry is around the community and the capacity of the community to be able to support where we're going in terms of the health care system and where we need to go, perhaps, in serving seniors and putting supports. Those two pieces: How do you get, locally—understanding the community and what your community providers can provide in the way of support? As a system and as LHINs, or whatever that regional authority might be, how do we support those community providers and the capacity of the community sector to be able to step up and fulfill the expectations that I think we increasingly have for that sector?

M^me^ France Gélinas: Mr. Maisey?

Mr. Robert Maisey: I go back to your opening comment, which was around you coming to this for the first time today, and you asked advice around questions. I think the questions that you've been asking today are a number of the big questions to be asked around boundaries, around what a regional model looks like—we've done one in Ontario before where it was a ministry-driven model; this one is a different model—around who should be under those regional models and who need not be, for whatever the reasons may be. What are the performance metrics? How do those change? How do those get communicated?

M^me^ France Gélinas: Thank you.

The Chair (Mr. Ernie Hardeman): That's it?

M^me^ France Gélinas: That's it. I'm saving time.

The Chair (Mr. Ernie Hardeman): Thank you very much. Then, back to the government: Ms. Jaczek.

Ms. Helena Jaczek: I'll just start off, and I think Mrs. Cansfield would have some as well.

The Chair (Mr. Ernie Hardeman): That's fine.

Ms. Helena Jaczek: Just to get back a little bit to what Mr. Colle was talking about in terms of communication: Certainly, I would say, over the six years since I've been elected, which corresponds pretty much with the establishment of LHINs, I've seen tremendous progress in terms of the way I'm being communicated with by the LHIN board chair and the LHIN CEO. They tried in the Central LHIN. The first crack was a breakfast for all MPPs at 8 a.m. or something—when we were supposed to be in the House at 9—up in Markham somewhere, and 17 of us expected to attend. Now I get, pretty much twice a year, a visit from the board chair and the CEO, so I'm finding that that communication has dramatically improved.

But I guess I'd like to go back a little bit to what the LHINs' communication with the public is and what is required under the legislation. As I understand it from Mr. Maisey, it's essentially that they must have a website; board meetings are open to the public, and the assumption is that the agenda goes on the website.

Having said that, I have heard from people, actually, from across the province, that quite often the community is unaware of the potential for an integration or an amalgamation of services. The community is not aware and they find out way too late and, naturally, they are sometimes quite concerned about services being provided further away from their home. It's the natural kind of reaction.

If the legislation has a provision that there be a website—I mean, I would like to see that, somehow, that be far more generally known, that changes in health care in your local area are under the auspices of this thing called a LHIN; they have public board meetings; this is on the agenda this month.

How would you see that kind of more open dialogue with the community? Presumably, we wouldn't need legislative change, but how would you ensure that our constituents understand more about what's going on?

Ms. Catherine Brown: I'm not sure how to answer that, how would we ensure more, but we can certainly remind the LHINs.

I will say that in addition to their websites, we work with them on communications on a regular basis as decisions are made by the province to change something, to do something differently, to add something new. We work with them locally on how that information is provided. They share with us regularly. We know their minutes are made public and their board meetings are open, but they will often share with us when something has taken place that may be locally contentious or raise concerns. So from where I sit, it seems the LHINs are

doing much of what—certainly if not all of what—they're required to do, but to your point, it doesn't necessarily have to be legislated.

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I think, no doubt, you will hear from the LHINs themselves at some point. I think they would be in a better position to tell you what they are doing locally to reach out to people—not that you're not people—not just to MPPs, not just to service providers, but to the people in their area. I believe most of the LHINs, if not all of the LHINs, on a regular basis have opportunities for the public within their area. Perhaps not, as Mr. Colle suggested, a general one-on-one on health care, but as things change and as things are evolving, they would be in a better place to tell you what they do on a—

Ms. Helena Jaczek: So you basically suggest to them, "Put out press releases to all your local media"—

Ms. Catherine Brown: We work with them whenever we're doing something like that to share with them communications, questions and answers and information. They also make decisions locally that they communicate and share back with us, that they're making an announcement or will be providing information locally.

To the question earlier: They share that with one another, to say, "This is how we've communicated that in our area. You may want to base your information on what we've provided," and upload that to their websites.

Mr. Saäd Rafi: I would say that we all understand there are traditional forms of communication, because I think you've said that that isn't always picked up by people in their day-to-day lives, but they have undertaken town-hall-like activities on initiatives all across their LHIN, and they do so on a regular basis. Now, it's not for everything they do, of course, and one might argue, "Well, they're not hitting the people that they should be hitting." That may be true, but it's not from a lack of trying. Communications is something that always can be improved, and you all know better than I that you can never do enough of it.

Ms. Helena Jaczek: So in other words, the general direction from the ministry to the LHINs is, "Make sure your community is aware as much as possible as to our activities." Presumably they have some index of suspicion if it's going to be a controversial kind of situation, that they get out in front of it.

Mr. Saäd Rafi: But community engagement starts with the legislation and goes right through all of their instruments and requirements. If the point is about their performance against those requirements, I would accept that, as you said, there's improvement there, for sure—always.

Ms. Helena Jaczek: Mrs. Cansfield has questions.

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

Mrs. Donna H. Cansfield: Thank you very much. Thank you for the opportunity to ask a couple of questions, as I'm not a regular member of this committee, but obviously in having four LHINs and four CCACs, I have a great interest in looking at some of the challenges and obviously some of the opportunities.

It seems to me that sometimes when we look at these issues, we look at them at 40,000 feet, as opposed to where the rubber really hits the road, which is in the communities and in the constituencies, some of which you've heard today, and that is the misunderstanding or the lack of communication or whatever you wish to call it between the physiotherapy and actually what is happening in those long-term-care retirement homes and in the community. Trust me, they're not jibing. Ms. McKenna is not the only one who is struggling with this.

For me, the interesting part is that, even though the LHINs have the same mandate, they interpret it 14 different ways, and so you have a real disconnect. They do not talk to each other. I'll give you a good example: Try palliative care, end-of-life care, and how they deal with it in each of their respective LHINs. It is quite different, and yet the motion that was put forward in the House—I know it, because I put it in—actually spoke to a similarity of care right across this province, and that has not occurred. That's the challenge.

I look at your issue around chronic care. I understand and know the 5% issue you've got, but the interesting part for me, when you talk about an integrated approach—and I'll give you an example of someone who's in an extraordinary chronic care situation; it's costing the system, I guess, a great deal of money. She can't walk but she lives in a basement. So housing is an obvious issue around care and around making sure that individual—and yet, those two, health and housing, had not connected for that individual.

For me, looking at the LHINs means having an honest assessment of what works and what doesn't work, and how you improve it, and I think we need to look at some of the basic things, such as the fact that most major operations occur in downtown Toronto, whereas the patient lives in Etobicoke, St. Catharines, Welland, Bruce county or wherever. Those two folks don't talk to each other, but if they do it's typically five days apart, and you've got a real problem, because then the family is in crisis. They're in crisis to begin with when there's an operation, unless it's something that they're used to.

Part of what I would ask you is the same thing France has asked you. You have to be able to say, "Look, for seven years we looked at this. This is what works, this is what is not working and this is what we need to change, especially in a system as complex as this." We've all had people who have come after 25 years; I've had folks say to me, "I can't navigate the system," and I'm in it—I'm in it, and I don't know what to do. I think we have a problem, if that's the case.

I never get to see one of my LHINs. They just don't bother with me, because it's that part of my riding—as if it doesn't care, and yet the service the person receives in that top end is different from the service two blocks away. How do I explain that to my constituents? I can say, "Oh gee, Toronto gets $170 per person or $180; poor little old Mississauga Halton LHIN only gets $110." Sorry, they don't care. What they care about is that if Mrs. Jones gets this service, why doesn't Mrs. Smith get

this service? They live in the same area. That's a real challenge with the LHINs.

That's part of what I think is our responsibility: to get at, get under and get to it, and say that if this is a system you want to work, then we've got to peel back the onion and have a really good look at the governance. We need to look at the funding. I don't disagree with you; if money was the issue, we would have solved it a long time ago.

We just have a system that isn't quite jelling and working. It isn't as integrated. They don't even use the same forms—did you know that? One CCAC doesn't use the same forms as another CCAC to transfer that patient.

I have accountability agreements where three quarters of the way through a year, a CCAC goes bankrupt or has no money. You guys bail them out, but the question is, should they have two-year funding? Not everybody turns 65 in a year, so their seniors change, right? It's over a two-year period.

They used to say you couldn't get people pregnant in lots of 20 for kids 20 in a class; it's no different with people turning 65. They do that throughout the year, and do we accommodate for that? Do we look at an integrated system?

I'm going to use this, and I've used it before: The LHINs tell me time after time that they do not have the autonomy you say they do. They do as you tell them to do. What's fact or what's fiction, I don't know; I can't seem to separate it out, but I do know that you took the aging-at-home money and put it into acute-care bed release and acute-care bed return. I understand that, but what it did mean was that I ran around telling everybody about aging-at-home money that didn't exist.

How do we go back to our constituencies and deal with this if we don't have the facts in front of us with which to deal? How do we find a way to really improve this system if, in fact, we're going to have a number of people that will turn 65—what is it? I think it's 1,600 a year or every so many months within the next few years.

In my riding alone, in Mississauga Halton LHIN, the number of people who will turn 85 will grow by 71.2%. My question is, are you prepared for that? I don't get an answer. For how many years, of the 14 LHINs, only five had an aging-at-home strategy. They didn't have anything to do with their seniors. That's the inconsistency that I see in my four, and I suspect you might see it across the LHINs.

I just share this with you because I really think you have the opportunity to work with us to make a difference. I'm not your biggest critic, probably, but I'm actually offering to help you make the system work, because if it doesn't work, it will implode. It will implode by the sheer numbers of the demographics, because you can't handle that number of people who are aging as fast as they are unless we change how we do business in this province in terms of health and the LHINs. Again, I only have four, so I can't speak to the other 10, but I can tell you that my four aren't working all that well. They do some things okay, some not, but they sure don't all work together, where my population all lives in my same area.

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So, yes, there will always be a boundary. I appreciate that. I come from the school sector. That sucks. However, four of them dissecting a constituency really sucks, because they don't care, as I said earlier. I can't say, "You're in Mississauga-Halton." They say, "What in the hell is that?"

The last I'll share with you is about communication. When you need the health care system, typically, you're in a problem. The last thing you do is go on the Web to find something you can click onto. I'm sorry; it doesn't work that way. What you do is you phone somebody and say, "What do I do? Where do I go? Who can help me? How do I navigate this?" I thought we put money in for navigators. Remember that? That didn't work out all that well either, because the CCACs just sucked them back into the system.

We haven't even touched the whole issue around long-term-care placement and all that stuff with LHINs.

I won't come back because I'm a difficult person at times, but I needed to be able to say this to you because it's that important to me. If we don't get this right, we're going to have a really serious problem.

So I appreciate the opportunity, and I do ask you—actually, I plead with you—to give us your advice. Your opinions are important because you know the system better than anybody else. You know where all of the bumps and the holes and the goods and the bads are, and if you can't share that with us and be honest with us—if you need a closed session with these people to do it, do so. But at least give them the benefit of your expertise. There has to be about 400 years sitting here of good knowledge that they could really benefit from significantly. Thank you.

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

M^me^ France Gélinas: Can I clap?

Ms. Lisa M. Thompson: That was very well said.

The Chair (Mr. Ernie Hardeman): Anything further from the government side? Nothing further? Well, it looks like maybe that was the benediction. Benedictions usually are just very—but anyways, very well.

I do want to thank you for coming in, but I think as has been mentioned by the last speaker and others before, this is the first meeting, and this was an opportunity to update the committee on where it's going and what we need to look forward to as we're moving forward in this review. But I would suggest that they do—they haven't yet made the list of all the people they wish to speak with, but I would be quite surprised if it didn't include the ministry again, to hear from you, as we're moving forward with this review, your advice and what needs to be done in the future.

We very much appreciate what you've given us today, and we hope that we can collectively work to make it a better system for the people of Ontario. So thank you very much for coming in.

Mr. Saäd Rafi: Thank you.

The Chair (Mr. Ernie Hardeman): Secondly, I just want to suggest to the committee that we have an in-camera meeting to discuss where we go, because we do have to get that—and you're quite welcome to stay, Ms. Cansfield. But we have to set up a schedule, because the House resolution mandates that we meet again next Monday, or at least the first meeting of next week, so we must have some direction for the Clerk to get ready with the committee.

M^me^ France Gélinas: I was afraid you were going to do the rotary thing and send us all out. I'm waiting to look at our schedule. At least we'll have an idea as to what days work and what days don't.

The Chair (Mr. Ernie Hardeman): Okay. Before we can do the meeting, we have to have a couple of minutes to shut off the system for an in-camera meeting.

The committee continued in closed session at 1745.

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