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ISSN 1180-4335

Legislative Assembly of Ontario

First Session, 38th Parliament

Assemblée législative de l'Ontario

Première session, 38e législature

Official Report of Debates (Hansard)

Wednesday 18 May 2005

Journal des débats (Hansard)

Mercredi 18 mai 2005

Standing committee on government agencies

Intended appointments

Comité permanent des organismes gouvernementaux

Nominations prévues

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

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

LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON GOVERNMENT AGENCIES

Wednesday 18 May 2005

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DES ORGANISMES GOUVERNEMENTAUX

Mercredi 18 mai 2005

The committee met at 0904 in room 151.

SUBCOMMITTEE REPORT

The Vice-Chair (Ms. Andrea Horwath): Good morning, everyone. Welcome to our standing committee on government agencies. The Chair is delayed this morning, so I'm standing in for him briefly, I hope.

Our first order of business is to approve the report of the subcommittee on committee business that's dated May 12, 2005. Can I get someone to move the adoption of that report?

Mr. Michael A. Brown (Algoma–Manitoulin): Do we have that?

The Vice-Chair: It should be in your packages.

Mr. Brown: I'll so move.

The Vice-Chair: OK. All in favour? Any opposed? That's carried. Thanks a lot.

COMMITTEE BUSINESS

The Vice-Chair: The next piece of work we need to do is extend some deadlines. Pursuant to standing order 106(e)11, unanimous consent is required by the committee to extend the 30-day deadline for consideration of the following intended appointees, and there's quite a long list, so bear with me: Ian Wilson, Kuldip Kandola, George Todd, Mina Grossman-Ianni, John Whitfield, Juanita Gledhill, Michael Welsh, Kathryn Durst, Kenneth Morrison, Ruben Rosen, Mathilde Gravelle Bazinet, John Magill, Penny Thomsen and Gregory Andrew Joy. The issue here, though, is that we can extend for 30 days, 60 days or 90 days. I'm in the hands of the committee in terms of what you want to do.

Mr. Brown: Madam Chair, it is our view as the government that we would like to hear the 12 candidates for the LHINs remaining after today. I understand that the House leaders have agreed that we can use May 30, in addition to June 1, to do that. For the LHIN appointees, I would like to move that we extend the period to allow that to happen on May 30 and June 1. I don't actually have the list in front of me, so I'm a little—

The Vice-Chair: I think that will take in everyone that you're talking about, if we extend just until June 29, and then if we need another extension, we can do it at that time. We don't need to do it all today.

Mr. Brown: But the government's view is that we want this done on May 30 and June 1, because there are some time constraints on doing that. Can we incorporate that into the motion?

The Vice-Chair: I think the scheduling of the meeting is not a problem, unless we want a motion to that effect, that we have the committee meet on those particular dates. That has to be a House motion.

Mr. Brown: I'm sorry?

The Vice-Chair: Apparently, there needs to be a motion in the House for that to occur, because the regular committee day is Wednesday. You'll have to get your House leader to put a motion to the House to allow us to sit on days other than our regular days. I don't think there's a problem with that; I think everybody wants to see those LHINs interviews occur and get that happening, so Mr. Duncan will have to bring a motion to the House to allow us to sit on days other than our regular committee days. In the meanwhile, we'll just extend the deadline by 30 days, if I can get a motion to that effect, and that will take those dates into consideration.

Mr. Brown: I make that motion to extend for 30 days.

The Vice-Chair: That's moved, then. Any discussion? All in favour? Any opposed? That's carried. Thank you very much.

As has been the normal practice, if there is any other business, we'll put it to the end of the agenda, if that's all right with the members.

INTENDED APPOINTMENTS

NORM GAMBLE

Review of intended appointment, selected by the third party: Norm Gamble, intended appointee as chair and president, South West Health Integration Network.

The Vice-Chair: We'll now move into the section of the agenda to deal with appointment reviews. Our first interview is with Norm Gamble. He is the intended appointee as chair and president of South West Health Integration Network. Mr. Gamble, are you here?

Mr. Norm Gamble: I'm here.

The Vice-Chair: Welcome. Have a seat wherever you're comfortable at the end of the table. I'll let you know the process. You're the first one today, so you're going to be the person who shows everybody else how it works.

Initially, you have an opportunity to make some remarks and tell us about yourself, anything you think we should know that we would be interested in, even stuff we're not interested in—I'm just kidding. We're interested in everything. So you have that first opportunity, and then, subsequent to that, on a rotational basis, the members will have an opportunity to ask you questions. Each party has about 10 minutes for questions, and again, it will be in rotation, starting with—who are we starting with this time?—the official opposition. Any time you take in your presentation will be deducted from the government side in terms of their allotment of time.

With that process in mind, again, welcome. Good morning.

0910

Mr. Gamble: Thank you, Madam Chair. I recognize that I am the first one up for the LHIN recommendations. I appreciate the opportunity to appear before the committee. I'm pleased to have been nominated.

The background you have seen in my application is relatively straightforward, although I could highlight some of it. I've recently retired from a position as chief administrative officer for the county of Grey. I had spent some 32 years in municipal administration, the last 15 of which as administrator for Grey county. During that time, my experience with health care gradually increased. As many programs were devolved from the provincial level of government to the municipal level, we found ourselves more heavily involved in such things as long-term care, financial support to the hospital sector, public health and, in recent times, land ambulance. I recognize that some of those are not part of the LHINs' responsibilities, but they have given me some insight into community health concerns.

For the most part, my time with Grey county was spent with municipal restructuring, trying to assist some 27 municipalities become nine, including the conversion of the separated city of Owen Sound into a member municipality in a county system. That gave me plenty of opportunity to experience change first-hand and to experience the successes, and perhaps some failures, that come with that type of change.

Prior to being with the county of Grey, I was with the city of Cambridge in administration—in parks and recreation administration at the outset; my initial training was in municipal recreation. So my experience has been varied but restricted to the municipal administration sector.

I'd be happy to answer any questions, Madam Chair.

The Vice-Chair: The first group of questions will come from the official opposition.

Ms. Laurie Scott (Haliburton–Victoria–Brock): Welcome, Mr. Gamble. You have an impressive resumé and background. How did you hear about the position?

Mr. Gamble: Last October and November, as the Ministry of Health was planning some regional workshops to introduce the LHIN concept, I attended one of those workshops because of the county's involvement in health care, particularly in long-term-care homes for the aged. That was the first information I received on the LHINs.

At Christmas and in January 2005, I made my decision to retire from municipal administration, and at the same time saw the newspaper ads for board and chair positions for the LHINs. That came coincidentally with my own personal timing, and I thought it would be something I would enjoy and find challenging. So I took the newspaper ad and placed applications for both chair and member.

Ms. Scott: You applied, then, through the normal process on the Web site?

Mr. Gamble: As far as I knew, it was the normal process. I did apply electronically through the Web site and sent hard copy in by mail.

Ms. Scott: It's been difficult to find out how the process is working with the LHINs, since you are the first one to be interviewed and the LHINs are just starting to be assembled. Just three members are appointed to each LHIN right now. Is that correct, according to your knowledge?

Mr. Gamble: My understanding is that three members have been nominated for each LHIN so that the LHINs can be incorporated as not-for-profit corporations. That's the reason for that number.

Ms. Scott: Are you aware of the letters patent, which is the first priority you may be dealing with, and how that process is to work?

Mr. Gamble: Yes, I'm familiar with letters patent.

Ms. Scott: Could you explain it a little bit?

Mr. Gamble: I'm familiar with letters patent because of other experiences, but my understanding is that the government intends to establish the LHINs as not-for-profit corporations. As such, they will need signing authorities, and that's the reason for nominating three people at this time. The not-for-profit corporations would be stand-alone corporations, at arm's length from the government, but would work through a memorandum of agreement with the government in terms of what their responsibilities and performance would be.

Ms. Scott: Are there other names you have been given—you were going to select, then, the remaining LHIN members?

Mr. Gamble: My understanding is that eventually there are to be nine members of each LHIN board. At this point, three have been nominated. They want to move very quickly with nominating another three. The initial boards of three or six will be involved in adding the necessary bodies to give it full membership.

Ms. Scott: So at this point you haven't been given any other names of the remaining six that the three of you will choose for your LHIN?

Mr. Gamble: My understanding is that the three of us will have input. Whether it's on the remaining six or the final three, I'm not sure.

Ms. Scott: So you haven't been given any further direction.

Has there been a date given when you have to be set up and finalized?

Mr. Gamble: My understanding is that initially there was a target date of April. The target date now is June, and the full membership target date is the end of 2005.

Ms. Scott: So it won't be till the end of 2005 that they're going to be fully operational?

Mr. Gamble: I can't say whether they'd be up and operational without full membership. I assume they would try to be.

Ms. Scott: You haven't been given any direction, or there has been no information sent to you with any more specifics than what you've just said to me?

Mr. Gamble: If I have, I haven't done a very good job of reading it all.

Ms. Scott: There was the recent bulletin that came out, I think, on May 16. I don't know if you were able to see that on the Web site.

Mr. Gamble: I tried yesterday morning. Unfortunately, I haven't accessed since then, so I haven't seen the one from May 16.

Ms. Scott: Each of the LHINs represents a huge part of the province, and they're going to have a tremendous responsibility. I do hear a lot of concerns from my constituents, and there are a lot of concerns from all over Ontario. We're hearing from the Ontario Hospital Association, especially, that the amount of funding the government is directing to the hospitals is inadequate. How do you think you're going to be able to juggle the demands for health care services within your LHIN?

Mr. Gamble: I think it's premature for me to say how something like that will roll out. I know the intention is that there will be a progressive rollout, first, of a planning responsibility, then of an integration and coordination responsibility, and finally, of a funding responsibility. So the perhaps more challenging mandate of funding will not happen initially. I think that's wise, in terms of giving the LHINs the opportunity to get on their feet and running before they're confronted with some of the more difficult mandates.

Ms. Scott: Do you feel that the LHINs are going to be an increased layer of bureaucracy? Personally, I would not want that they be seen as an increased layer of bureaucracy. How do you think they won't be, and will be an effective body, considering that the district health councils are now dissolved?

Mr. Gamble: The information I've been able to read is that the intention is it would not be an additional level. If anything, perhaps it would have the ability to streamline the processes that are there. That's not the intention, as far as I've read the information.

Ms. Scott: You have a lot of experience in the background. Do you have your own feelings about how the LHINs may work? Regionalization is what is occurring. Do you see this as being a positive impact on the delivery of health care?

Mr. Gamble: Perhaps the best way to respond to that is, I had experience with the previous government's Ontario Smart Growth process as a panel member for southwestern Ontario. Initially, in that process, I was not a great fan of Ontario Smart Growth, particularly with the geographic boundaries that were established for it, which coincidentally, in the southwest, are very similar to the LHIN boundaries. As I worked through the Ontario Smart Growth process, I became more and more supportive of the concept of regional planning in particular. I saw that while there's always going to be a lot of difficulty with drawing geographic boundaries, the thrust of doing larger regional planning, larger regional co-operation, has a lot of merit to it. So if the LHINs evolve in some way that the Ontario Smart Growth had the opportunity of evolving—and maybe still is; I'm not sure—then I would be supportive.

0920

Ms. Scott: Have you been told where your office is going to be?

Mr. Gamble: My understanding is that it's going to be in London.

Ms. Scott: Where did you get that direction from?

Mr. Gamble: Ministry staff.

Ms. Scott: You haven't read any legislation or anything that gives you what your powers and responsibilities are going to be as chair.

Mr. Gamble: I've read a profile of what the chair's responsibilities would be. That started with the newspaper ads that were placed early this year. Any other information, such as the bulletins on the Web site, seem to just reinforce that same role again and again. That's where I've read it.

Ms. Scott: So there has been no official legislation or anything that you've read; it's just through the Web site.

Mr. Gamble: I'm not aware of what the legislation—all I know is that I'm here as a nominee and that more information would follow if the nominee is successful.

Ms. Scott: We'd like to see more information also.

Who have you been told that you're going to report to?

Mr. Gamble: From what I've read, the chairs would report to the minister. The chairs effectively report to their boards too, but my understanding is that the chairs would report to the minister.

Ms. Scott: So would the minister have final approval on all the recommendations that came from yourself and the board? Have they told you?

Mr. Gamble: I don't know that level of detail.

Ms. Scott: So you don't really know who you're going to report to, other than the ministry in general.

Mr. Gamble: I know that the intention is that the ministry would sign a memorandum of agreement with each LHIN, which would outline the expectations of the minister and the ministry. Presumably, that's the means of reporting, by that memorandum of agreement.

Ms. Scott: Thank you very much. I believe I'm out of time.

The Vice-Chair: Yes, that's it. Thanks very much, Ms. Scott.

First of all, I'm going to apologize. Someone was supposed to be sitting in for me for the third party questioning, but unfortunately he took ill, so he's not here this

morning. I apologize for that, and hand it over to the government side for any questions.

Mr. Brown: Good morning. I really don't have any questions. I would just like to thank you. I've looked at your qualifications. They look like they will fit the bill. It looks like you've had a lot of expertise at bringing people together, and that is something that will be required in this particular enterprise. Thank you very much for coming.

The Vice-Chair: That's all there is, Mr. Gamble. Thank you very much for coming in this morning. What happens now is that we will continue interviewing for the rest of the morning. Around noon, probably, we'll be wrapping up, and that's when the final vote will take place. You have options: You can stick around for the rest of the morning with us or you're free to leave at any time. But thank you very much for appearing this morning.

Mr. Gamble: Thank you, Madam Chair.

FOSTER LOUCKS

Review of intended appointment, selected by third party: Foster Loucks, intended appointee as chair and president, Central East Health Integration Network.

The Vice-Chair: Our second interview is with Foster D. Loucks, the intended appointee as chair and president for the Central East Health Integration Network. You can come forward, Mr. Loucks.

Thank you for joining us. Welcome. As you make yourself comfortable, I'll take you through the process, which you've just seen, actually. You will be given a few minutes to make an opening presentation if you choose to do so. Subsequent to that, we will go around the table in order, starting with the government side this time, asking various questions of you. Each party will have about 10 minutes. Any time you take for your initial statement will be deducted from the government side. Other than that, I think you've seen the process. I hope you're comfortable, and welcome again. The floor is yours.

Mr. Foster Loucks: Thank you very much. I appreciate the opportunity to meet with this committee. It's a new process for me, and I welcome it. I assume that my CV has already been presented to you. That provides you with some of my background, but I would like to spend a few minutes to highlight some of that and try to give the committee a sense of who I am and why I hope I'm acceptable to the committee as the chair of the Central East LHIN.

First of all, I'd like to start by saying that I was born and raised in Haliburton county. My family roots go back to the early pioneers in that area. Haliburton is the most northern part of the Central East LHIN, and so I'm pleased that there will be someone who in a sense has an understanding of the rural part of the area that Central East will serve.

I'm proud to be able to say that, along with my twin sister, I was born in the original Red Cross Hospital in the village of Haliburton. In those days, I suppose we allowed risk that would be unthinkable today: twin babies born to a 40-year-old woman in a setting without surgical backup and, in those days, at least 90 minutes from the nearest larger hospital, in contrast to the options available today, including ultrasound, amniocentesis and the ability even to control the timing of the birth. My mother suspected, but did not know, that she was expecting twins, and all of this in a setting that numbered, in beds, on less than two hands. I don't recommend this level or standard of care, of course, but I wish to underline by way of this example just how far the delivery of health care services has progressed in Ontario over the years, and that includes Haliburton county.

If I could for a moment, I'd like to keep my comments personal. You see, I was born with an inherited genetic disorder known as hemophilia, sometimes referred to as the bleeder's condition. I have severe hemophilia. I raise this as a matter of interest to the standing committee for three reasons.

First, it has meant that I've had a lifetime as a consumer of health services. I realize that we're all consumers of health services, or most of us will be at one time or another. But since infancy, I've had a relationship with the health care system that's up close and personal. I bring to the LHIN, therefore, the knowledge and experience of the patient viewed not from the bedside but from the bed. This is a learning position that I'd recommend to any health care professional or administrator at least on occasion.

Secondly, my chronic illness has led me to see the need for the various parts of the health system to work together. Remember, I grew up in Haliburton, and Haliburton is not known for its academic health sciences centres. It was crucial, in managing my episodic bouts of bleeding, that one hospital worked with another and that the health professionals knew and accepted their individual roles and expertise and that they were prepared to work within the framework of a team.

Thirdly, it has left me with a profound respect for the Canadian system of universal health care. I am alive today because my life has coincided not only with the remarkable advances in medical research but also with the initiation and development of publicly funded health care. My family was not born with silver spoons in their mouths, so you can appreciate why I'm grateful for having the good fortune to have been born a resident of Ontario and Canada.

Now I have the opportunity to help to ensure that what I believe is the best health care system in the world is sustained and survives. With your approval, I hope to serve as chair of the Central East Health Integration Network.

0930

My career has also been focused on health care. In acute care, I have served as the chief executive officer of hospitals in both Ontario and Nova Scotia, and in each of these cases, it involved pulling divided communities together so we could get more efficiencies and a better quality of care. In each of these cases as well, the range of services in small communities usually led to models of

integrated care in a natural kind of fashion that included supportive housing, social services support, diabetes care and programs focused on prevention, as well as acute services such as surgical and medical programs and emergency care.

Long-term care was also a part of the facilities I managed, so I had the occasion to look after chronic care units, as they were called at the time; today, they would more likely be referred to as complex continuing care. I've had the opportunity, as a senior manager, to lead a chronic care hospital in Scarborough at the Providence Villa and Hospital. As the administrator of the Lakehead Psychiatric Hospital, I was responsible for nearly 80 patients who suffered from psycho-geriatric conditions.

In addition to my experience at Lakehead, early in my career I worked at the Oak Ridge division of the mental health centre in Penetanguishene for about five years. In addition to this institutional experience, I've had the responsibility for the development and oversight of community mental health programs. In northwestern Ontario, I initiated and led a mental health network covering all of Kenora–Rainy River and the Thunder Bay districts.

More recently, I've had the chance to chair the Haliburton, Northumberland and Victoria Community Care Access Centre, which has enabled me to round out my knowledge of the community health sector and its pivotal role in the integration of health care service delivery. I also served as the executive director of the Thunder Bay District Health Council in the mid-1980s. So I've had plenty of exposure to broad planning functions.

I suppose no resumé is complete without reference to volunteer work, which I've done. In my instance, it includes sitting on the board of the Ogden East End Community Health Centre in Thunder Bay, the Thunder Bay Family and Children's Services, sometimes referred to as children's aid. I guess it's not referred to in that way any longer, but it was at the time. I've also been a founding member of the board for the branch of CUSO in Thunder Bay, and I served one term on the Ontario Hospital Association board of directors. I currently am the vice-chair of Sir Sandford Fleming College.

I suppose it's fair to say that I'm aware that my experience will mean little if I'm unable to bring other assets to the board, so I conclude by saying that I believe I have qualities that may be especially important as LHIN chair. I'm thinking of my diplomacy and tact, my patience, my ability to think systemically, my ability to listen and my ability to find middle ground. I have a sense of teamwork. I'm serious-minded, with a dash of humour.

I'd like to thank you again for this opportunity to meet with you today.

The Vice-Chair: Thank you, Mr. Loucks. You've taken up most of the 10 minutes. If there's a comment the government side wants to make, that's fine, but we've pretty much run out of questioning time.

Mr. Lorenzo Berardinetti (Scarborough Southwest): Just very briefly, Madam Chair, if I may.

I want to thank you on behalf of the committee and myself for coming out today and for applying for the position. I notice that you had some connection with the Providence Villa and Hospital in Scarborough. You don't need to comment, but it's an excellent facility located in my riding. I'm glad you were there, and I'll let the people who are there now know that you came out today to continue to work for the community here in Ontario. Thank you.

The Vice-Chair: Now it's time for the official opposition.

Mr. John O'Toole (Durham): Thank you very much. Sorry I missed some of your presentation, but I'll just share the time.

I'm quite familiar with the central-east area, and I just want to make a comment here. Central-east stretches from the towns north of Haliburton and south to the 401 and to Warden Avenue and eastward to Brighton. This is a comment by Bette Hodgins, who's involved in Lakeridge, Port Perry: "Even with the best of intentions to engage local communities, it would seem an impossible task to keep abreast of local needs, never mind responsiveness to them." Could you comment on the central-east dilemma, with its very large, diverse and growing population, with the traditions based in not just the integration of services that the LHINs are attempting to do, given the fact that on a per capita basis, they're probably the lowest-funded in all areas, from mental health to children's services to hospital services on a per capita basis ranging in the hundreds of dollars. How are you going to deal with this large area? Do you have any comments at all?

Mr. Loucks: Certainly I'd agree that it is a very large area; not the largest geographically in the province, of course. The northwest, I'm sure, would take that honour, but in terms of population, it will be the largest LHIN. I think that's going to present a challenge for us, but I think it's going to be a matter of designing and putting in place mechanisms in order to get the input we need. By that I mean pulling together people with common interests, and that could be around certain disease entities; it might be around certain functional roles. In that way, I'm hoping that we can develop systems and mechanisms to garner input from the grassroots and filter that up.

Mr. O'Toole: There's been much work by the district health councils, and there's been much work by governments of all stripes, from multi-service agencies, which was the NDP plan, down to the role to the CCACs. As far as patient intake and case management, do you see an integrated role here for the CCACs to bring community-based services into a much more coordinated—whether it's respite services or palliative care services. All these services and seamlessness in health care are extremely critical and they're very community- and often voluntarily driven. Is this a manageable task, given the population growth and size, or is this just more centralization by another name?

Mr. Loucks: I don't think it would be fair to cast it as centralization, because I think what we have now is a

centralized model with the whole province in a sense being centralized through the ministry. To comment on what I think I hear you saying about the access centres, I think they're going to have an absolutely pivotal role in pulling together some of the functions you're referring to, but particularly trying to pull together the inputs of a lot of the other community service groups. Sometimes those might include self-help groups. I'm hopeful that far from centralizing, we'll actually be able to get more input from some of those groups, which in our current system often get lost in the shuffle because the bigger players get to dominate the show, if you like.

Yes, I suppose we could have had double or triple the number of LHINs, but I think, if I understand the way regionalization has worked in other sectors, including the municipal sector that we were just hearing about from the previous interviewee, it has to be of a certain size. Whether central-east is going to turn out to be too large or not, I think time is going to tell.

Ms. Scott: Thank you very much, Mr. O'Toole, for coming; you have such great interest. I've known Foster for many years and can certainly vouch for his contribution to the medical community and the community in general. He's just been a tremendous citizen and contributor to the health system. So thank you, Foster.

I'm pleased he did mention Haliburton, and it is the farthest geographical spot that we have in the LHIN in the concerns that were brought by Mr. O'Toole. Being a nurse in Lindsay, in kind of the middle of health care, I've been closest to admin in Haliburton hospitals, where I live. I've been involved with the health care system for a long time in my riding. When I saw the central-east LHIN being created, I saw Scarborough hospitals in our mix. That's not a place where we usually send patients. We usually send them to Toronto or to Kingston.

I guess my question for you, Foster, is, how do you see the boundaries of the LHINs? Can we cross boundaries easily when we need to send our patients out to care centres that are not within the proposed LHINs?

0940

Mr. Loucks: Thank you very much, Laurie, for your welcome. I do appreciate the opportunity to meet with you in this setting, as I have in other settings in the past.

It's my understanding that there's not going to be any restriction on where patients can seek care. As a case today, just because there's a boundary line along County Road 30, or wherever it is, between Durham and York, that doesn't mean that a patient has to seek care there. In terms of how that funding will then work, we'll have to work out those mechanisms later on. Whether a patient needs to get specialized care in Toronto or has a GP in some other area, it's not going to make any difference.

Ms. Scott: I'm pleased to hear that, and I hope that is certainly the case when it comes to delivery of care for the patients.

Because I have Foster here, I'll do a few riding-specific questions. We have a cardiac rehab facility. We had a pilot project in Lindsay, and it was a good central area for our catchment to go to. Now the Lakeridge Health Corp. in Oshawa is going to be the only deliverer of cardiac rehab care. Do you think there are going to be possibilities for a cardiac rehab centre, for example, or other rehab centres or cancer care satellite spots to be done, instead of going to where they're designated as the centre? The distances for our patients to travel at the further part of the LHINs—do you think there would be some flexibility in that? I brought it to your attention; I didn't know if you knew it existed. Maybe within the board there's going to be some flexibility. Hopefully, with the ministry, we can get those satellite services or something closer to home.

Mr. Loucks: I don't know that I can comment on the specifics of any particular region, because I'm not close enough or familiar enough with it. I think the flexibility that's going to be needed is going to be driven by our stakeholders. What I'm hoping is that we can develop mechanisms for that input, and that it's done on a collaborative basis.

There's always going to be a need to balance. You need to have enough patients in any particular area to justify and to keep the expertise of professionals and specialists up to a certain standard. You can appreciate that we're not going to be doing heart transplants in the Haliburton hospital in the near future. There are economies of scale that also have to be balanced against the issues of access and geographic proximity. I would think that our board will be taking those kinds of considerations into account, both the geographic proximity and how many patients it takes to keep the skills of a particular specialty in surgery up to a certain standard. Of course, the cost is a major factor in that as well.

Ms. Scott: We'll be looking for those processes to happen. Being the chair, I was wondering if you had been given any reference from the ministry as to the organizational structure of the LHINs, the human resources policies? Do you have the ability to hire and fire staff within the LHIN itself, set staff salary ranges or approve individual staff salaries? Those are many questions, but have you been given any direction as to what your authority is going to be as the chair?

Mr. Loucks: I just have a broad direction in terms of what the role of the chair will be, and that material is on the Web site. I am not expecting that, as a board, we will be directly involved in the hiring of staff, apart from the CEO, which is the traditional role of the board. They hire the CEO; the CEO hires the others.

From what I've read, I think the ministry is trying to make every effort to standardize the size of the LHINs, the number of staff, and there's an expectation, as part of this community consultation and getting the input we need from stakeholders, that we will try to use some of the resources that are already in the field.

Ms. Scott: Have you received direction as to whom you will be reporting to?

Mr. Loucks: It's my understanding that the reporting relationship, if you like, is one to the minister, by virtue of the appointment being through an order in council.

That's my expectation, that it's a relationship to the minister of the day.

The Chair (Mr. Tim Hudak): Thank you very much—

Ms. Scott: I'm out of time. I was just going to thank Foster for coming.

The Chair: Excellent. To the third party.

Ms. Andrea Horwath (Hamilton East): Thank you, Mr. Chairman. We're playing musical chairs here this morning, but it gives me an opportunity to ask a few questions.

I wanted to ask you about some comments that the Minister of Health recently made regarding the rationalization of surgeries in hospitals. You just talked about open-heart surgery not being something that would likely happen in Haliburton hospital. The minister said it would likely be the LHIN's responsibility to take on this rationalization process. I'm just wondering, if that was assigned to you as a job to do, how would you tackle it? How would you go about trying to rationalize surgeries?

Mr. Loucks: I don't know about the surgeries. But whether it's surgeries or the medical management of other diseases, I think we have to start out trying to free up some hospital capacity so that hospitals are not trying to be all things to all people. In saying that, I don't really want to fault hospitals, because I think we have expected that of hospitals over the years. Hospitals have had to be the safety valve for gaps and shortcomings in the health system. The emergency room always had to be open and so on and so forth. In fact, increasingly, primary care has taken place in the emergency room.

To me, it's a matter of being able to free up some of the capacity that hospitals have by developing primary care systems. If we can do that on the front end, where patients are coming into hospital, and if we can do it on the other end when we're trying to get patients out of hospital, the hospitals will have a better ability, through greater resources, to conduct increased surgeries and other forms of care.

I'm not sure that's actually answering your question, but I think it's got a lot to do with setting the stage so that surgeries, if not rationalized, perhaps can be done in more instances closer to home.

Ms. Horwath: Can you describe what you would see as the major health care issues for the region? I think both Mr. O'Toole, when he was here, and Ms. Scott indicated the size of this particular LHIN as being a concern. What would you say are the major health care issues or concerns for the area?

Mr. Loucks: My sense of it is that one of the major issues is the distribution of health professionals, and not least of all physicians. I don't think that's as big a problem in Scarborough or in parts of the GTA that are part of the Central East LHIN, but it is a problem outside of the Toronto area. So I think being able to get physicians not only into the most northern part but also into good-sized centres like Peterborough and Lindsay is one of the big problems that we face.

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Ms. Horwath: Any ideas about how to try to resolve that particular challenge?

Mr. Loucks: Well, I've been serving as the chair of a recruitment committee, and I guess if I had been really successful, I could point to our successful ideas. I think these days it's a matter of being able to create the conditions for practice that are attractive to younger doctors. Younger doctors—newer graduates is perhaps the way I should refer to them—don't want to have to work night and day, seven days a week. They expect to be able to join a team, they expect reasonable time off like other people and they expect to be able to have a normal life. They're looking for practice settings where there is a team of professionals, including other doctors, so that things like being on call are more reasonable.

What I think will work best is something along the lines of the family health teams. We haven't seen what the outcome of the family health team concept is going to be, but I think it's that model that will, in the end, in the longer term, solve some of the problems we face now.

Ms. Horwath: We've already been through the fact that there are going to be three members initially: the chair and two others. What kind of process do you think is best to be able to build the rest of the board of the LHIN?

Mr. Loucks: It's my understanding that the minister and his staff are going to provide the input for perhaps the next three of the board and then, after that, they will work with us to see who else should be added to the board, up to a maximum of nine. What I would like to see in the long run is that, broadly speaking, we have representation from the different parts of the area, without that representation being directly tied to any particular interest group or any particular municipality.

Because our board is going to be relatively small and the geographic area that we're serving is relatively large, I would like to think that we would have a dispersion of our members from around our area, from around the Central East LHIN, not least of all so that those board members can take a lead in their area when it comes to community consultation and engaging the stakeholders in that area. As one member and as the chair, I'm not going to be able to get to all of the meetings that I should be attending, so as a board we're going to have to work together to see that we're present at meetings and community engagement events that we should be attending.

Ms. Horwath: Do you have any other languages? Are you unilingual or do you speak French?

Mr. Loucks: At this point I'd have to say that I'm unilingual. At one point I had thought I might be able to learn and keep up my French, but I can't now.

Ms. Horwath: It's just that the advertisements and the applications, I think, talk about the preference for bilingual candidates, but that's fine.

We didn't ask any questions around your political beliefs or where you lean. Are you a member of any political party?

Mr. Loucks: I'm not a member of any political party and I have voted the spectrum and vote the candidate.

Ms. Horwath: Do you have a history of donating to any particular political party?

Mr. Loucks: I don't. I realize that it's a tax advantage, but I haven't done so.

Ms. Horwath: Thanks very much.

The Chair: Mr. Loucks, thank you very much for your appearance before the committee. As you probably know, we move to our votes at the end of the session, so probably between 11:30 and noon, I would think, would be the time. So please stay and enjoy the show.

Laughter.

The Chair: I don't know why people laugh at that. It's entertaining.

The Chair wishes to recognize Mr. Brown. It's nice to have a senior member joining us in the captain's seat on the government caucus. Mr. Brown, welcome.

I also want to thank my Vice-Chair, Ms. Horwath, for filling in very capably today. In fact, she has attracted a much larger audience than we usually get with the usual Chair. Andrea, thank you very much for pitching in. It's much appreciated.

MICHEL LALONDE

Review of intended appointment, selected by third party: Michel (Paul) Lalonde, intended appointee as chair and president, Health Integration Network of Champlain.

The Chair: We'll move now to the next intended appointee, Michel (Paul) Lalonde. Monsieur Lalonde, bonjour. Bienvenue. Welcome to our standing committee. Do you prefer Paul for the record, or Michel?

Mr. Michel Lalonde: Michel.

The Chair: Super. Monsieur Lalonde is the intended appointee as chair and president of the local health integration network of Champlain. Monsieur Lalonde, make yourself comfortable. I think you saw the procedure that we follow here. You're welcome to make an opening statement about your interests and your qualifications, and then each party will share time with any questions they have for you, beginning with the official opposition. Monsieur Lalonde, the floor is yours.

Mr. Michel Lalonde: Thank you, Mr. Chair, for allowing me to be here today. I have prepared an opening statement. It will last only three or four minutes. I will guide you through this.

First, Mr. Chairman, I'd like to say that I'm honoured and privileged to be nominated to serve as the founding board chair of the Champlain health integration network. For those of you who don't know what territory Champlain covers, it's the Ottawa Valley from Pembroke in the north to Hawkesbury in the south, from Cornwall in the east to Arnprior in the west. It serves a population of roughly 1.1 million people. I appreciate the government's trust and look forward to the challenges ahead in serving the citizens of our region.

My experience in serving the Ontario health care system spans a period of more than 30 years, always in senior executive roles, starting with the position of associate executive director at l'Hôpital Montfort, one which is well-known by all; an additional five years as vice-president of the Ottawa Health Science Centre; and finally, 17 years as chief executive officer of the Hawkesbury and District General Hospital. I don't want to repeat the major achievements that are stated in my curriculum vitae, but I would like to highlight some experiences and traits that I will bring to the Champlain LHIN that are directly related to the necessary qualities that will lead the board and its partners in achieving success.

In my years as chief executive officer, I made it a point to constantly remain abreast of leadership and management developments by continuously learning and adapting the skills of management to the requirements of the changing times. As an example, after learning the skills of teamwork, and with the support of the senior management team, we transformed the traditional organizational structure to a team approach, by which the decision process for the delivery of care and services was transferred to the front line, to the clinical teams composed of physicians, nurses, technicians and support staff. It required a great amount of trust and commitment from everyone in the organization. We truly became a patient-centred organization through this effort.

The continuing learning process gave our organization a leading edge in making our hospital a learning organization. This creative and unique initiative in health care led us to obtain a five-year pilot project, sponsored by the government, for the hospital-in-the-home program. Ten years after the establishment of this program, it's still in operation. It was highly regarded by staff, patients and families in our community. This experience became a means for every team leader and team to use resources efficiently. It was a win-win situation for the community and for the hospital.

This type of leadership practice by senior management and clinical teams opened new frontiers and new opportunities to do more with less and make every team in our organization part of our accomplishment and successes. In 17 years at the Hawkesbury and District General Hospital, we always managed to balance the budget, year after year, and in fact used the surpluses to attract physicians and buy new equipment.

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As a final note, I would like to take you back to the late 1990s and the Ontario Health Services Restructuring Commission, at which time our institution, as a result of the restructuring plan, proposed to integrate the management and support services of two community hospitals—Hawkesbury and Winchester—with the partnership of the academic health sciences centre to provide secondary and tertiary care in a cohesive manner to our communities and form an association similar to what is proposed by this government in terms of an integrated system.

Integration is not a new concept. As you are well aware, Ontario is the last province to move in this direction.

Changing times, the complexity to deal with numerous health care structures and silos, the need for a coherent and coordinated management and clinical information system, and the importance of involving the citizens of our community in the planning process and providing them with a report card on how well we serve them are only a few of the challenges that await us at local health integration networks in Ontario.

Governance as leadership has taken the centre stage of our systems and organizations in the private and public sectors. There must be a shared sense of the nature of the work and enough common knowledge to do the work together, and good governance will drive leadership and accountability. We need to work wiser and smarter.

I believe that the success or our Champlain LHIN lies in the creation of a renewed relationship with all our partners. The local board and management of each health care institution and agency in Champlain region, physicians, professionals and, most of all, the citizens of our communities need to be a part of the creation of a vision of health for our region.

I believe that through devolution to local LHINs we have a tremendous opportunity to become masters of our destiny in our health care system and make the difficult but appropriate and necessary decisions on a local level. Based on a set of standards and measures, the providers will be able to manage the system effectively and efficiently and facilitate the development of a continuum of care for all patients in our community.

I believe that the health care providers, agencies and institutions in Champlain are ready and willing to take the necessary steps to achieve integration, which will result in improving access to our citizens, a higher quality of care and services and, most of all, the sustainability of our system for the next generation.

I believe in the supremacy of values guiding organizations, such as trust, respect, empathy, openness and accountability. Those values will support our vision and mission.

I believe that the process of establishing the LHINs will be evolutionary. The Champlain LHIN's philosophy must be inspirational in nature, and continuous learning for everyone must be an integral part of its role.

The Champlain local integration network will position itself to be a leader in the process, and as chair, my wish is to make a genuine contribution to the health care system and make a difference in serving my community.

The Chair: Thank you, Monsieur Lalonde. Obviously you put a lot of thought into your presentation. We appreciate it. We'll begin any questions we have with the official opposition.

Ms. Scott: Thank you, Mr. Lalonde, for appearing here before us today and giving us your background.

When you first applied, you applied as a director, I believe, at the LHIN.

Mr. Lalonde: Correct.

Ms. Scott: How did this evolve that you're now a potential appointee as chair? Can you tell us a little bit about that?

Mr. Lalonde: First of all, my interest in applying to the LHIN was in a role specifically tailored to someone who is retired, with lots of years of experience and a passion for health care. The fact that it required a bilingual individual knowledgeable in health systems proved to be an asset to me. I guess it was seen in Toronto as that possibility.

I was approached by the minister to see if I had any interest in letting my name stand for the position of chair. It didn't take long for me to accept the challenge, especially with the honour and privilege. I didn't necessarily see myself as the chair, but I am certainly willing to try out the task.

Ms. Scott: So Minister Smitherman approached you to be chair specifically.

Mr. Lalonde: Correct. Yes.

Ms. Scott: Have you seen any legislation in regard to the LHINs?

Mr. Lalonde: No, none.

Ms. Scott: Have you seen the latest bulletin that came out on May 16? I know it's just—

Mr. Lalonde: No, the last bulletin I have is bulletin 11, May 1, in which it describes the role of the board and the CEOs.

Ms. Scott: Were you able to do a lot of investigative work about the role of the chairs? There's limited information out there; I realize that. But I didn't know if you were able to access more information or have been speaking to the minister—

Mr. Lalonde: Other than what appeared in the paper as the role of the chair and directors, along with the white paper published by the OHA and other write-ups—I understand extremely well that the process, first and foremost, is to have us go through this process of order in council to get our position appointed, nominated, before we do anything. I realize extremely well that it's an evolutionary process and that we first need to go through this particular process here of appointment before moving on to find out the details. But I imagine that as a board chair, the board and the relationship to CEOs and to the minister will evolve as time goes by.

I read an article in the Ottawa Citizen not too long ago that said it's like buying a new car without a manual. Well, I hope the manual's not written, because the system is changing so fast, and we need to adapt it to the times and need to involve, more than just the government, the people of our communities in making sure that this system is going to work.

Ms. Scott: I am concerned because the district health councils are now dissolved and there is a gap in the system right now for the delivery of health care. Who is guiding the delivery of health care in all the areas we have? Foster Loucks mentioned that the access centres are going to play a key role. I've been certainly communicating with mine about their comfort level of what we know of as transpiring so far. Do you have any comment, once you get your letters of patent, about what your first priorities are going to be and when you're going to get up and—

Mr. Lalonde: Personally, my sense is that it's going to be so much, as I said in my presentation, the human side of organization that needs to be dealt with. I know there's a lot of fear out there and there's a lot of unknown, and that's common with change. But one will certainly be to create a new culture, a new relationship with the partners, because we will be using what's in place now. The structure is not going to be destroyed and rebuilt. But in terms of what's in place right now for the planning of services, whether it's French services or bilingual services or any health care services, it needs to be addressed by everyone, not just by the LHIN. LHIN is basically an organization that will plan, coordinate, integrate and standardize things. Eventually, maybe in two or three years, according to the writings so far—it may take two or three years before we get any responsibility relative to funding.

The knowledge is out there. The DHCs are no longer in existence, but the knowledge is there. The corporate knowledge is still continuing on. I have had the pleasure to meet with the outgoing executive director of the DHC, and I know where to get at the information. It's also, I imagine, at the ministry level.

Ms. Scott: So you feel that you're also going to be reporting directly to the Minister of Health and Long-Term Care? Maybe you could also comment—I've asked the question before—on what you see, as a chair, your actual authority is. Is it going to be hiring the staff, the organization structure? Have you been given any education, if Minister Smitherman has spoken to you directly?

Mr. Lalonde: Not really on that. I'm waiting to see any change in the legislation for this to happen. But I imagine by delegation some of the duties can be put into effect relatively quickly, to at least set up shop, as we say in our community, to make sure we build up the process of getting everyone on board and hiring the executive director and so on. But still, the primary concern right now is to get the three positions approved through an order in council. After that, we'll become very curious if we're successful.

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Ms. Scott: Were you given any indication of how much the position pays?

Mr. Lalonde: I have declared to the minister that I will refuse any payment for this position. I owe too much to the system, having been a cancer patient twice in my life, over a period of 20 years. I have too much honour to the existing board of health care organizations. To keep credibility, I cannot accept any remuneration for any position, even though for the first six months to a year it may be a full-time position. I have reached a level in my life, at 62 years old, where I can afford to do so. I intend to do so in the normal fashion that has been accepted by the Ontario health care system for decades.

Ms. Scott: That's a very generous statement that you've made.

Mr. Lalonde: No, it's a principle.

The Chair: You're still OK. You have about two more minutes.

Ms. Scott: Where do you see the location of your office as being? You have a large LHIN; I take the claim for the largest LHIN that's going to be created. It's central east.

Mr. Lalonde: I'm dying to learn.

Ms. Scott: So you don't have any knowledge of where your potential office will be.

Mr. Lalonde: I have no idea.

Ms. Scott: Where do you think the needs of your community are? We've certainly heard a lot about doctor shortages. Do you have any indication of where you think that—

Mr. Lalonde: Well, it's a national problem. I think, as Michael Decter of the national council on health has stated, that one of the four problems is certainly manpower; not just physicians, but all professionals in health care. I think we'll need to address this, along with the necessity, if we wish to achieve integration, to make sure that we have an information system that will allow us to measure so that we can make appropriate decisions based on logic, not just on perception.

Ms. Scott: That's all. Thank you very much.

The Chair: The third party.

Ms. Horwath: Welcome. One of the first questions I have for you is around services in French. Are there any challenges there? Do you think there's enough opportunity for people to receive health care services in French? What's your assessment of that?

Mr. Lalonde: Well, with the establishment of Bill 8 on language issues in Ontario, we've been fortunate enough to have a network, Réseau des services de santé en français, located in Ottawa. It was mandated by the previous government to ensure the designation of each health care organization in the province, but specifically in our area, in Champlain. They have done so quite successfully. In fact, I was on the initial board of the Réseau des services de santé en français and saw the progress reports and the role that they played along the line.

Of course, there's always going to have to be particular attention paid, not because French service is a problem; French service is an opportunity—really, they are part of the solution, not part of the problem. I've contacted key individuals at the Réseau and also at the Montfort Hospital to make sure that we're on the same wavelength. I know right now that the health resource team established by the ministry is specifically looking at that and will come out with a policy direction in relation to how this will occur facing the LHINs.

Ms. Horwath: I wanted to ask you a question about rationalization of surgeries or procedures. If I were to use an example, for instance, of hip and knee replacement surgeries, the minister said that maybe we should be rationalizing these, to have fewer hospitals undertaking those kinds of procedures so that those hospitals would then have larger volumes and economies of scale. Therefore, the expertise of the doctors would be there, and they'd be handling those large volumes. Any opinion on that particular idea?

Mr. Lalonde: It has begun to happen in our region in the sense that because of the five priorities set by the government in resolving issues, such as hip and knee replacement, cancer, heart, MRI and CAT scans, and cataracts, they've given a memorandum of understanding with certain organizations that if they can afford to do so many more, they will pay them according to an arrangement that they have come to with each organization.

Integration is occurring on that basis and it needs to occur on a wider basis, but to be able to analyze all sectors of health care, we need to have an improved information system. That's key to making sure that integration will occur. That kind of thing will happen not just in hip and knee, cancer clients or whatnot, but throughout the sector. It needs to happen.

Ms. Horwath: I'd like you to talk a little bit about your vision for your LHIN. There are going to be a few people at the beginning and then the organization will build from there. Any vision for that? Can you share any kind of vision on how you'd like to see your LHIN develop, both in terms of strengths for different people you'd like to see as part of the board and then also organizationally?

Mr. Lalonde: As previously expressed by my colleagues, it's pretty well along the same lines, a wait-and-see kind of situation where we'll see what the ministry expects to do. I think the most important element that we know from bulletin number 11 is that their right of approving the appointment of the CEO is going to be one of the first jobs of the chair. I think this is a crucial element, because I can't see why our board chair would not participate in making sure that at least the vision and the capacity to work together with the executive director has got to be a perfect relationship; otherwise it won't work. I think that is a possibility.

In terms of other members of the board, I hope that the ministry will look to us also for some direction or some recommendations or suggestions as to what kinds of members we want to see on the board. Certainly, one that I appeal for is to have board members who are willing to work in teams and not individually. It's a skills-based board that I hope will be happening, and I guess that's the direction that the ministry wants to take.

Ms. Horwath: OK. In terms of the executive director and other staff, would you then as the chair see yourself being the person to do hiring and firing, that that would be your—

Mr. Lalonde: The executive director, yes.

Ms. Horwath: And then other members of the organization would—

Mr. Lalonde: No. The only role that the board needs to relate to is the executive director.

Ms. Horwath: You've talked a lot about your belief in integration, your strong belief that that's the direction we need to go. You've indicated that you feel that's already beginning to happen in many ways in your region. How do you see your role as speeding that along or ensuring that that happens? What kinds of strategies will you be able to use, or do you envision using, to move that process along?

Mr. Lalonde: Certainly, a lot has to do with the kind of relationship we need to have with our partners, whether it's hospitals, CCACs or other kinds of agencies. It is crucial that we make them feel comfortable with the concept. The concept of integration is not new; it's here to stay. It's not just a buzzword that's going to go away. To me, it's a survival kind of mode where, if we don't integrate, that is, for the ultimate purpose of delivering good care, of having sustainability, of having access for our patients to a system, and use our resources in the most optimal way, we won't get it. It's only through that concept of integration that we can achieve this.

Literature from Shortell to many others has demonstrated this quite clearly. Each province has its own model. The Ontario model is very good because it involves people. It didn't collapse all the boards; it respects the entities. I think we just have more people committed to the same goal, and this is crucial. If there's anything that we need to work on as a board, number one is a common vision. To have a common vision, you have to involve everybody, from the community to the partners, and hopefully eliminate the silos and the personal agendas and the self-interest in the system. That's what needs to happen. We need to focus on the community, which is our ultimate to stewardship goal.

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Ms. Horwath: How do you get over that, though? How do you see the way to get people to put their self-interest aside? It's got to take some particular skill.

Mr. Lalonde: If I look at what happens in other jurisdictions, I can see what led to a change in culture. You change culture by responding to the question, "What's in it for me?" Sometimes, it's through plans that will recognize contributions or through incentives of all sorts—not just monetary incentive, but all sorts of incentives that make people feel proud about what they do and how they do it, some kind of recognition. There's a lot of human element in making change happen. In all the documentation and all the readings I did on integration, the first step is through the hearts of people, making them know that whether you're in Hawkesbury or Pembroke, we're still serving the 1.1 million population. It has a human appeal to be able to serve and to recognize our true role as servant of the community. That's what stewardship is all about.

The Chair: To the government side.

Mr. Brown: Thank you, Mr. Lalonde. We on this side have listened very carefully to your presentation and to your interaction with my two colleagues. We're very impressed. I want to thank you.

I agree that this is an evolutionary and devolutionary process and that it won't be easy. There are interests out there that need to be contended with, but we have every confidence that you will lead this particular LHIN in a fashion that is extraordinary. Thank you very much for putting your name forward.

The Chair: Mr. Lalonde, thank you very much for the presentation. Please stick around. We'll get to our concurrence votes between 11:30 and noon.

GEORGINA THOMPSON

Review of intended appointment, selected by official opposition and third party: Georgina Thompson, intended appointee as Chair and president, South East Health Integration Network.

The Chair: Our next intended appointee is Georgina Thompson. Ms. Thompson is an intended appointee as Chair and president of the South East Health Integration Network. Welcome to our committee. I think you've seen how we work. Just make yourself comfortable. You're welcome to make a presentation about your interest in the position and your background. I'll begin any questions with the third party and do a rotation. The floor is yours.

Ms. Georgina Thompson: Thank you very much, and good morning. Mr. Chair and committee members, I am pleased to appear before you this morning as a nominee to the Chair position of the LHIN for southeastern Ontario. As you may or may not have had a chance to review my CV, I thought it would be helpful to give a brief overview of my work and volunteer history to this point.

Since 1970, I have been in the health care system as a hospital nurse and as a hospital supervisor. From 1970 to 1975, I worked as a registered practical nurse in a psychiatric hospital in Nova Scotia. In 1978, I was a graduate of the diploma nursing program at Loyalist College. From 1978 to 1981, I was a registered nurse at Belleville General Hospital, which is now known as Quinte Health Care.

From 1981 until just recently, I was president and director of care at All-Care Health Services, a private nursing and home support community agency. From 1981 to 1989, I was the founder and executive director of the Regional Hospice of Quinte, which was the first five-bed freestanding hospice in Canada. From 1990 to 1996, I served as governor, and in the last year as vice-chair, of the board of Loyalist College, and was re-elected in 2003. In 2002, I achieved my bachelor of nursing science from Laurentian University.

From 1992 to 1996, I was a board member for the Ontario Palliative Care Association. In 1994, I was chairwoman of the United Way fundraising campaign. From 1989 to 1995, I was a municipal councillor in Thurlow, where I presently live. From 2001 until recently, I was a member of the local health care network for Quinte and the rural health science network of southeastern Ontario. From 2003 to 2005, I was an elected councillor in the city of Belleville. In 2002, I was businesswoman of the year for Hastings and Prince Edward county, and in 2003, I won the Harry Jerome award.

Finally, it is my belief that my work and volunteer background has allowed me to gain a grassroots perspective of the health care needs in the region I propose to serve. I believe it was these qualifications that achieved the title of nominee for a LHIN position. It is my hope that as a committee, you will see the positive attributes I can bring to the board.

Thank you. I welcome your questions.

The Chair: Ms. Thompson, thank you very much for the presentation on your background and interest. We'll begin any questions with the third party.

Ms. Horwath: I've asked the other interviewees, and I would like to ask you as well, the process by which you would undertake rationalization of services in hospitals, particularly surgeries. The last one I used as an example was hip and knee replacement surgery. What would you see as the way to achieve the rationalization?

Ms. Thompson: I'll go along with my colleague who was just up here before me. In our area, the Quinte area, we have started to do some of those things already. With the Quinte Health Care corporation, for instance, they have integrated three hospitals, and they have separated eye surgeries into one and surgeries into the other.

I think that it's a process that has to be worked out with the partners in the hospital to achieve a positive outcome, and I believe that it can happen, depending on the populations of the area. It's a difficult position, to get doctors to go far up north for hip and knee surgeries. If we can combine them in a large area, then we're sure to have the doctors there to perform the surgeries. I think working with our community partners and looking at where the larger needs are and where the larger scope of people go for the surgery is where we should be concentrating our efforts.

Ms. Horwath: So you support that whole direction?

Ms. Thompson: I support it.

Ms. Horwath: Can I ask how you currently see yourself as being connected to the region that you'll be heading the LHIN for? How would you describe your connection to that region?

Ms. Thompson: I view my background since I've been there, since 1975, and my work history—I've worked, as I said, with the rural health science network, and I've worked with the health care network of Quinte—has allowed me to get to know some of the players from the Brockville-Kingston area. I believe I've formed some good friendships with them. Through that, and through my business, I have gained insight into what the needs of the areas are. The needs from my area to Kingston to Brockville aren't really that different. They're the same health care needs as those across the province: looking at the gaps in services and what the needs of the consumers are.

Ms. Horwath: So what would you describe as the major health care issues for the region?

Ms. Thompson: The major health care issue for the region is integrating and bringing all the services together, getting rid of the silos, having partners work together, looking at the larger scope, not just at what the needs of one area are; what are the needs of the whole region that we are here to represent, and how can we make it so that clients can flow seamlessly through the system, from one area of the region to another or straight across Ontario?

Ms. Horwath: I take it, having looked at your resumé and your experience, that you're in the private sector in terms of health care delivery?

Ms. Thompson: Yes.

Ms. Horwath: Do you have any opinion on the debate around private versus public provision of health care?

Ms. Thompson: That has always been a debate since I started the business back in 1991. I believe, as long as the system is overseen by the government, that there is a place for both parties. I also believe that competition is good for the soul. It keeps us all on our toes and makes us all realize the things that we can do. We can do it together; it doesn't have to be private versus public. We're a team out here. We're all serving the same needs; we're all serving the same clients. I'm hoping that over the next few years, we will look at each other as a team.

In the region where I work, I sit on a lot of committees with not-for-profit organizations at our community-based agencies. We work together in the best interests of the clients, and I think that's what's most important.

1030

Ms. Horwath: In terms of cost-saving types of initiatives in the health care system, do you support competitive bidding processes, first of all, and then second of all, controversial moves such as contracting out of services that some organizations are facing right now?

Ms. Thompson: Let me say that there's always been a competitive move out there ever since I started. When I started in 1981, it was a competitive process then, so to me it hasn't changed. A competitive process is good. It helps to keep costs down and it also helps to provide efficiencies. I don't believe that because there's a competitive process, you don't get good service from one or the other. I think all agencies, regardless of what background they come from, strive to do their best out there. It has been there; it's not a new thing. It came to be called the community care access centre, but when it was the home care centre, we still had contracts at that time that we had to bid on. So I don't see it as a new process.

Ms. Horwath: Do you speak any other language?

Ms. Thompson: No.

Ms. Horwath: As you move forward with the LHIN, what kinds of strategies do you think you're going to need to develop to build a strong and effective LHIN?

Ms. Thompson: Building on partnerships that are already there, consulting with consumers and our partners in the community and looking at where we are here and now: Do you destroy it all? Will you take it, massage it and fit it into the role of where we're attempting to go? I see that as very vital and very important to making this thing move forward. I know everybody isn't doing the wrong thing out there; we just need to do it together.

The Chair: You still have about four minutes, Ms. Horwath.

Ms. Horwath: That's great. As the president and chair of your LHIN, what would you see as being the vision that you wanted to achieve for the LHIN? I hear you talking about partnerships, so I can see where you're going in terms of the piece that involves a direct relationship with the community. What about the building of your actual board? How do you see that?

Ms. Thompson: I think the board should be built from across the region. I think that you should have a number of members from each section that are in the region to represent their consumers and their partners in their area. I would hope that that would be the way we'd go, that they all wouldn't come from, say, Quinte's spot or Kingston's spot, but would be from across Brockville and over.

Ms. Horwath: Can I ask you about your political affiliations?

Ms. Thompson: Yes.

Ms. Horwath: Are you affiliated with any political party?

Ms. Thompson: Yes, I am.

Ms. Horwath: Can I ask which one?

Ms. Thompson: I've been a Liberal since I was born. I've worked for the party; I've attended functions and fundraisers for them. I actually ran probably about 11 years ago, when Hugh O'Neil stepped down, for the candidacy for my riding and lost by 28 votes. But I've also attended other party functions as well and have been invited to other party functions, which I've attended.

Ms. Horwath: So you're a card-carrying member and you regularly donate to the Liberal Party?

Ms. Thompson: Yes, I do.

Ms. Horwath: That's provincially and federally?

Ms. Thompson: Yes, I do.

Ms. Horwath: Have you ever actually held political office?

Ms. Thompson: I was a councillor from 1989 to I think 1996, and then, until recently, I was a councillor in Belleville, which I resigned when I was approached about the nomination for this position.

Ms. Horwath: Thank you. Those are all my questions.

The Chair: The government side.

Mr. Brown: Thank you, Ms. Thompson, for appearing before us today. I first want to thank you for putting your name forward. This is going to be a challenging but rewarding experience, because it appears to me that it will be, as I said to a previous applicant, both an evolutionary and devolutionary process, and one that does require partnerships with a large number of players and the province to provide this service. I'm very impressed with your qualifications, and I want to thank you sincerely for appearing before us today.

Ms. Thompson: Thank you very much.

The Chair: The official opposition.

Ms. Scott: Thank you very much for appearing before us. It's great to see nurses going forth. I'm a nurse also, and I actually trained at Loyalist College, Belleville hospital and all the hospitals that will be in your LHIN, being Napanee and—what are the other hospitals?

Ms. Thompson: They would be Napanee, Kingston, Hotel Dieu, Brockville—the larger major hospitals up there—Bancroft and Picton. Those are part of the Quinte Health Care corporation.

Ms. Scott: Yes, and you've got the combination of rural and then the larger Kingston centre.

Ms. Thompson: Yes, very much so.

Ms. Scott: I know because I keep a little bit more in touch with the area in Belleville and the challenges that are faced by the Quinte hospital, and they are several. Do they see the LHIN helping to solve a lot of the problems that exist at the present time at the Quinte hospital?

Ms. Thompson: My sincere hope is yes. My sincere hope is that working with an outside group, we can help bring some of that cohesiveness back. When I worked at Trenton Memorial Hospital in the emergency department, and I also worked at Belleville, they were great, happy places to be. I'm not necessarily saying that they're not, but there is a lot of turmoil under there. Hopefully we as a LHINs board, working together with them and their partners, can help them iron out some of the kinks that are still going on.

Ms. Scott: You spoke with Ms. Horwath about some consolidation of services. Do you see some more services that may leave the Quinte hospital and, say, go to Kingston?

Ms. Thompson: I don't know if I'm in a position to answer that at this point in time. I think that would have to depend on what the service was, because of the area, because we have a large rural population, and that is the major hospital for that region. You'd really have to look at what services we're talking about going to Kingston and how vital they are to our area. So I think you would have to look at it in that sense.

Ms. Scott: Do you see the LHIN as having a lot of authority over the hospitals, over the hospital boards, over their functions and service? We've talked a lot about where we're a little confused, of what authority the LHIN chairs are actually going to have. I've never asked, I don't think, all the other intended appointees, what authority do you feel you're going to have over the hospitals' administrations?

Ms. Thompson: I don't believe we're going to have authority over them. Our role is to work with them to help them bring to us, and in conjunction with us, service plans that they see as a fit for them. But I don't see us as being authorities over them.

Ms. Scott: You will be reporting to the Ministry of Health and Long-Term Care? That is what your indication has been there.

Ms. Thompson: Yes.

Ms. Scott: So you will make recommendations, and the minister will have the final say. Is that what your—

Ms. Thompson: We would follow their own strategic directions and then bring back recommendations to them from our local areas.

Ms. Scott: OK. We've asked before, do you feel you will be in charge of hiring the remainder of the LHIN members?

Ms. Thompson: As mentioned, I think it's important that the CEO is involved with that process. The rest of the staff will be under the CEO, so I believe it's their responsibility to hire them, because they're the ones who are going to be working with them on a day-to-day basis.

You didn't ask this question, but as you mentioned before about firing the CEO, I don't think that's my position. I think that's a board position.

Ms. Scott: You have on here that you have a nurse practitioner—

Ms. Thompson: I'm in the process—

Ms. Scott: You're in the applying process, which is great. I'm certainly in favour of bringing more nurse practitioners into primary care, especially in the rural areas where our needs for doctors are greater. How do you see them playing more of a role in your LHIN, or if you want, just in your community, to use the community you're most familiar with as an example?

Ms. Thompson: I would think in the whole area. Maybe I'm biased because I'm trying to complete the process, but I think that nurse practitioners, because of the lack of physicians, are very important in the whole province of Ontario. Because we do not have enough primary care members, nurse practitioners can take up the duties and roles that the doctors are performing now—that we do a lot of, as it is—and allow them to free up their time for their more acute clients out there, because there are a number of acute clients who don't have physicians right now. But if we could help fill in those spots, then that would ease the system, because we're not going to turn out doctors that fast in the next few years. So I think they're vitally important.

Ms. Scott: Some of the family health teams were just announced, and nurse practitioners have a role there. I don't know if there were many in your area; I'm sorry, I don't know that.

Ms. Thompson: We have one in Picton and then one in the LHIN next door to us. So they're really fairly close.

Ms. Scott: Do you think we could make some more changes to allow nurse practitioners, if they weren't in the family health teams, to work more independently on their own? I'm just looking into maybe legislation that would help them to be more independent bodies and able to set up practice more easily, and maybe the possibility of directly billing OHIP.

Ms. Thompson: May I speak from my own perception?

Ms. Scott: Please.

1040

Ms. Thompson: As the process of doing this, I would see me working in conjunction with a physician. I think you can have your own practice and work in an environment where there are physicians. Aside from education and training, while in depth and valuable, I like to know that I've got right here, next door, a GP to consult with if I need him. I enjoy the prospect of being my own practitioner but working in an environment where I have colleagues around me.

Ms. Scott: That's ideal, but in some rural settings it's not quite that luxurious.

Ms. Thompson: That's true.

Ms. Scott: With referral to a doctor, he certainly has to be somewhere in close proximity. But to free up the system so that more nurse practitioners can get out in the field more quickly—I think there may be some challenges we can look at later on down the road.

Ms. Thompson: For sure it has been proven up north that they can function quite nicely on their own because there are no physicians up there, and in those situations they have to. I agree with you that it is vital that they set up practice in rural areas.

Ms. Scott: The LHIN staff and the chairs, the whole LHIN body: Do you think they would be able to be a strong advocate for the communities and the patients or do you feel like the ministry is going to exert more power and maybe not let you do as much as you'd like within the communities, taking out the financial restrictions? Just in general, if you have been given any direction, have you spoken to the minister directly?

Ms. Thompson: No. I haven't spoken to the minister directly. I have read some material that we have out. I don't perceive at this point in time that the ministry is going to look to take control of the process. They put means in place for the LHINs to work with the local partners and the local community, develop strategies, plan, coordinate and integrate services. I believe, from my perspective, that that is what they'll allow us to do.

Ms. Scott: Have you read any legislation or have you seen any with respect to the LHINs?

Ms. Thompson: What I have read is about what the role of a chair is, what the function of the LHINs will be, but I haven't seen any legislation per se. I don't believe that that is actually in place yet. What I've read is based on the legislation passing it. I've been around when groups were going around and doing their workshops. I attended the workshops in our region so I was part of the groups down there that were looking at the plans and strategies and gaps for our area.

Ms. Scott: Your information has come just off the Web sites and is the same as we've seen. There was one released on May 16. Were you able to access that?

Ms. Thompson: Honestly, I didn't see the one on May 16.

Ms. Scott: That's fine. It was kind of just slipped in there. OK.

Do you think it will be correct to continue to be a member of a political party if you are successful in being appointed as the chair of the LHIN?

Ms. Thompson: Yes, I do. To me, being a member of a political party stands for principles that I believe in and that I value. A number of people who are members of the Liberal Party have a number of jobs. I would not understand why, in this position, one could not continue to be a member of a party. I would want to continue to be a member of a party.

Ms. Scott: You're going to be appointed by the order in the council and receive a salary of—do you know how much?

Ms. Thompson: No, I don't.

Ms. Scott: You were never informed about how much pay, no range, nothing? OK. That's a big leap. Are you going to continue in your business if you're successful?

Ms. Thompson: No, I'm not. This is a conflict of interest, as was the council that I sat on. I've resigned from that. I'm in the process of divesting myself of All-Care, turning my shares over, that will eventually go into a blind trust, which will eventually be divested of.

Ms. Scott: So there is going to be a salary involved but you don't know what it is.

Ms. Thompson: No, I don't.

Ms. Scott: But you feel comfortable—

Ms. Thompson: I feel comfortable with it.

Ms. Scott: —that it's going to be sufficient to meet your needs. OK.

Ms. Thompson: I could be wrong, but yes.

Ms. Scott: You do have as a reference Hugh O'Neil, a former Liberal MPP. Do you think that has any influence on your intended appointment?

Ms. Thompson: I would hope not. I would hope that my work experience and background were the key factors of why I was nominated for this committee. I would hope the fact that he was down as a reference for me was not the key factor.

Ms. Scott: You do have an impressive background. As I said, I like to see nurses more involved and taking leads. I thank you for your time today and for your answers.

The Chair: Ms. Thompson, thank you very much for the presentation and the responses to questions. Please stick around. Our concurrence votes will probably transpire between 11:30 and noon.

MARY KWONG LEE

Review of intended appointment, selected by official opposition party: Mary Kwong Lee, intended appointee as member, Health Integration Network of Erie St. Clair.

The Chair: Our next intended appointee is Mary Kwong Lee. Ms. Lee is an intended appointee as member of the Health Integration Network of Erie St. Clair. Ms. Lee, welcome to the committee. Please make yourself comfortable. Our procedure is, you're welcome to make any opening statements about your interest and qualifications for the position, and then members of all three political parties have an opportunity to ask you any questions. We'll begin our rotation with the government members and any time that you take up will be taken out of the government members' time for questions.

Due to Ms. Horwath's very competent leadership, we're actually ahead of schedule today. Go right ahead. The floor is yours

Ms. Mary Kwong Lee: To the members of the standing committee, thank you for your interest in my being selected as appointee for the LHIN, the local health integrated network, to serve in area 1, Erie St. Clair.

My experiences and expertise are listed on my resumé that is set before you. It is my pleasure to answer questions you may have for clarification of my skills and

public service history. I offer, with humility, an openness of mind to help me learn and perform such duties as will be outlined in my future endeavour if I'm appointed as directed by the Ministry of Health and Long-Term Care of Ontario.

My experience and history of work are centred on health services. I was trained and educated in British Columbia, Saskatchewan and Ontario. My first job was at the Vancouver General, where I became the head of neurosurgery. My final 18 years were in Ontario, where I acquired my experiences in infection control and environmental control.

I was elected as a municipal councillor for three terms in Chatham, Ontario, and retired when there was a family illness. I continued to volunteer service in many areas, as you have seen listed on the resumé.

With my offspring working in distant cities and countries, I need to serve where I am most capable and thus I answered the ad that was in the Globe and Mail for people to serve on LHINs.

Thank you for offering me this half-hour and honouring me with the privilege to meet with you.

The Chair: Thank you very much for your presentation, your opening remarks. Any questions or comments from the government members?

Mr. Brown: Yes. I guess you're the first person here before us today applying for a member's position on a LHIN. As a personal note—I've got to say this because Ms. Scott always refers to nurses, she of course being a fine one—I married a nurse who was trained at Chatham Public General, so I feel like I have some relationship to Chatham and that particular part of the world.

This is an important position. It's a position that I think will be evolutionary and, as things proceed in partnership with the community—a large community—and the ministry, there will be important roles to play.

I just want to thank you for putting your name forward and answering the advertisement, because I think you are proving to us that public service matters and that people with particular expertise will be of particular value on the LHIN. Thank you.

The Chair: Thank you, Mr. Brown.

Ms. Lee: Excuse me, sir, could you speak a little bit louder. I'm just recovering from an ear infection and I can't hear too well. Thank you.

The Chair: Thanks very much. Mr. Berardinetti.

1050

Mr. Berardinetti: I just wanted to also thank Ms. Lee for coming forward today and to mention that I have family members in the nursing profession as well, including a sister. We know the amount of work you put into your profession. My mother-in-law is actually a nurse as well, and my wife is from Chatham.

The Chair: Thank you. Does anybody else want to brag about their connections to the nursing community? Ms. Scott, do you know anything about nursing?

Ms. Scott: No, but I'm glad I started the ball rolling on everyone's nursing background. That's super. Anyway, thank you for appearing here before us today. Am I speaking loud enough for you?

Ms. Lee: Yes.

Ms. Scott: OK, that's great. You do have an extensive background in a lot of areas of our country and, as well, you were in Atlanta for training, is that correct? Did you go to Atlanta, Georgia, for training?

Ms. Lee: Yes. I trained at the Vancouver General Hospital. I worked there for about seven years and I became the youngest nurse to become the commander of the neurosurgical division, so to speak, and then I married and came to Ontario.

Ms. Scott: And you've been in Ottawa and now in Chatham. Did you practise in Ottawa?

Ms. Lee: I haven't been in Ottawa. I worked in Chatham from 1969 until I retired in 1988, and I was invited to learn the first job of being an infection and environmental control nurse in hospital. That's why I have such a list of different places where I had to take the learning. I retired there when my husband was ill. Then I came back to work as an alderman for the city of Chatham-Kent, and I was on that for nine years. So since then, because of family illness, I took time also to continue with my public service, and that's why I have such a large list of wards and communities I've been serving, because I felt I needed to do some work to keep my mind going.

Ms. Scott: That's great. That's very commendable and I thank you for your community service. That's wonderful. It will be nice to have a background in infectious disease in the day and age we live in—post-SARS, and with other possible pandemic flus coming—so that will be a valuable asset to the board that you have applied to be a member.

Ms. Lee: Actually I took special courses with Health Canada on infectious disease and epidemiology. This was way back when they still had that program. Then I went on to the National Centre for Infectious Diseases in Atlanta, Georgia, to learn about infectious diseases. I went to the University of Ottawa to take the course in infectious disease and I've been sort of learning all along what the research has brought up, and I've done a lot of teaching on it.

Ms. Scott: That's great. That will be an added asset to the board, certainly. Do you see how much time the LHIN is going to take up? When it initially starts, I would think there will have to be a lot of time devoted to its beginnings.

Ms. Lee: How much time this new work will take?

Ms. Scott: Yes. Do you have any indication or have you been given any kind of direction as to what your responsibilities are if the appointment goes through and how much time it's going to take?

Ms. Lee: Well, I really can't make any comment on that because we haven't been given enough information as to what the plan is. I've only studied it recently, when the information that is given out to the public was sent to me, and I've thoroughly investigated it. I'm really looking forward to what the whole plan is and what the

responsibilities will be when the Ministry of Health and Long-Term Care sends out the goals and objectives and so forth.

Ms. Scott: I'm assuming it's going to be a lot of time and I thank you for offering that up. Have you ever been a member of a political party?

Ms. Lee: When I came to Chatham in 1950—and I don't mean to endorse anybody—I came from British Columbia, and because I'm Chinese, I was not ever allowed to vote. So when I was allowed to vote, I didn't know which party to support. I spent my years joining different ones to learn all about the inner workings of a party. Presently, I don't belong to any party.

Ms. Scott: Well, I'm glad times have changed. Have you ever donated, given money, to a political party?

Ms. Lee: Well, I think my husband gave a lot of money to the different parties. I didn't have all that money to give.

Ms. Scott: We just have you down as a donator in Chatham–Kent–Essex in 1999. Would that be correct?

Ms. Lee: Which?

Ms. Scott: The Chatham–Kent–Essex riding in 1999.

Ms. Lee: Yes?

Ms. Scott: Did you donate money?

Ms. Lee: I did do work for them at that time.

Ms. Scott: For the Liberal Party?

Ms. Lee: Well, I went along as one of the people who put out the pamphlets, because I really didn't know too much.

Ms. Scott: Did you donate money to the Liberal Party?

Ms. Lee: I did do that for the Liberal Party, but I had also done it for the NDP when Bob Rae was going into government. I've also worked for the Tory party, because I was going through a learning process and wanted to know what each party stood for. I learned a lot from all parties, and they're all good.

Ms. Scott: That's good to hear. Are you a current member of any party, then?

Ms. Lee: I don't have any.

Ms. Scott: You have a LHIN. Do you feel the size is large? Do you know the hospitals, the long-term-care centres? Is it a large area? Do you think the LHIN is going to be able to be a patient management or more of a direct delivery type of body for all the health care services that are needed in the area?

Ms. Lee: For long-term care, as I received training at the Vancouver General, we had to concentrate on learning how to look after these people too. So as I've come out into the world, I have become very interested in what long-term care is doing. Whenever I gave seminars for our hospital staff, they were invited to attend. So I know something about long-term care.

Ms. Scott: As well as, obviously, the hospitals. Do you have much knowledge of your access centre in your area?

Ms. Lee: Yes.

Ms. Scott: Have you worked with the access centre or know much about them recently—delivery of care services?

Ms. Lee: I don't.

Ms. Scott: That's OK. The access centre that you have in the area.

Ms. Lee: The asset?

Ms. Scott: Access.

Ms. Lee: Access. Yes, I have access to it, because when I do volunteer work, quite often I get to do that. When I was on the council, I had access to the long-term care. Actually, I was on the board of one of the homes way back in 1989-90 but I'm not on anything right now in that area.

Ms. Scott: All right. Thank you.

The Chair: To the third party.

Ms. Horwath: Do you have to sign confidentiality agreements with your role? Will you have to sign a confidentiality agreement with your role on the—

Ms. Lee: Oh, yes. I did sign.

Ms. Horwath: It's already been signed? Do you think that that's a necessary step?

Ms. Lee: I discussed it to make sure that I had no conflict of interest.

Ms. Horwath: Do you think that that's an appropriate thing to do, sign an agreement?

Ms. Lee: Anywhere else?

Ms. Horwath: No, for this particular—

Ms. Lee: I signed it here, but in all the work I did in hospital, because it was so intimate and so private, I had to sign confidentiality agreements with them, and that is the reason why I cannot expand and speak on those conditions in any way.

The Chair: Excuse me for one moment. Ms. Lee, will you put the microphone a little closer to your mouth? We're having trouble picking it up for Hansard. Perfect. It's because we record the hearings so that we have it—

Ms. Lee: Is that better?

The Chair: Perfect. Thank you very much. Ms. Horwath?

1100

Ms. Horwath: Thanks, Mr. Chairman.

I missed a little bit of your initial comments. What attracted you to apply to be on the LHIN?

Ms. Lee: I have extensive experience in health care in more ways than the hospital and the long-term care. One of the things that I had to do at the job I was hired for at the hospital was to do environment and infection control. I had to know the entire environment of the hospital and the institution, and I had to know every single member who worked for the hospital, because I had to oversee what each one did, what their performance was and how the environment was controlled, how it was cleaned and where the bacteria were going and so forth. So I have a very extensive understanding of a hospital, because I had to go through each unit.

A hospital is like a conglomerate of businesses. I had to see what the laundry people were doing so that they didn't get an infection, what the people were doing in

food services so that they didn't get an infection and spread it. I went through the entire division of the hospital, every department, and I wrote about 152 procedures and helped each staff member set up a manual for their particular department.

I was proud to say that we didn't have any hospital-acquired infections because everything was so thoroughly done. A hospital-acquired infection is different from any other infection; it's an infection that a patient receives from someone else in the hospital that they did not have before they came to hospital. So that was the importance of this program, for which I won recognition with my peers.

Ms. Horwath: Great. What do you see as being the big health issues facing your region right now?

Ms. Lee: I don't know very much about LHINs to make any decisions or see what they see at this moment, because I really haven't got the authority or the information. However, from applying for this position, I felt our greatest problem arising—and in my volunteer service I have tried to encourage people to think about obesity, because that age group is due for hospital care, and I don't know of any hospital that has doorways large enough, beds large enough to accommodate these people. With all the other changes in health care, we don't have to change the building, but with obesity we have to have larger beds, wider doorways and equipment that can be moved in and out to do whatever procedures we have to do for these people.

What bothers me and gets me centred on this is that we still have nurses as big as I am and it takes four or five people to move one of these patients—because we have some of these patients in hospital now. That, I feel, is the rising problem for health care, especially in Chatham-Kent. We're considered the fattest city in all of Ontario and we have the most doughnut shops.

Ms. Horwath: The most doughnut shops?

Ms. Lee: But they're beginning to come in. I have a friend in there, and when they move him, they have to get four or five nurses. When they want to take him home for a weekend, it takes two ambulance services to get him into the ambulance and out.

I've not had an opportunity to present this problem to the public. All I can say is that this is on the horizon and what are we going to do about it?

Ms. Horwath: OK. Any ideas?

Ms. Lee: I think that's about it for now.

Ms. Horwath: No ideas about how to deal with that problem?

Ms. Lee: At one time, when I was studying long-term care and health care, the federal government had special funding. If you were going to rebuild a hospital or a long-term-care facility, there were funds designated for this specific purpose, where we could get larger rooms, bigger doorways and bigger beds. I thought the most interesting thing was that when they built this building, they'd put a lift in the ceiling, because these people are so heavy to lift. And that was money granted to hospitals, but I don't know whether too many hospitals or long-term-care facilities know that it exists. Perhaps this is information we can bring to the ministry and see what they're going to do about it. Recently, my friend had to be moved out of his room in an emergency, and they couldn't move him out. I don't know how they finally did get him out for the emergency.

I'll explain a very simple problem to you, because we've gone through this: When we get one of these patients, we tie two beds together. Then we tuck the sheets on two mattresses put together, but the weight of the patient keeps pushing the mattresses off the bed, so they end up lying on the bedsprings. These are problems that nurses are facing, and that I hope further up the line other people will see what we're doing and what problems we're having.

The Chair: Ms. Lee, thank you very much for your presentation and for your responses to the members' questions. That concludes our time together.

JOE McREYNOLDS

Review of intended appointment, selected by the third party: Joe McReynolds, intended appointee as chair and president, Central West Health Integration Network.

The Chair: Our sixth and final intended appointee for this morning's session is Joe McReynolds. Welcome to the standing committee on government agencies. Make yourself comfortable. You're welcome to make an opening statement about your experience, background and interest in the position, and then we'll do a rotation of questions from all three parties, this time beginning with the official opposition. Mr. McReynolds, the floor is yours.

Mr. Joe McReynolds: Thanks to the committee for the opportunity to address you on why I'm interested in the appointment and why I feel I'm qualified. As you can see from my application, I grew up pretty poor. I grew up poor because the health care system cost my dad all his savings. I have great respect for the current health care system, and I'm very proud to be part of the Canadian health care system.

Based on almost 40 years in the broader public sector, I believe I can provide some leadership to help the health care system become more coordinated and integrated. With 30 years in the public sector, I believe I understand government processes quite well. I have always been a community developer; I've been involved in helping my communities throughout my life. It was something I was left with from my parents.

My current position, from which I have now resigned, has meant that I've spent the last eight years very involved with the health care system. I've served as the chair of the Ontario Health Providers Alliance. That's a group that represents about 95% of the health care system in Ontario. I've led the development of a broad coalition on primary health care, which involves, at the provincial level, family physicians, pharmacists, home care providers, community support services and mental health and addiction. In 1996, I was appointed to the Halton-

Peel District Health Council, and I have subsequently acted as its chair. In 2003, I was elected by my peers to be the voluntary chair of the Ontario district health councils. I think these activities demonstrate my understanding of the health care system.

I believe the biggest challenge we're going to face is to break down the silos in the health care system and to have the providers focus on the total needs of the client or patient. I believe my application indicates my involvement and understanding of the community, which is going to be most important in the transformation of health care in Ontario. On a personal level, I am offering my values, experience, expertise, commitment and skills to help with a change I really believe in.

The Chair: Thank you very much for your opening remarks. We'll begin any questions with the official opposition.

Ms. Scott: Thank you, Mr. Reynolds—

Mr. McReynolds: McReynolds.

Ms. Scott: —McReynolds, for appearing before us here today. We're at the end of the list; what can I say?

Mr. McReynolds: It often happens. I got a letter from the minister thanking me for my district health activities last night, and it was addressed to Mr. Reynolds. I'm sensitive this morning.

Ms. Scott: They should know better.

You were a former district health chair?

Mr. McReynolds: Yes, I was.

Ms. Scott: Do you feel this is a proper evolution: to dismantle the district health councils and bring them into the LHIN system?

Mr. McReynolds: I do, and I actively participated with the district health councils in that discussion. I believe strongly in the district health councils process. It was a very positive process, but what it lacked in some ways was an authority to have a major influence on its plans. What I see evolving here is an opportunity—not an opportunity, a responsibility, really, to not only help communities develop the kinds of plans they need for a health care system, but also to have a local body understand and support that. I really think it's an evolution of the health councils at this point. That's my view, anyway.

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Ms. Scott: So you feel that you're going to have great authority with the Ministry of Health and Long-Term Care, because this is what I've been concerned about and have asked repeatedly about throughout the morning. We don't want you to have gag orders. If you're in the community seeing the front lines, we want you to have input with the Ministry of Health. You feel that obviously the district health council—you were correct; they didn't have a lot of authority—did tremendous work, and I thank you for doing that and all the other health council members. So you feel that you're going to be able to report to the ministry and action will be taken based on the needs?

Mr. McReynolds: Yes. Obviously, the ministry—the government, I should say, more than the ministry, needs to set some directions and some standards. But as far as I'm concerned, the councils have a responsibility then to actually implement that. So I think they do have the authority, and I'm certainly hoping they do, and it's always been my intention that they would.

Ms. Scott: Since this evolution has taken place, you've never seen any legislation with any description of specifically—you're kind of buying the car also and just—

Mr. McReynolds: No. I've only seen, to the most extent, what everybody else has seen. Because I've been involved in the health care system and active in it and actually sat on the advisory committee for the LHINs—the action committee which involved all the provider groups in Ontario—I've understood, perhaps more than most people, what we're trying to achieve, but I haven't seen any legislation. I understand that it may come one day soon; I hope that will be so.

Ms. Scott: Well, we're hoping to; we've been asking.

You've been involved for a long time; you were in the process of the LHINs being set up. Can you give an example from your area? I'm sorry; I don't know it that well. Do you think your area is too big to service? Do you think that you can break down these silos? Do you see an example of maybe hospitals that will lose services, which will go to a larger hospital? How will it affect the rural and urban areas?

Mr. McReynolds: The area I'm to represent and appointed for is a combination of a very rural area and a very urban area—a fast-growing urban area. Brampton, of course, is one of the fastest-growing communities in Ontario, a community that is growing at about 20,000 to 25,000 a year, and many of those are new Canadians. So there is a real issue looking at the health care system for them. I don't think the area is too large. I think it's going to be challenging from the point of view of the mix of the population that is to be served. I've lived most of my life in rural or small communities, but I've also lived in Toronto for five years, so I have an appreciation. I ran the welfare system in the city of Toronto for several years, so I have a really strong appreciation for what a community and neighbourhood means. I don't think it's going to be too large at all. I think that because of the area we're in, because of the jurisdictions of the hospitals and other services there, it's going to be relatively easy to align services with the LHINs.

Ms. Scott: Yet you will probably have more ease than I will have with—I think I have the largest land and huge geographical challenges within that.

Mr. McReynolds: Yes, you do; you have a large map.

Ms. Scott: A very large one.

Have you been instructed as to where the LHIN office will possibly be?

Mr. McReynolds: No, I have not as yet.

Ms. Scott: Have they indicated how much the salary will be for this position?

Mr. McReynolds: They've indicated to me that there's a per diem of $350 a day.

Ms. Scott: Who indicated that to you?

Mr. McReynolds: The minister's staff.

Ms. Scott: The Minister of Health and Long-Term Care.

Mr. McReynolds: And the public appointments committee; I met jointly with both.

Ms. Scott: Do you feel the access centre in your area is going to be able to accommodate the changes that may come forth with the LHINs? Have you heard feedback from your access centre?

Mr. McReynolds: Not really. I know the thinking over there and many of the board quite well. I have no reason to believe they can't accommodate that. I'm not sure I fully understand, though, your question.

Ms. Scott: Well, it was mentioned earlier that the access centres in the areas are going to be integral in the implementation of the LHINs or getting feedback and the delivery of services. So they are going to be integral. I speak with my access care centre about the size of our LHINs and to see if it's manageable. There are going to be some challenges. So that's where my question was really derived from. Maybe your area is somewhat different, but the access centres and their staff and how they're run is going to be key.

Mr. McReynolds: You have to realize I have a bit of a bias here. I only see home care as one part of a broader health care system, a community health care system. I see access centres playing an important role in that, and in our area, I don't see any problem with them working. In fact, my own personal objective is to try to see it much more integrated—the access centre with the other community health services in our area.

Ms. Scott: Do you know of any other people who applied for the LHINs and when you're going to possibly activate the process of hiring?

Mr. McReynolds: I expect as soon as our appointments are sort of approved, we will get involved with the discussion of the CEOs. As far as the first part, do I know of anybody else? I had one individual I know and have worked with in the past. So I know one person, at least, at this point.

Ms. Scott: Are the people who were serving on the district health councils—is this a normal evolution that they apply and be part of the LHINs, do you think?

Mr. McReynolds: I personally don't know how many of them applied. I haven't heard, from the area I've been involved with, of any of them that applied. Of course, I don't know the list.

Ms. Scott: I think that's all the questions. Thank you for coming here today and your candidness. I appreciate it.

The Acting Chair (Mr. David Orazietti): I move to the third party.

Ms. Horwath: Welcome. I don't think we asked any questions about your political affiliations, if you're a member of any political party.

Mr. McReynolds: Currently, I'm not a member of any political party. I had been a member, both of the Liberals and the NDP, in the past, and for very unusual reasons, mainly to do with my family.

Ms. Horwath: Have you donated to any political campaigns?

Mr. McReynolds: I would suspect I have donated to all three parties because of the nature of my job. I guess the record would show that.

Ms. Horwath: I wanted to ask a little bit about your work with the Ontario Community Support Association, particularly around some of the comments that you made about the system needing to be fixed. I think that was in regard to some of the work that Ms. Caplan was doing around the competitive bidding process and things like that with the CCACs. Can you give me some information about how you see the system now and how it could be fixed?

Mr. McReynolds: I'm looking forward to Ms. Caplan's report. I'm hopeful that it will address some of the issues that I've spoken out on in the past, and the association has spoken out quite strongly. I think that there does need to be a much stronger stabilization of the human resources in the sector. I don't think we can afford, from a quality of care point of view, not to stabilize the workforce. So I'm optimistic that some of those issues are going to be addressed in the report.

Ms. Horwath: What do you see as the optimal way to achieve the stabilization of the workforce?

Mr. McReynolds: Pay them good wages, and benefits and good working conditions, quite frankly.

Ms. Horwath: What about the bidding process?

Mr. McReynolds: I've certainly spoken up with some concerns about the bidding process in the past. Again, I'm hopeful that some of those issues are going to be addressed. I've also said very strongly that home care should not be a different business from the rest of the health care system. If we're going to apply one approach there, we should apply an approach across the board, or vice versa. That would be some of my thoughts, anyway.

Ms. Horwath: OK. Thank you. I appreciate that.

Can you share with me a little bit of what you see your particular vision for the LHINs being? It's clear that you've participated through the whole process in terms of the establishment of the LHINs. How about sharing some of your vision with the rest of us in terms of the LHINs?

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Mr. McReynolds: I can try to. I'm still formulating, like everybody else, I guess. I see, as I think has probably been mentioned before this morning, that we're trying to achieve a situation where a client or a patient doesn't feel that there's a big change in the service they receive, whether they receive it from one provider or another. I see that one of the keys to that is to look at the transition points in the system so that when somebody leaves the hospital, we're sure that the family doctor knows those circumstances, that the meal program that's going to serve them, maybe a home care provider—that the system is really working so that the client or patient does not see anything but service to them.

So that's part of the end product of what I see the vision as being. How we get there, of course, is going to involve an awful lot of discussions with the providers to

break down some of those silos that exist, and also with the general public to understand and appreciate our health care system.

Ms. Horwath: How do you see your development or putting together of a good, solid board that will be able to achieve some of that vision?

Mr. McReynolds: I'm pleased that the government has looked at it as a skills-based board. I've taken liberty with the word "skills" because I believe it needs to represent understandings that people have as well.

Certainly in the area that I'm involved with there is going to have to be some broader representation brought to the table from some of the multicultural communities. There's going to have to be some understandings around the differences between the rural and urban issues that are brought forth.

I see part of the job as getting out and meeting as many of the public as possible and really starting to get a feel for who would be good representation, who does have the skills and experience to do that.

Ms. Horwath: You mentioned in your comments the challenge of the rapidly growing population in your area. Would you see that as one of the major health issues, and are their other ones that you—

Mr. McReynolds: That is a major one, because in places like Malton and Bramalea, we do not have a very extensive health care system. We have individual providers, but I think one of the major challenges is to try to find out how we can bring together a more comprehensive—I mean, in that area, there are some real possibilities around primary care that need to be addressed, so I'm hopeful about that.

The Caledon-Shelburne-Dufferin county area is a unique situation. But there is a lot of progressive thinking in that area going on about the kinds of ways that they can bring their community health together and link it to their hospital system and family doctors.

I believe part of the region also includes north Etobicoke, which presents another challenge altogether, from a health point of view. So there are going to be differences there.

The Chair: To the government side.

Mrs. Linda Jeffrey (Brampton Centre): Can I ask how much time I have?

The Chair: Of course. Actually, Mr. McReynolds took three minutes, so you guys have seven minutes for your side of the questions.

Mrs. Jeffrey: Great. Thank you for coming. I see that you're intending to be the chair and president of the Central West Health Integration Network, which is my riding of Brampton Centre.

Mr. McReynolds: Yes, it is.

Mrs. Jeffrey: I couldn't help but notice that you sat on the Halton-Peel District Health Council from 1997 to 2004. One of the issues that you dealt with was the Brampton hospital siting task force group. I wondered if you would elaborate on your time there.

Mr. McReynolds: Because you're from the Brampton area, you know that the politics are fierce and ferocious at times. Around this particular issue, the government asked us at the time if we would try to play a relatively neutral role in deciding on the siting of the hospital. We set up a pretty elaborate process, which developed some expert panels, as well as some around consultation with the community. In fact, it's a model that is now being repeated in several parts of Canada. It did allow for public input. As I said, on the expert panel we had five individuals from across Canada who had expertise in the various aspects of hospital development, and we think we came up with a reasonable solution to them.

Mrs. Jeffrey: So you are supportive of the existing site?

Mr. McReynolds: Yes, I am.

Mrs. Jeffrey: Have you been by it lately?

Mr. McReynolds: No, I haven't, actually.

Mrs. Jeffrey: I don't like to brag, but there are five cranes working on the site, which gladdens my heart.

Mr. McReynolds: It's about time, would be my comment.

Mrs. Jeffrey: It only took 30 years, so that was a good thing. I was interested to hear, and I think you spoke with the other members about, some of the challenges. There are opportunities too but it certainly is challenging within this LHIN area that it's got a rural and urban and suburban kind of flavour to it and the growth that is hugely a challenge, I think, specifically with a lot of the growth and the diversity that you'd have to deal with. Do you have any ideas about how you would deal with that challenge?

Mr. McReynolds: At this point my thoughts are to get out and to engage myself and the rest of the board and our staff as much as possible in dialogue with people. I think engagement is the critical part. It comes first, and you start to understand and ensure that we understand and ensure that people feel they have the opportunity to make us understand some of the challenges and opportunities we have. That's where I would like to start, from my perspective.

Mrs. Jeffrey: You sound like a great candidate. I hope you're successful. Thank you.

The Chair: Any other questions from the other members?

Mr. Brown: I just briefly want to congratulate you again for putting your name forward. This is a significant challenge and a significant opportunity, I believe. We need people with the kinds of qualifications you've put forward and we really appreciate your doing that, so thank you very much.

The Chair: Mr. McReynolds, thank you very much for your presentation and your responses to the committee's questions.

Folks, that concludes our intended appointee interviews. Now we'll proceed to our concurrence and motions in the order in which the intended appointees appeared before the committee.

We will now consider the intended appointment of Norm Gamble, intended appointee as chair and president, South West Health Integration Network.

Mr. Brown: I move concurrence.

The Chair: Any discussion on Mr. Gamble's intended appointment? Seeing none, all those in favour? Any opposed? It is carried. Mr. Gamble, congratulations. I know he was here earlier.

We will now consider the intended appointment of Foster D. Loucks, intended appointee as chair and president, Central East Health Integration Network.

Mr. Brown: I move concurrence.

The Chair: Any discussion on Mr. Loucks? Seeing none, all those in favour? Any opposed? It is carried. Congratulations, Mr. Loucks.

We will now consider the intended appointment of Michel Lalonde. Monsieur Lalonde is the intended appointee as chair and president of the Health Integration Network of Champlain.

Mr. Brown: I move concurrence.

The Chair: Any discussion? Seeing none, all in favour? Any opposed? It is carried. Congratulations to Monsieur Lalonde on his now appointment as chair and president of the Champlain LHIN.

We will now consider the intended appointment of Georgina Thompson, intended appointee as chair and president of the South East Health Integration Network.

Mr. Brown: I move concurrence.

The Chair: Any discussion? Seeing none, all in favour? Any opposed? It is carried. Congratulations, Ms. Thompson, who remains with us.

We will now consider the intended appointment of Mary Kwong Lee. Ms. Lee is the intended appointee as member of the Health Integration Network of Erie St. Clair.

Mr. Brown: I move concurrence.

The Chair: Any discussion? Seeing none, all those in favour? Any opposed? It is carried. Ms. Lee, congratulations. All the best to you.

We will now consider the intended appointment of Joe McReynolds, intended appointee as chair and president of the Central West Health Integration Network.

Mr. Brown: I move concurrence.

The Chair: Mr. Brown is hogging all the concurrence motions today. Any discussion? All those in favour? Any opposed? It is carried.

Mr. McReynolds, congratulations and all the best with the LHIN.

Folks, that concludes our concurrence votes on the intended appointees today. Before we adjourn the meeting, I will ask if there's any other business to be discussed.

Mr. Berardinetti: Where's Joe Tascona when we need him?

The Chair: Mr. Tascona is unable to join us, but he threatens to come back twice as strong at the next committee meeting now that he's rested.

Mr. Berardinetti: When is our next meeting, then?

The Chair: We have set our next two meetings for, if I recall—and the clerk will correct me if I'm wrong—June 1 and June 8.

Just before I finish the point, we had agreed last week as well to begin the meetings at 9 a.m. and continue until noon to enable us to deal with more intended appointees.

Mr. Brown: Earlier I put forward the government's motion, which I understand has the concurrence of all three House leaders, that the committee actually meet May 31 and then June 1. I understand that it's beyond the scope of the committee to decide, but I understand that the House leaders have already taken it up and agreed to it and that the government House leader will make that motion.

The Chair: I appreciate that notice; I'm not aware of it. Any other comments or questions?

Ms. Scott: Is it the 30th or the 31st? I just wanted to clarify. I thought I originally heard the 30th.

Mr. Brown: Yes, I believe it was the 30th. It's the Monday.

The Chair: OK. We'll see what transpires in the Legislature. Is there any other business to discuss today?

I will see what motion is brought forward, but we are still scheduled, despite that, for June 1 and June 8—and remember they're 9 a.m. meetings—to try to get through the backlogs. I've also called for a subcommittee meeting immediately after the June 1 meeting, just so we can discuss what kind of backlog still exists and then begin some discussion about meeting over the intersession before we return for the fall session of the Legislature.

Seeing no other business, the meeting is adjourned. We'll see you on June 1, or sooner if the motion is passed in the House.

The committee adjourned at 1132.

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Mrs. Linda Jeffrey (Brampton Centre / Brampton-Centre L)
Mr. Khalil Ramal (London–Fanshawe L)

Also taking part / Autres participants et participantes
Mr. John O'Toole (Durham PC)

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