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# Official Report of Debates (Hansard)

**Monday 30 January 2006**

# Journal des débats (Hansard)

**Lundi 30 janvier 2006**

**Standing committee on social policy**

**Comité permanent de la politique sociale**

Local Health System Integration Act, 2006

Loi de 2006 sur l'intégration du système de santé local

Chair: Mario G. Racco
Clerk: Anne Stokes

Président : Mario G. Racco
Greffière : Anne Stokes

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

# STANDING COMMITTEE ON SOCIAL POLICY

# COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Monday 30 January 2006

Lundi 30 janvier 2006

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*The committee met at 0902 in committee room 151.*

## SUBCOMMITTEE REPORT

**The Chair (Mr. Mario G. Racco):** Good morning and welcome to the meeting of the standing committee on social policy in consideration of Bill 36, An Act to provide for the integration of the local system for the delivery of health services.

Our first order of business before we commence the public hearing is the motion for the adoption of the subcommittee report. Ms. Wynne, please.

**Ms. Kathleen O. Wynne (Don Valley West):** Yes, Mr. Chair, the report of the subcommittee:

Your subcommittee considered on Wednesday, December 14, Thursday, December 15, 2005, and Monday, January 16, 2006, the method of proceeding on Bill 36, An Act to provide for the integration of the local system for the delivery of health services, and recommends the following:

(1) That the committee meet for the purpose of public hearings on Bill 36 on Monday, January 30 in Toronto; on Tuesday, January 31 in London; on Wednesday, February 1 in Ottawa; on Thursday, February 2, 2006, in Thunder Bay; and on February 6, 7 and 8 in Toronto. Times and locations are subject to change based on travel logistics.

(2) That an advertisement be placed for one day in all English and French Ontario dailies and weeklies, and also be placed on the ONT.PARL channel, the Legislative Assembly website and in a press release.

(3) That the deadline for those who wish to make an oral presentation on Bill 36 be 5 p.m. on Friday, January 13, 2006.

(4) That after the deadline the clerk will provide the members of the subcommittee with a list of those requesting to appear and locations, so that the subcommittee may make final decisions regarding meeting dates and locations.

(5) That if there are more witnesses wishing to appear than time available, the clerk will provide the subcommittee members with the list of witnesses, and each caucus will then provide the clerk with a prioritized list of witnesses to be scheduled.

(6) That the time allotted to organizations and individuals in which to make their presentations be 15 minutes.

(7) That the deadline for written submissions on Bill 36 be 5 p.m. on the second day following the last public hearing.

(8) That the research officer provide the committee with a summary of witness presentations prior to clause-by-clause consideration of the bill.

(9) That amendments to Bill 36 should be received by the clerk of the committee by 5 p.m. on Thursday, February 9, 2006.

(10) That the committee meet for the purpose of clause-by-clause consideration of Bill 36 on Monday, February 13 and Tuesday, February 14, 2006, in Toronto.

(11) That the minister be invited to speak to the committee for 15 minutes on the first day of public hearings.

(12) That options for videoconferencing or teleconferencing be made available to witnesses where reasonable.

(13) That requests for reimbursement of travel expenses for witnesses to attend hearings be subject to approval by the subcommittee.

(14) That the clerk of the committee, in consultation with the Chair, be authorized to commence making any preliminary arrangements to facilitate the committee's proceedings.

**The Chair:** Thank you. Any debate on the motion? None. Therefore, I will take a vote.

All in favour? Those opposed? It carries.

**Ms. Wynne:** Mr. Chair, I'd like to move another motion on an item of business: Bill 210.

I need to move that we meet for the purpose of clause-by-clause on Wednesday, February 15, and that we request that the House leaders give us permission to sit on that day.

**The Chair:** Any comments on the motion? We also need to know the deadline for amendments.

**Ms. Wynne:** So if the clause-by-clause is on Wednesday, the 15th, would we be asking for amendments the Friday before?

**The Chair:** Mr. Arnott.

**Mr. Ted Arnott (Waterloo–Wellington):** Mr. Chairman, I've received no prior notice of this motion coming forward. I think it would have been an appropriate courtesy, perhaps, to share with the opposition the rationale before moving the motion. I would just like to ask Ms. Wynne to explain to the committee why it's necessary to move this motion at this time.

**Ms. Wynne:** It's necessary to move this motion. We had talked about considering clause-by-clause of Bill 210 that week, but because Bill 210 and Bill 36 are coming at the same time—we have no permission in this committee to sit on a Wednesday; we only have permission to sit on Monday and Tuesday—so we need the House leaders' permission to do that. That's why I'm bringing the motion. It had always been the intention to consider the bill that week.

**Mr. Arnott:** And the date, again, that you're suggesting?

**Ms. Wynne:** Wednesday, February 15.

**The Chair:** Madame Martel, please.

**Ms. Shelley Martel (Nickel Belt):** Mr. Chair, I'm subbing in on this committee, and I don't sit on the committee when it deals with Bill 210, so do I have some assurance that the other party members who sit are aware of this, know that the motion was coming and agree to it?

**Ms. Wynne:** My understanding is that that is the case. That's what I've been told. If you'd like to wait until later in the day to finalize this, I'd like to put the motion on the floor, and perhaps we could vote on it later. Is that okay?

**The Chair:** Any other comments? Are we in favour of dealing with the matter now, or should we defer it for later on?

**Mr. Arnott:** I prefer that it be stood down until later in the day.

**The Chair:** Fine. Thank you.

## LOCAL HEALTH SYSTEM INTEGRATION ACT, 2006

## LOI DE 2006 SUR L'INTÉGRATION DU SYSTÈME DE SANTÉ LOCAL

Consideration of Bill 36, An Act to provide for the integration of the local system for the delivery of health services / Projet de loi 36, Loi prévoyant l'intégration du système local de prestation des services de santé.

## MINISTRY OF HEALTH AND LONG-TERM CARE

**The Chair:** At this time, it's a pleasure to have the minister joining us and giving his opening remarks. Welcome, Minister.

**Hon. George Smitherman (Minister of Health and Long-Term Care):** Thank you very much. Good morning. It's a great privilege for me to be here to address this committee on the first day of public hearings on Bill 36, the Local Health System Integration Act.

This piece of legislation is very important to me. It's very important to our government, and above all, it is important to the more than 12 million Ontarians who depend on the health care system that this bill is reshaping. Reshaping, fundamentally changing, improving: That's what we set out to do with Ontario's health care system with this bill. It's a tall order, and it's a daunting one, particularly when you consider the consequences of not getting it right, which is why I'm so grateful for the work that you're undertaking here today.

Mr. Chair, we have a good team on hand to assist your committee's work. Kathleen Wynne is here to help work this bill through committee, alongside my legislative assistant, Dan Carbin, as well as a ministry team led by Tracey Mill, director of the LHIN project team.

It sometimes seems a shame to me that when it comes to the work that we do here at Queen's Park, so much media and public attention is focused on question period—actually, some days that seems a lot worse than just being a shame—because as important as that work is, it's not remotely the best of what we do. This is. Every bill that I've had the privilege of bringing forward as Minister of Health and Long-Term Care has been subsequently improved during the committee process, and I'm quite certain that this one will be as well. I'll be disappointed if it's not.

I know, for example, that concerns have been raised about the legislation not doing a good enough job meeting the unique needs of our francophone and aboriginal communities. I've reviewed the reports commissioned by my ministry—the First Nations task force, the Metis report, the francophone report—and I'm eager to hear more during these seven days of hearings. The constitutional rights of aboriginal people and our government-to-government relationship must be recognized. The requirements of the French Language Services Act are equally clear with respect to our francophone community. So I look forward to these hearings and the work that is going to get done.

This is a tough process, but it's a critical one—or maybe I should say a critical process, but a useful one—because at the end of the day it is about making sure that we pass the very best piece of legislation that we can, legislation that actually does what it sets out to do, which is to place patients squarely at the centre of the health care system. That really is what it is all about: establishing a new kind of conversation in health care, one that involves patients instead of excluding them.

We set out to craft a piece of legislation that would ensure that many of the absolutely critical decisions that are made about health care in this province are made closer to the action, by people who are closer to the action in the communities, where the impact of those decisions will be felt, after consultation with the people who will feel their effect and with input from people who actually do the work.

We set out to craft a piece of legislation that would ensure that decisions would be taken in a transparent and accountable manner, based on priorities set in communities and taken at open, public meetings. In a environment where we all agree that there will be fewer resources than we might prefer, it's just common sense that we ask people from local communities, closer to the action, to help determine which local priorities must be supported first.

**0910**

We set out to craft a piece of legislation that would allow the Ministry of Health and Long-Term Care to rise

up to a more strategic level, plotting the overall direction of health care in this province and leaving the day-to-day negotiation of the twists and turns to people closer to the ground. That's what we set out to do. I think we did a pretty good job, and I'm looking forward to your help in making it even better.

I want to take a moment to talk about the nature of change, because change is at the heart of what we're going to be discussing here today and over your deliberations.

There's no question about it: Bill 36, the Local Health System Integration Act, represents a pretty radical change for a system that has been too comfortable with the status quo for too long. I'm not going to be coy about this. We're changing things. We're proposing to devolve significant power and authority from Queen's Park to people at the community level through 14 organizations that didn't exist one year ago. We want to give these organizations control of more than half of the health care budget in this province—a whopping $21 billion. We want to align and reduce the number of community care access centres from 42 to 14 and return control of the CCACs to the communities they came from.

We've closed district health councils, and we're closing regional offices. We are putting like functions under one roof, for once. We're redesigning the health care system in this province because patients have told us that the status quo simply isn't cutting it. We are changing things, and change is hard. That's a simple little saying, but it's very, very true. Change is hard, and we recognize that.

A very great deal of what I expect this committee will be hearing over the next few days of hearings is reflective of that simple fact. Change is hard, and many people resist it out of pure reflex.

I want to be clear. I'm not minimizing the concerns that people might have, but that does not excuse what we have seen in the two months since our government introduced Bill 36, which is an organized campaign of attacks that are often baseless, poorly researched and appear to be driven simply by the desire to provoke fear.

I fully expect many of these attacks to be repeated before this committee, and I would urge my colleagues to examine them carefully, to distinguish between what is valid criticism and what is deliberate misinformation and simply the folly of those with too vivid an imagination. Above all, I would urge you to ask the simple, critical questions: "Where does the bill do that? Where in the bill does it say that?" If you do, I predict that you will, to torture an old expression, find a lot more chaff than you do wheat.

I'd like to spend the rest of my time here today talking about that. I want to examine some of the attacks that have been manufactured and then levelled at this legislation. Baseless attacks and deliberate misinformation are harmful to this process and a threat to what we're really trying to do, and they must be exposed as such.

Let me predict, if I may, a few of the things you're going to hear as you conduct these hearings. Example: Local health integration networks are going to open the door to privatization and to two-tier health care. Really? I've read Bill 36 very carefully. Not only does it not say that, in fact it specifically prohibits any integration that would result in an individual being required to pay for a health service, and also affirms our government's commitment to publicly funded medicare.

I also recall another piece of legislation that our government passed: Bill 8, the Commitment to the Future of Medicare Act. That bill made two-tier, pay-your-way-to-the-front-of-the-line health care illegal, and enshrined in law the principle of publicly funded medicare.

The simple fact is, our government defines itself by its commitment to a strong, equitable, publicly funded health care system. We have proven this with our actions, and nothing in Bill 36 should give anyone reason to doubt that commitment.

Let me move on to another oft-repeated attack: Local health integration networks are going to close hospitals. No, they're not. The legislation clearly states that they can't; only the minister can, and that hasn't changed. But this minister is standing before you to say, as I have said many times, that not a single hospital is going to close on our watch. Period.

I might also add, for the conspiracy theorists who insist that this government's secret, wicked dream is to cut hospital services, that it was surely a little odd of us, then, to provide hospitals with stable multi-year funding increases that will total more than $1 billion over the next two years.

Here's another: Local health integration networks are going to extend the competitive bidding model to the entire public health care system. Well, I don't want to seem repetitive, but I'm holding the bill right here—although I'm not—and, as I've said, I have read it many times. Folks, it doesn't say that anywhere—not anywhere.

Local health integration networks are designed to better manage and coordinate health care services in order to ensure better access to those services. That does not mean competitive bidding, but it does most certainly mean that we believe we can do a better job of integrating the various health care services, to the benefit of patients.

Moving on: Another thing we've heard is that there has been no consultation about local health integration networks. First off, nobody can pretend that this initiative came out of the blue. We signalled our intentions in this regard within four months of forming government, and in February 2004 we announced the development of this made-in-Ontario solution. Since then, we've held a vast array of public meetings and working sessions attended by more than 6,000 people. Representatives of patient advocacy and community groups, unions, health care providers and health-related associations have all helped to shape the development of local health integration networks. This is a made-in-Ontario plan and it is very much a made-by-Ontario plan.

Another charge: Local health integration networks will result in patients having to travel further for services.

Let's be very honest. The facts are well established. Clinical outcomes are simply better when they are provided in an environment where more of them are done. Pretend if you wish, but it is simply unrealistic to think that we can provide comprehensive first-class acute health care on every street corner of this province. What we can do, and what LHINs will do, is to make decisions about health care in local communities based on input from patients, providers and the public at open meetings and through extensive consultation. Any decision to consolidate a service must be made in the public interest.

Notwithstanding the fear factor campaign, our government believes that a population health model of health care planning will lead to a repatriation of services; for example, satellite dialysis. Ask the people from Bancroft, Moose Factory or Woodstock. They know. They're not travelling any more to access those services.

Our critics also charge that local health integration networks will mean lost jobs and lower wages. They are ignoring, it seems to me, the basic fact that health care spending is only going one way, and that's up, and that 80% of health care funding is in fact spent on human resources. Presumably, if our intention was to slash and burn, we would not be continuing to invest billions of new dollars in health care—but we are.

Our critics point to the recently announced plan to close our seven regional offices as proof that jobs will be lost. But aren't these the same people who very recently said that local health integration networks were simply a new layer of bureaucracy? It is true that with the closing of those offices, some jobs may be lost. But new and different opportunities within local health integration networks, the ministry and the broader health care sector abound for talented and experienced people.

Those wedded to the status quo are ignoring the fact that for Ontario patients the status quo was not getting the job done in a timely way. For decades we've heard that the silo mentality of the Ministry of Health was impairing patients' ability to seamlessly experience what we all refer to as the proper continuum of care. We're toppling the silos and creating a new dynamic for planning and decision-making closer to the action, where the patient has a place in the conversation. That is the integration that we seek.

Finally, and really of all the myths being perpetrated by critics of local health integration networks, this might be my favourite: that local health integration networks are not responsive to the needs of communities. If there is one thing—just one thing—that you need to know about local health integration networks, it's that we created them specifically in order to make health care more responsive to the needs of the community. I spoke about this at the outset. This is what local health integration networks are all about.

Pretend if you want, but you cannot appropriately micromanage a $33-billion operation from head office. So we're building a system where critical health care decisions will be made at the local level, by local people who understand the needs of the community and in many cases probably know by name many of the patients being affected by those decisions.

You know that we're not inventing the wheel here, although I like to think we're improving it. Every other jurisdiction in Canada has introduced some form of regionalization in health care, a model that Roy Romanow has been calling for for years, and he wasn't alone. As long ago as 1996, the Ontario Nurses' Association published Vision for Saving Medicare, which involved—get ready for it—an integrated delivery system. It called for a system that "provides high-quality, appropriate, consumer-oriented, outcomes-based and cost-effective services within ... locally created system structures designed to meet each community's unique needs." I couldn't have said it better myself.

**0920**

Now, all of the pretend arguments aside, I want to repeat something that I said at the outset: I am not out to minimize people's legitimate concerns. These hearings are all about examining the bill to see where it can be made better, and I look forward to hearing from this committee and to working with all of you to make Bill 36 deliver on its promise: the promise of a true system where the patient is at the centre of the discussion and the discussion takes place at the centre of the community. Thank you.

**The Chair:** Thank you, Minister. I'm sure your comments will assist us in providing answers to the deputants. Could we have a copy of your speech so that the clerk will be able to provide all of us a copy? Thank you again.

We'll move on to the presentations.

## CARDIAC CARE NETWORK OF ONTARIO

**The Chair:** The first presentation after the minister is the Cardiac Care Network of Ontario. Dr. Kevin Glasgow, Dr. Eric Cohen and Jane De Jong, please. You can start any time. You do have 15 minutes total. If you don't use it all, we might be able to ask some questions of you.

**Dr. Kevin Glasgow:** Thank you for this opportunity to provide comments on Bill 36. For many years, the Cardiac Care Network of Ontario has advocated for health system integration and an end to silo-based cardiac planning. We are extremely encouraged that the LHIN legislation provides opportunities to improve access to care, service quality, system efficiencies and outcomes for Ontario's cardiac patients and their families. But more is required to enable a truly system-wide integrated approach to cardiac services.

My name is Kevin Glasgow. I am CEO of the Cardiac Care Network of Ontario and I am a public health physician and medical officer of health by background. I believe very much in connecting prevention to treatment, to rehabilitation. I'm accompanied by Dr. Eric Cohen, who is a practising cardiologist at Sunnybrook and Women's College Health Sciences Centre as well as being CCN's medical officer.

By way of background, CCN is a non-share capital corporation funded by the ministry. We operate North America's largest population-based cardiac registry and integrated wait list monitoring and management system. We're also an advisory body to the ministry, well-known for our consensus panel reports. A copy of CCN's objects is attached as schedule A.

CCN is a national and international leader in facilitating timely and equitable access to care. We do this on a province-wide basis for selected cardiac procedures, specifically cardiac surgery, coronary angioplasty and cardiac catheterization. In conjunction with our 17 member hospitals and our regionally based cardiac care coordinators, more than 85,000 patients per year benefit from CCN's: clinical urgency rankings; maximum wait time guidelines; monitoring while on the wait list; and patient management to ensure that the most urgent patients receive priority access to care.

For more than a decade, CCN has publicly reported wait times by cardiac hospital, and we provide on a monthly basis detailed reports to clinicians, hospitals and the ministry. Through our collective efforts and with the support of successive governments since 1990, cardiac procedure wait times have been substantially reduced and equity and access improved.

In light of these important accomplishments for Ontarians, why are we here today? CCN has two major issues which we ask the committee to address in reviewing Bill 36. The first issue is the critical need to ensure that there is inter-LHIN coordination in cardiac care and other province-wide health matters. We cannot afford to retain a silo-based approach to matters in which there are or should be provincial standards and strategies. CCN suggests solutions to this, including (a) amplifying the objects of each LHIN with respect to inter-LHIN coordination; and (b) ensuring that each LHIN works with agencies, health care registries and other persons with a ministry-endorsed provincial mandate such as the Cardiac Care Network.

The second issue is the vital need, mandated through legislation, to develop a comprehensive and integrated pan-provincial cardiac strategy that will improve the health of Ontarians through better access to cardiac services via the effective and efficient management of the health care system. CCN is prepared and positioned to take on this essential role of developing a provincial cardiac strategy.

In our written submission, we have proposed legislative amendments to address these two issues, and we respectfully request the committee's consideration of these proposals. In order to stay within our time allocation, we will not talk about the details. We will, however, speak to two overriding issues.

Firstly, inter-LHIN coordination: LHINs offer the opportunity to address access, quality, outcomes and efficiency across the continuum of care for cardiac and other disease areas. To most appropriately address these issues, the LHIN legislation and its regulations need to facilitate an overarching planning and coordinating mechanism that ensures that Ontarians in all 14 LHINs are equitably served. There must be pan-provincial standards that apply to all 14 LHINs, and an umbrella monitoring and assistance set-up that ensures compliance with these standards. We must ensure that this legislation does not result in the creation of 14 new silos that reinvent the wheel and that do not efficiently interact with one another.

In the case of specialized cardiac services, such inter-LHIN coordination is particularly vital. Two of the 14 LHINs currently lack a cardiac catheterization lab; five of the 14 LHINs do not contain a cardiac surgery centre; and four of the LHINs do not contain an angioplasty centre. Furthermore, the LHIN boundaries in many areas of the province do not correspond to natural patient movement and referral patterns. Therefore, inter-LHIN coordination is vital to ensure equitable access to cardiac services and, given finite health care dollars, to ensure most efficient use of current resources.

Our second overarching issue is that of provincial cardiac strategy. Due to CCN's historical mandate, which limits our interaction with other providers and planners of the health care system, what CCN does on its own is far from adequate in addressing the overall needs of cardiac patients. From an access to care perspective, only revascularization-related procedures—that is, surgery, angioplasty and cardiac cath.—are tracked electronically in the province's cardiac registry. The advent of LHINs is an opportunity to look at systematically monitoring and promoting access to care and other procedures such as arrhythmia procedures and, just as importantly, access to non-procedure activities such as cardiac rehab, downstream, and prevention programs, upstream.

CCN is committed to the need for a provincial cardiac strategy. This is essential to guide the activities of LHINs. Ontario has a provincial stroke strategy and a provincial cancer plan, but, despite the fact that cardiovascular disease is the number one cause of death in our society and the fact that many billions of taxpayers' dollars are spent every year on addressing various facets of cardiovascular disease, there is no provincial coordinating integrated strategy. Provincially, prevention is not well connected with treatment, which is not well connected to rehabilitation. While there is broad language in Bill 36 that alludes to three-year LHIN strategic plans being in place by the end of this year, we must ensure that the appropriate structures are put in place to bridge the LHINs from the onset.

The Cardiac Care Network of Ontario is ready, able and willing to take on a broader role in the promotion and monitoring of access, the assurance of quality service delivery, the examination of health outcomes and the efficient use of resources. We have a demonstrated, internationally acknowledged track record of success in those activities for which we have been given a ministry mandate. It is time to develop a provincial cardiac strategy and apply our learnings across the continuum of cardiac care, working in conjunction with other sectoral leaders, in the interests of better serving Ontarians. CCN is positioned to take on this role in conjunction with other sectoral leaders.

By way of summary of our proposed legislative amendments, they are as follows and are set out in detail in schedule B.

(1) Add a new object for LHINs to ensure inter-LHIN coordination, and amend the objects such that LHINs are obliged to work together with province-wide organizations.

(2) The minister should consult with province-wide organizations to ensure that the provincial strategic plan is comprehensive and reflects the best expertise possible.

(3) There should be a specific obligation for LHINs to consult with province-wide organizations in order to ensure that LHINs have common approaches in areas in which there should be provincial standards. In the cardiac context, for example, it will be important to ensure that all LHINs have common cardiac priorities particularly with regard to access standards; for example, maximum wait times.

(4) Require health service providers to work with province-wide organizations to identify opportunities for integration.

(5) Require LHIN accountability agreements to be consistent with agreements between the ministry and province-wide organizations.

(6) Require service accountability agreements to be consistent with agreements between the minister and province-wide organizations.

(7) Each LHIN should include within its integrated health service plan priorities and strategic directions that reflect those set by CCN and which are in accordance with the provincial strategic plan.

(8) Bill 36 should include a requirement for a provincial cardiac strategy.

**0930**

By way of concluding remarks, CCN recommends that the legislation be amended to clarify the needs and mechanisms for inter-LHIN coordination in matters of provincial standards, and to include within the LHIN legislation the requirement for a provincial cardiac strategy.

You have the opportunity to optimally shape inter-LHIN coordination and provincial standards for cardiac care in Bill 36 and its associated regulations. The Cardiac Care Network of Ontario can be leveraged in your efforts, and we request your legislative support for our proposals. Our mission is similar to that of the Ontario government and of every LHIN: to ensure prompt and appropriate access to care for all Ontarians. These proposals are intended to better serve patients and most effectively utilize finite health care resources.

Thank you for your attention. We would be pleased to address questions.

**The Chair:** Thank you. There are about three minutes, so one minute each. Mr. Arnott, please.

**Mr. Arnott:** Thank you very much for your presentation. It's very thorough, very detailed. You're the very first presentation in the course of these hearings, so I'm sure everyone on the government side is very attentive to what you've suggested. Also, your suggestions on amendments are very specific and detailed. For our part, we'll be studying them carefully and hoping to be in a position to bring them forward to ensure that the bill is refined to reflect the needs of patients, cardiac patients in particular, in the province of Ontario. Thank you very much.

**The Chair:** Madame Martel.

**Ms. Martel:** I don't have any questions, Mr. Chair.

Thank you very much for your presentation.

**The Chair:** Ms. Wynne, you have a minute or so.

**Ms. Wynne:** I want to thank you for the specificity of your document.

I had a question. In schedule B, your amendment to the objects, number 5(h), you talk about "agencies, health care registries and other persons with a ministry-endorsed provincial mandate such as Cardiac Care Network...." I take your point about provincial organizations and the need for coordination. You will recognize, I think, the issue of there being a number of provincial organizations. So what you're looking for is a mechanism or some overt statement of the need to coordinate with the provincial organizations. If we didn't name those provincial organizations, for fear of in the future leaving one out, could you live with that?

**Dr. Glasgow:** Yes, we could. Clearly, we would prefer to be named, but the intent is to reflect the meaning, such as you have conveyed. So that would be satisfactory.

**Ms. Wynne:** Okay. Thank you.

**The Chair:** Thank you very much for your presentation.

## ONTARIO ASSOCIATION OF NON-PROFIT HOMES AND SERVICES FOR SENIORS

**The Chair:** We'll move on to the next presentation from the Ontario Association of Non-Profit Homes and Services for Seniors. Donna Rubin, please. Ms. Rubin, you have 15 minutes' total. With any time left, there is an opportunity for questions or comments. Thank you. You can start any time you are ready, please.

**Ms. Donna Rubin:** Thank you, Mr. Chairman. Good morning. I'm Donna Rubin, CEO of the Ontario Association of Non-Profit Homes and Services for Seniors, known as OANHSS. With me today is Margaret Ringland, director of member relations at OANHSS. We are a provincial association with over 350 member organizations across the province. They include municipal and charitable long-term-care homes, non-profit nursing homes, seniors' housing and community service agencies. In total, we represent over 26,000 long-term-care beds and well over 5,000 seniors' housing units. All OANHSS members deliver services on a not-for-profit basis.

I will be focusing my remarks today specifically on the impact of Bill 36 on the not-for-profit long-term-care sector in Ontario.

We applaud this government's bold drive towards a more efficient, coordinated and responsive health care

system with the creation of local health integration networks, or LHINs. From the outset, our members have supported this initiative and have committed to playing an active role in the transition process. If passed, Bill 36 effectively moves health care transformation from rhetoric to action. This legislation sets out the ground rules, clearly identifying the power and authority of both LHINs and the Minister of Health and Long-Term Care.

As the legislative process has unfolded, our priority has been to make certain that the new system ensures the continuation of a strong, viable not-for-profit sector, preserves governance at the local level and respects consumer choice.

In reviewing Bill 36 as it has been tabled, we have some very serious concerns.

Certain aspects of this legislation not only jeopardize the future of not-for-profit long-term care in Ontario but also blatantly discriminate against not-for-profits and could have the unintended result of increasing private, for-profit care in our sector.

Not-for-profit long-term-care providers have a long history of leadership in providing integrated services. Many offer a continuum of service for people with varying levels of need. For example, these homes often function as service hubs for day programs and for Meals on Wheels for seniors living in the community.

As well, not-for-profit homes have a long history of serving their communities and delivering added value. Many reinvest their surplus dollars to enhance and expand the level of service provided to residents. Not-for-profits typically contribute additional resources beyond what the province provides, topping up provincial funding with charitable donations and municipal transfers.

Not-for-profits are deeply rooted in the cultural, religious and geographic communities they serve. They are actively supported by local volunteers and they are sensitive to local needs.

For all these reasons, we believe government should be doing everything it can to ensure that the not-for-profit sector is protected and supported. Bill 36, if passed into law, will do just the opposite by giving unfair advantage to for-profit operators.

Of greatest concern is subsection 28(1), which gives the Minister of Health and Long-Term Care sweeping powers over not-for-profit health service providers, including the authority to force integration, closures and mergers. More specifically, this section gives the minister the authority to change the scope of services of a not-for-profit health service provider, transfer the property of one provider to another, and even close a public facility. Inexplicably, the bill gives no such powers to the minister in the for-profit sector.

This clearly is open discrimination and places the not-for-profit long-term-care sector at a serious disadvantage. To appreciate our concern you need to understand the unique environment in which long-term care operates in Ontario. Ours is the only sector where the government directly funds and regulates both for-profit and not-for-profit providers to deliver health care. To be clear, basically the same funding formula is used for all 600 homes in the province, regardless of whether they function on a not-for-profit or for-profit basis. Ever since 1993, when the homes for the aged were brought under the Ministry of Health, which already funded and regulated nursing homes, the regulatory framework for the two sectors has been identical. The section 28 exemption of for-profit operators from ministerial action, therefore, is contrary to over a decade of public policy and poses a very real threat to the future sustainability of not-for-profit long-term care in this province.

As an example of how this could play out, consider a situation where the government determines that an area that currently has two long-term-care homes, one for-profit and one not-for-profit, requires only one home. The not-for-profit home would most certainly be the target of a section 28 action since the for-profit operator would be protected from the minister's authority to force a closure. For a government that once was resolute and vocal in its opposition to private, for-profit health care, Bill 36 appears to be a fundamental policy reversal.

The potential consequences of Section 28 are significant. From a financial perspective, not-for-profit long-term-care homes enter into mortgages and other financing obligations. Section 28 creates the risk that they may be closed, merged or amalgamated through unilateral and unchallengeable action by the minister. That risk will be reflected in higher costs for debt financing, increased difficulty in obtaining long-term financing and more difficulty in generating charitable donations.

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From a governance perspective, section 28, and section 26 for that matter, set up a conflict with the role of a governing body of a not-for-profit health service provider to manage the business and affairs of the organization in the organization's best interests. The government can force action on an organization against the wishes of the governing body, and the governing body has no recourse whatsoever. Incidentally, we find it remarkable that there are multiple sections in Bill 36 to indemnify and hold harmless the LHIN boards and executives, and the minister, for whatever actions they take, but nothing similar for boards of directors and executives of health service providers that are in the position of doing whatever the LHINs and the minister tell them to do. Considerations such as these will make it much more difficult for not-for-profit organizations to recruit and retain directors. Questions of liability will ultimately arise, particularly if LHINs impose actions that directors oppose. This legislation may undermine the spirit of volunteerism that has been fundamental to the fabric of our society. The contributions of a vibrant voluntary sector will be severely hampered if every significant decision for an organization in future will be made by the LHIN.

For consumers it will mean a reduction in health service delivery by not-for-profits, and the smaller, more vulnerable organizations are most at risk. Smaller

organizations offer a valuable contribution as they often meet special population needs, are in smaller communities and can be flexible and responsive to emerging needs. Ultimately, consumer choice will be reduced.

Section 28 also calls into question the legitimacy of the government's integration efforts as they pertain to long-term care if the government doesn't have the authority to deal with the entire sector in the same way. For-profits operate over 39,000 of the province's 75,000 long-term-care beds in Ontario. To what extent will the government truly achieve integration if for-profits are excluded?

Good public policy is based on the public interest, and we would strongly suggest to you that it is not in the interests of the public to erode the not-for-profit sector, which is what Bill 36 has the potential to do. We cannot fathom how the public interest could possibly be served by exempting for-profit organizations in section 28. Quite frankly, if for-profit providers choose to operate in the publicly funded health care system, they should be under the same rules as everyone else.

The government has stated, "The proposed legislation does not provide for more privatization." On the contrary: By virtue of the fact that section 28 excludes for-profit operators, Bill 36 very clearly opens the door to increased privatization in the delivery of long-term care.

As I noted earlier, for-profit providers now operate more long-term-care beds in Ontario than not-for-profit providers. This preponderance of for-profit beds is a fairly recent development, with the shift occurring over the last six years, when more than 65% of the 20,000 new beds were awarded to the for-profit sector. Bill 36 could further tilt the balance, leading to further erosion of not-for-profit care and increased privatization of service delivery.

OANHSS is calling on this government to either remove section 28 from the bill or apply it to all providers so that there is no discrimination, so that long-term-care delivery does not become dominated by private operators and so that consumers continue to have meaningful choices for care and services. To do otherwise will not only threaten the future of the not-for-profit sector; it will ultimately not be in the interests of Ontarians.

Thank you for allowing me to present our comments. We will be providing a more fulsome written submission by the February deadline.

**The Chair:** Thank you for your presentation. We have two minutes left; one each. Madame Martel, will you start, please.

**Ms. Martel:** Thank you, both of you, for being here this morning. I know you were here for the minister's comments when he talked about some of the people who are levelling criticisms at this bill. He said, "Baseless attacks and deliberate misinformation are harmful to this process and a threat to what we're really trying to do, and they must be exposed as such." And his first baseless attack was that LHINs "are going to open the door to privatization and to two-tier health care."

I don't consider your criticisms, your comments here today to be baseless or deliberate misinformation. Section 28 is very clear in the bill: It doesn't apply to the for-profit sector; it allows the minister essentially to shut down, transfer assets, amalgamate, disintegrate not-for-profit providers.

Do you have any comments with respect to what the minister had to say about your concerns that this will increase privatization?

**Ms. Rubin:** Well, our sector is the only one where there is this dynamic of the two providers, for-profit and not-for profit, currently in the system, so to us it's very clear. While we have reassurances that it may not be their intent to look to our sector, it certainly is very clear, in black and white, in the bill. We have to bring that up as an issue, and as governments change or different players are in positions, it raises a significant concern for our sector.

**The Chair:** Thank you. Ms. Wynne.

**Ms. Wynne:** Thank you very much for your presentation. I certainly take your point about the unique dynamic in your sector, but I think the word that the minister used, as opposed to the word that you're using in your presentation—he talked about patients and you're talking about consumers. I think what's really important is that the minister, as the steward of the public good, needs to have—if we're going to transform the system the way it needs to be transformed—that ability to take organizations through this transformation. That's why the mechanism is there.

The other thing that's important to know about this bill is that it would also allow LHINs to transfer funds from for-profits to not-for profits. That possibility is there.

The question I'd like to ask you is, do you think it's reasonable for the minister to have mechanisms in place to guard the public good by performing these transformative integrations?

**Ms. Rubin:** I think that if he wants to make the kinds of sweeping changes he wishes to make, he needs to be able to go as far as he can. But if he's only going to be able to do it on a small part of the sector and be excluded from looking at the—as I say, there are 39,000 beds delivered by the private sector. Then he's only able to integrate, amalgamate or close our homes. I think that's not in the public good.

**The Chair:** Madame Witmer, please.

**Mrs. Elizabeth Witmer (Kitchener–Waterloo):** We just heard Ms. Wynne say that this bill does give the minister the power to transfer resources from the profit to the not-for-profit sector. Did you find that in the bill here somewhere?

**Ms. Rubin:** I think you meant from the private to the—

**Mrs. Witmer:** From the private; yes.

**Ms. Rubin:** No, we did not see that at all, but we see that there's the ability to transfer property from a not-for-profit that is being closed down, integrated or merged to another entity, and that's very concerning.

**Mrs. Witmer:** Did you have any input into this bill? The minister says there was lots of consultation.

**Mrs. Rubin:** We were able to provide comments, and there have been technical briefings where we were told quite candidly that our concerns are valid. That's what will happen.

**The Chair:** Thank you very much for your presentation.

## REGISTERED PRACTICAL NURSES ASSOCIATION OF ONTARIO

**The Chair:** We will go to the next presentation, from the Registered Practical Nurses Association of Ontario. Joanne Young Evans, please. You can start any time.

**Ms. Joanne Young Evans:** Thank you very much. Good morning. My name is Joanne Young Evans. I'm the executive director of the Registered Practical Nurses Association of Ontario. Joining me this morning is Don Gracey.

I world like to thank the committee for giving the RPNAO an opportunity to provide our thoughts regarding Bill 36. This is a very important piece of legislation in that it directly involves the delivery of health care services in Ontario. As a result, it is critical that it receive a thorough review and scrutiny from all stakeholders involved, whether they be from the government, the associations representing health care professionals or the consumers of health care services.

I believe you have in front of you a copy of RPNAO's written submission. I would like to briefly highlight some of the points outlined in the submission this morning, and hopefully I'll leave plenty of time for more detailed questions for Don and myself.

Let me first say that the RPNAO applauds Minister Smitherman for tabling Bill 36. The RPNAO believes that any legislation or initiative by the ministry or the government that has the overall objective of improving the delivery of health care systems in our province is not an easy task and should be commended. The RPNAO supports a more community-based health care delivery system which will improve access to health care services based on the needs and requirements of the individual communities and regions.

While we support a more decentralized approach to health care service delivery, our association is somewhat alarmed at the thought of having to deal with 14 different bureaucracies spread across the province rather than one central ministry. The time, cost and organization necessitated by the need to communicate with all 14 regional LHIN boards is something that our association is not looking forward to. As it probably is for all of the smaller associations, our biggest fear and worry is that we will simply be unable to get our message and communication out to each LHIN board and, as a result, the professions that we represent will be phased out in favour of the larger professions.

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However, if Ontario is to move to a more decentralized, community-based approach to the delivery of health care services, it will be incumbent on us as an association to address those challenges and deal with them as best we can. I simply want to warn that a decentralized approach is always more susceptible to co-optation, if I can put it that way, than a centralized approach.

With regard to the specifics of Bill 36, the RPNAO has serious concerns with a number of the provisions. To be more precise, we feel that Bill 36, as it is currently written, does not accomplish the goal of providing for an integrated health system to improve the health of Ontarians through better access to health services, coordinated health care and effective and efficient management of the health system at the local level, as the preamble of the bill suggests. Rather, the RPNAO strongly believes that, in practice, Bill 36 will not realize the positive potential of the LHINs. We have outlined in our submission a number of reasons why we believe this to be so, and I'd like to discuss a couple of those reasons now.

First and foremost, contrary to the intent of Bill 36, it does not give effective decision-making powers to the community, but rather keeps the vast majority of the powers at the ministry level. But at the same time, the bill shifts all accountability to the LHIN. While Bill 36 establishes a number of powers for the LHIN, such as providing or changing funding to a health service provider and facilitating and negotiating the integrations of persons, entities or services betweens health service providers and a non-health service provider, the minister still retains ultimate control of each LHIN. For example, the minister has the power to unilaterally impose an accountability agreement upon LHINs; bylaws developed by each LHIN may be required to receive ministerial approval; and the minister has the power to appoint members of each LHIN board, the board chairs and vice-chairs. Furthermore, Bill 36 also proposes a number of areas where cabinet approval is also required for a host of LHIN activities.

The RPNAO fully recognizes that there has to be reasonable ministerial accountability and responsibility, particularly with respect to the disbursement of funds to each LHIN and subsequently to each health service provider within each LHIN. However, if all the control mechanisms proposed in Bill 36 are exercised, local responsibility, initiative and community decision-making authority will simply be an illusion.

Bill 36 goes far beyond what is reasonable and necessary in terms of control and grants the government and the ministry greater powers than existed before Bill 36, all the while conveying the illusion of local autonomy and accountability.

Another concern we have with Bill 36 is that we fear it will provide an entree for the expansion of managed competition and privatization in the health care system. A number of stakeholders have publicly expressed similar worries, and the RPNAO concurs. There are valid concerns that in their quest for efficient delivery of health

care services, LHINs will expand the CCAC model of managed competition which has been so destructive of quality care, practitioner continuity and reasonable remuneration in the home care sector.

You have just heard from the association representing non-profit, long-term care, which quite ably expressed its members' concerns that Bill 36 discriminates against the not-for-profit sector while favouring the for-profit sector. We completely concur with those sentiments.

The RPNAO feels that subsection 28(1) establishes both an anomaly and a dangerous precedent by granting special status for for-profit health care providers within a publicly funded system. The for-profit exemption in subsection 28(1) would mean that not-for-profits will more frequently become targets for dissolution or amalgamation, even though in some cases the community would be better served through section 28 orders involving for-profit providers.

Furthermore, the statutory exclusion of for-profit providers for the purposes of section 28 of the bill, when added to the exclusion of physicians, podiatrists, dentists, family health teams, IHFs, medical laboratories and public health, seriously limits Bill 36's ability to achieve its integration objectives.

We understand that the LHIN jurisdiction applies only to approximately $20 billion of the ministry's total expenditures of around $35 billion—less than two thirds. How can LHINs accomplish what they are supposed to accomplish when so many important components of health care delivery are beyond their reach?

The RPNAO strongly believes that if the government wants to live up to its commitment of preserving a truly publicly funded health care system that is both transparent and accountable, section 28 should be deleted from the bill.

Our written submission also outlines our concerns respecting not-for-profit providers that rely on charitable donations, as well as the provisions in the bill that establish the health provisions advisory committee for each of the LHINs. For the sake of time, I'm going to leave those concerns for you to read in our submission at your leisure.

Let me close by again saying that the RPNAO lauds Minister Smitherman for tabling Bill 36 in terms of its overall objective of delivering an integrated, community-based health care system. However, we still feel that Bill 36 is deeply flawed. Quite frankly, this wasn't the bill that we had expected or the one we had been led to believe would be brought forward.

Bill 36 creates an even further centralized, ministry-driven health care system. Rather than make decisions on the delivery of health care at the community level, Bill 36 simply creates 14 regional bureaucracies of the Ministry of Health and Long-Term Care.

The RPNAO hopes that this legislation is amended appropriately in order to truly reflect the government's intent of creating a community-based model of health care. If not, we run the risk of slowly evolving towards a profit-driven health care system, severely affecting the delivery of health care services.

That concludes my remarks, and we will gladly take any questions that you may have.

**The Chair:** Mr. Gracey, any comments from you? No. Okay. There are about three minutes. I'll start with Ms. Wynne.

**Ms. Wynne:** Thank you very much for being here today. I'm just trying to get a handle on exactly your concern, because on the one hand you're saying that the bill goes too far, and you're using the word "centralization," which I think the minister anticipated in saying that it's exactly the opposite that we're trying to do. We're exactly trying to put more control over that, more than half of the health care budget, into the hands of local communities and organizations that understand what's going on locally. So that's on the one hand. Then, on the other hand, you're saying that Bill 36 doesn't go far enough because it doesn't include all these other health care providers. The truth is, from our perspective, we're trying to go as far as we can to coordinate locally. Down the line, if there are other groups that need to be included, we will need to look at that. But we've got to start somewhere, and this is what we're proposing.

So can you just explain that conflict in your presentation?

**Ms. Young Evans:** Bill 36 is going to make a situation even more difficult when it comes to integration and a multidisciplinary team. There are a number of regulated health professions that are not involved. We're finding that, although the accountability is given to the LHINs, the ultimate control is still with the minister—"You're going to be accountable for what you're doing, but I have control." So we do find that somewhat difficult to understand, as well as our responsibility in communicating with the LHINs. It's going to be very difficult, with small associations, to go out and be able to give that consistent message to each of them. I may come to a point where I come to the ministry looking for money for transportation and communication needs, only because having the ministry here being able to do that strategic planning and management with a centralized source is much easier for all of us, and I think it behooves the ministry to ensure that the LHINs are responsible for communicating with us on a regular basis.

**The Chair:** Madame Witmer, please.

**Mrs. Witmer:** Thank you very much for an excellent presentation. I guess we have heard that in this bill there is tremendous power shifted to the minister beyond anything in the history of this province.

What type of amendment would you suggest should be made to make sure that he or she would not have ultimate power?

**Ms. Young Evans:** Well, if the LHINS are to be made accountable, then the LHINs should have the power to make those changes. Section 28 aside, which we think should be just left out—or, as OAHNSS has suggested, given to all providers. The LHINs should also be able to

have the responsibility and the control to make the decisions that they need to make.

**Mr. Don Gracey:** If you look at all the regulation-making powers that are in Bill 36, basically the government has exactly the same control over LHINs as it does over Ontario's agencies, boards and commissions. So that is not a decentralized system. That is not a community-based decision-making system. What we would suggest is that the government back away from some of those regulation-making powers and other powers. For example, we don't think the chairman and vice-chairman of the board should be appointed by the government, because that's an essential prerogative of any board. Any board that cannot appoint its own chairman, where the chairman is appointed elsewhere, has been significantly neutralized. We think that at least some of the LHIN board members should be appointed locally, rather than by the minister. But, as I say, if you look at that extensive list of regulation-making powers, even to the point where the minister approves the bylaws of the LHINs, as far as we're concerned, that's excessive.

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**The Chair:** Thank you. Madame Martel.

**Ms. Martel:** Thank you both for being here. To follow up on that is the second point, which is that while the minister talks about this being at the community level and community involvement, the extent to which the community is actually going to be involved in any kind of decision-making is left to regulations, and there are no principles or priorities or objectives or a framework for that involvement anywhere in the bill. You've already highlighted those numerous sections in the bill where the government, i.e. the minister, has more control than ever before, not the community.

The point I really wanted to focus on was the managed competition. You were here earlier as well. You heard the minister say that those people who talk about managed competition don't know what they're talking about in reference to this bill, because it's not in the legislation. That is the point. There's nothing in the legislation that says how the LHINs are going to acquire, obtain or get their health care services. Competitive bidding wasn't a legislative change; it was a policy change by the ministry that had CCACs do that in that regard.

I wonder if you can just expand on your concerns about competitive bidding, seeing what you've already seen in the home care sector.

**Mr. Gracey:** Your point is exactly what we were trying to say. There is nothing in the bill that says that Bill 36 is going to introduce managed competition into the health care system, but there's a lot that isn't in the bill. As I said earlier, there's a ton of stuff that's going to be defined by regulation or otherwise. We don't know how those regulation-making powers are going to be used.

What we do know is that CCACs are going to be more integrated with the LHINs. CCACs have been using managed competition for some time. The government has not turned back managed competition. We have asked for assurances that the LHINs will not use the powers and the objectives given to them by Bill 36 to spread managed competition more widely. We have not been given that assurance.

**The Chair:** Thank you very much for your presentation.

## ONTARIO MEDICAL ASSOCIATION

**The Chair:** We'll move on to the next, from the Ontario Medical Association. We have Jonathan Guss, chief executive officer, Dr. Greg Flynn and Dr. Steven Harrison.

**Dr. Greg Flynn:** Thank you very much, Mr. Chairman and committee members. Good morning. I'm Greg Flynn. I'm the president of the Ontario Medical Association. Joining me today on my left, your right, is Mr. Jonathan Guss, our chief executive officer, and Dr. Steven Harrison, our director of OMA health policy. I want to thank you for allowing us the opportunity to voice our concerns about Bill 36. I also want to take the opportunity to thank those in the Ministry of Health and Long-Term Care, as well as the Legislature, for all their work to date on this important file. Following my presentation, I look forward to answering any questions the committee may have.

I've been working with the Ontario Medical Association in some capacity for many years. Now there are four months left in my tenure as president. Over these many years and throughout my presidency, the OMA's message to government has been constant: Doctor shortages and wait lists threaten the health and safety of our patients.

While we have struggled to provide the care we were trained to give, Ontario's doctors have been closely watching the government in their efforts to improve the health care system, first with Bill 8 and, more recently, with the transformation agenda: family health teams, information management, the wait list registry and local health integration networks. This plan is aggressive, and the timelines are short. The articulation of the plan has been less than clear. But while we have not always agreed, we've always been able to work together in the end to find common ground, to develop solutions that are beneficial to our patients. We hope to continue to work closely with you as the system moves forward in Ontario.

Before I speak directly to Bill 36, I'd like to make clear that our patients are the number one priority of Ontario's doctors. As such, we realize the importance of working with government to ensure that our patients are protected and that their care remains paramount in the development of this integrated system. Our patients deserve timely access to quality care, care that often only a physician can give.

I hope you'll agree that doctors play a vital role in the delivery of health care. We are on the front lines and the final lines of health care in Ontario. We take Ontarians from birth to death. We help them and care for them through all stages in between. We see how the system

functions first-hand as we work within it every day, collaborating with physicians and other allied health professionals, institutions and planning bodies to ensure the delivery of health care to all Ontarians.

There's no question that we must be able to bring these experiences to the table in order to find the best solutions to provide better care for Ontario's patients. Patients must remain the main beneficiaries of any change in our health care system. Their well-being should be the top priority when deciding what path to take.

That said, we feel that LHINs may be an opportunity for Ontario's patients, an opportunity to bring a local flavour to care. The term "local" does resonate for me; however, there is little that's local in some of these LHINs, which span possibly hundreds of kilometres from one end to the other. Hospital referral lines or not, some of the LHINs seem unwieldy in their size. Bill 36 and the institution of the LHINs in Ontario will fundamentally change the way health care is delivered in this province. The input of physicians will be paramount to achieve any success in this regard.

Our primary concern with the bill is here: The legislation, as written, does not specify a role for physicians to provide independent input. As such, the Ontario Medical Association asks that Bill 36 be amended to mandate a formal mechanism for physicians to provide meaningful input to the local health integration network decision-making process. Physicians need to be involved in the management and organization of health care where they provide it. We have an important role to play; our insight is unique and therefore vital.

Section 16 of the legislation allows physicians to provide input into a larger committee for health professionals: the health professionals advisory committee. We do not believe that this format will be workable or effective in bringing the real concerns of physicians to the local health integration network decision-makers. Where will physicians who work so closely with patients and with each other bring their concerns for solutions and their advice for improvement? The current format is not sufficient. In all other provinces and throughout the world, the major success factor in the integration of health care has come through the involvement of physicians in the process.

In Alberta, they attempted integration and regionalization without directly involving physicians for many years. They realized that the process was not just slowed; it was halted. After years of non-involvement and years of repairing a damaged relationship, Alberta now involves physicians one-on-one in their regional model, locally. The recent apparent success of the Alberta model in its endeavours of integration and regionalization can be linked to the involvement of front-line physicians in the decision-making process.

In British Columbia, their health care system endured significant turmoil and instability for almost a decade before the government directly engaged the physician community and relative calm was restored.

So I tell you now that direct physician consultation is essential in order to avoid the experiences in Alberta and British Columbia.

I encourage you to look to these examples. Do not make the same mistakes. This is a well-travelled path and one for which we now know the right direction. Learn from the mistakes of others. There is value in reflecting upon history and not charging blindly into the future. There is a way that the local health integration networks will work, and work well. We ask that you allow us to help you along that path.

The Ontario Medical Association has been working to develop a model of local representation for physicians that will be applicable in Ontario's new integrated system. We'd be happy to share this model and its organization with you for your consideration.

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I want to keep this presentation short, so in conclusion, I'd like to make clear our goal to assist in the successful integration of health care services in Ontario. We want to create a better system, one that is better for our patients and one that is better for physicians. Why wouldn't we? But we must ensure that local health integration network decision-makers learn from our experiences on the front lines in hospitals, long-term-care facilities, mental health facilities and primary care facilities across the province—the voices of Ontario physicians. Our advice and concerns must be heard where and when it is most important, where decisions are made that will affect how our patients receive their care. Our input is key to ensuring that patient care and access to care are not adversely affected.

We do look forward to working together to help ensure that Ontario's patients receive the best. They deserve it. I'm now pleased to take any questions that you might have.

**The Chair:** Thank you, Dr. Flynn. There are about four minutes and half, one and a half each. Madame Witmer, please.

**Mrs. Witmer:** Thank you very much, Dr. Flynn, for your presentation. I think you, like most other organizations, have indicated your support for the principle of LHINs and the integration and regionalization. But you've pointed out, I think I hear you say, the size of the LHINs, the huge geographic area, and the fact that the model currently doesn't provide physicians with an opportunity for meaningful input. Obviously, we've seen the consequences of that not happening in Alberta and BC, where I would agree there was some turmoil.

What would you recommend? What type of change should be made to this bill in order to ensure that physicians do have meaningful input?

**Dr. Flynn:** First, I want to say that the Ontario Medical Association supports the concept of a health professional advisory committee and would like to work in that environment, but I do recommend, because of the close relationship that I often refer to as the six degrees of separation between specialist physicians who have taken care of the same patient, there are complex

interrelationships that are necessary to recognize in order to provide integrated care. We believe that the full physician community, which includes primary care, community-based specialists, diagnostic facilities, long-term-care facilities, and the hospital-based physicians need a forum to provide medical advice.

**Mrs. Witmer:** Would that be a separate forum outside of the advisory committees?

**Dr. Flynn:** Yes.

**Mrs. Witmer:** Okay.

**The Chair:** Madame Martel.

**Ms. Martel:** Thank you for being here. Let me just follow on that model because I'm not aware of the Alberta model with respect to physicians. Is it a separate and stand-alone committee in each regional health authority, then, that provides input?

**Dr. Flynn:** Yes, it's—I don't want to prejudice your thinking about it by calling it a medical advisory committee, but they have a regional medical body.

**Ms. Martel:** That has an association with each regional health authority.

**Dr. Flynn:** That provides advice to the regional health authority.

**Ms. Martel:** And do physicians—are there other advisory committees of health professionals that physicians also sit on in Alberta?

**Dr. Flynn:** I can't speak for whether they sit on them, but there are other professional bodies that provide advice.

**Ms. Martel:** Okay. Thank you.

**The Chair:** Madame Wynne.

**Ms. Wynne:** Thank you very much for coming here today. I certainly take your point about the importance of the role of physicians. Subsection 16(2), you rightly identified, is where the health professionals advisory committee is outlined. You're suggesting that you do support that committee but that you'd want a separate committee. Is that what you're saying? You'd like a separate committee in addition?

**Dr. Flynn:** Yes.

**Ms. Wynne:** Okay. And I guess my question is, are you suggesting then that all other health professionals should have separate committees as well? That's where we get into a difficulty.

**Dr. Flynn:** I can't speak to that. What I can speak to is the need. As a patient makes their journey through the health care system, starting with the community services, moving through some institutionally based services, the relationships between the physicians of different specialties can't be accounted for in a multi-disciplinary body. I would tell you that because the doctors are unlikely to be as forthcoming about problems they are having in solving integration issues in a broad-based community like that.

**Ms. Wynne:** Well, maybe that's the issue we need to get at: how to get that dialogue going with all the health professions at the table. Thank you very much.

**The Chair:** Thank you, gentlemen, for your presentation.

## CANADIAN UNION OF PUBLIC EMPLOYEES ONTARIO

**The Chair:** We will move to the next one. It is from the Canadian Union of Public Employees of Ontario. Mr. Sid Ryan.

There has to be a change.

**Mr. Michael Hurley:** Yes.

**The Chair:** Just have a seat and I'm sure you will give us your name, sir.

**Mr. Hurley:** Michael Hurley. I'm the first vice-president of CUPE Ontario. With me is Doug Allan. He's a senior research officer with CUPE. I apologize; Mr. Ryan is in Cuba, actually, recovering from the federal election.

CUPE has 220,000 members in Ontario, of which 82,000 are hospital, retirement home, long-term-care, home care workers or workers in the affected social services. So we have a keen interest in this legislation.

I'd like to address up front the problems that we have with the government in terms of its vague assurances around the privatization issue. This is a government that campaigned against private-public partnership hospitals and has subsequently announced 23. So we're very skeptical when there are broad statements about opposing privatization made by the government, and we're looking for concrete measures in the legislation.

I'd like to say that there has been no consultation with the workforce in the health care sector around the LHIN legislation, which is stunning when you think about it. Even though we're all involved in delivering these services, there has been no consultation with us about that. And this is a workforce that has been subjected to ongoing restructuring, including, in the hospital sector, the hospital restructuring commission and massive change and disruption in the home care sector.

I would argue that there also has been no meaningful consultation with the public. Hundreds of people have asked for standing before this committee and have been turned down, and I'd ask that this committee look at scheduling additional days of hearings. The public meetings that were held to discuss the LHINs provided almost no real information and offered almost no opportunity for real dialogue. But the LHINs themselves are not democratic structures—they're not elected; they're not accountable to their communities—so it's no surprise that the process that purported to give them birth in terms of consultation was not a democratic one.

The government is concerned about health care spending, and rightly so, but the major cost drivers that are pushing up health care spending are the doctors and drug costs, and neither of these are covered by the LHINs. Let's just stop there for a second: The doctors are not covered by the LHINs. How do we have an integrated health care system which does not involve the doctors? Frankly, the doctors are not part of the LHINs, we believe, because they're too powerful to be included. Our members' wage increases of 2.5% and 3% in the last two

years are not the factors that are driving health care spending out of control in the province of Ontario.

The Minister of Health purported that the LHINs are moving control closer to the local level. We would challenge that assumption. We would argue that the LHINs are actually a massive power grab by the Ministry of Health and the provincial government over local institutions in their communities. This is a centralization of power masquerading as a regionalization. The scope of the restructuring is massive, and the consequences for local community organizations of a not-for-profit nature in hospitals and other settings are going to be huge. In fact, the governance structures that are in place, for example, in the hospital sector are not going to have a lot of meaningful control any longer about services.

LHINs are not local by any means at all. The geography of the LHINs is just incomprehensible. Metro Toronto, for example, is split into five LHINs. Each of Metro's homes for the aged is in a different LHIN. How can that be? The only rational explanation for that is to divide up the power of the people of Toronto to have, really, any meaningful say in the restructuring which is coming.

In terms of accountability, the fact that the LHIN boards are appointed by order in council and are not elected by their communities is a huge concern, especially in concert with basically taking all the powers away from local community boards. The LHINs will add another layer of bureaucracy to the health care system. We're not going to see more registered nurses, more registered practical nurses; we're going to see more lawyers, more accountants and people who specialize in putting stuff out to tender.

The LHINs are going to introduce the competitive bidding model. The minister says they won't. Then we ask: Make it explicit in the legislation that the LHINs cannot use competitive bidding or managed competition; they cannot tender for services. Make that explicit.

**1020**

In terms of what the minister has told us so far, he has told us that the government is going to set a price for services in hospitals, starting with the five areas that are targeted by the federal government for wait time reductions, and those are: cancer care, hips and knees, cataracts, MRIs and CAT scans. But his intention is to quantify every hospital service and to have the LHINs purchase that. That has two huge consequences, one of which will be the consolidation of these services into large urban centres and outside of smaller communities. That is going to effectively mean the closure of many hospitals. They may still have urgent care centres or emergency wards operating, but the days when you could give birth in Lindsay or Campbellford or Kenora are coming to an end under the LHIN regime.

The other consequence is the impact that competitive bidding is going to have in terms of care and on the labour market. In terms of care, you don't have to look any further than what happened when the previous government introduced managed competition as its policy in terms of how to deal with home care.

Dr. Jane Aronson at McMaster University has done studies which we'll include in our formal brief with our amendments, which we'll be tabling with you by February 8. She studied what happened to the people who received care in the home care revolution that occurred, as organizations like the Victorian Order of Nurses were plunged into bankruptcy because they could not compete with the multinationals that moved into the sector, which are now dominant in the sector; what happened, with turnover rates of home care workers which are now at 57% every year, in terms of care for clients who withered and suffered as a result of that. You need to process what managed competition really means in terms of care.

What it has meant in terms of the labour market has been a 10-year wage freeze at best, but oftentimes people are losing their jobs every two years as contracts turn over. They have no job security, they have no regular hours of work, they have no pensions, and they have no benefits. This is not a labour market model that we will accept in terms of expanding beyond home care at all. In fact, it has to be reversed in the home care sector.

The section 33 powers which the ministry has given itself to detach hospital support services and move them to other providers are a huge concern to us. You need to look at what's happened in other jurisdictions like British Columbia and the United Kingdom where there has been this enthusiasm for the privatization of support services, where those services are moved to multinationals and 15% or 20% of the money that's currently spent on something like hospital cleaning instead gets transferred to shareholders in Paris. What it means practically is skyrocketing incidences of hospital-acquired infections; what it means is people skimping on cleaning supplies, on gloves and on cleaning products so that they can deliver a more efficient service.

If this is the area that the minister believes there are huge savings to be made in and he's intending to accomplish it by detaching these services and privatizing them, then there's going to be a huge fight about that. It's one thing to argue, for example, that there should be one payroll system for Ontario health care facilities. That's fine, provided we're talking about what happens to the workers who are currently doing that work who are now going to be surplus. But if the proposal is to create one payroll service and to have it administered by IBM, Telus, Accenture or Sodexho or Compass—if that's the intent of the legislation, then there's going to be a huge battle about that with your workforce because we're already stressed to deliver these services with our current numbers. I can't imagine what's going to happen with the business plans that are in place for things like hospital business systems, which contemplate a 40% reduction in the workforce.

I'd like to talk about the impact on collective bargaining. The LHINs have the potential to destroy the provincial labour market systems which have been put into place—that is to say, provincial bargaining—and that is an unacceptable outcome.

Finally, I'd like to say that the amendments to Bill 136 that the government is contemplating are going to have the effect of squandering a lot of money—that should be spent on patient care—on legal issues and at the Ontario Labour Relations Board as we have representation votes every time a small group of workers or a program transfers from one institution to another.

I'd like to conclude by saying that there were a lot of statements this morning from the minister in terms of this legislation not introducing competitive bidding. I'd like to reiterate the challenge to you: If that is in fact your intent, then you make it explicit in the legislation that there will not be a managed competition model put in place for health care services in Ontario and that you're going to withdraw it from the home care sector. Thank you.

**The Chair:** We'll have about a minute and a half each. Before I recognize Madame Martel, just for the record, two thirds of the people who did ask to speak to us will be making a deputation. Originally the committee agreed on four days, plus more if necessary, and we extended it to seven days. We are going to have four days in Toronto, one day in London, one in Ottawa and one in Thunder Bay. So we have done that to accommodate as many people as possible.

Having said that, your comments are well received. I will ask Madame Martel to make her own comments.

**Ms. Martel:** Thanks to both of you for being here this morning. I appreciate the comments you made, specifically about managed competition, because you were here for the minister's comments when he said that it's not in the bill. No, it isn't; that's the exact problem, because there's nothing in the bill that says how they're going to acquire these services, and there was nothing in any legislation that allowed the Conservatives to do the same.

It's interesting that the government has not gotten rid of managed competition or cutthroat bidding in home care. The government hasn't even responded to Caplan's report, even though they promised to do that last fall. I remain very worried that cutthroat bidding is coming to health care services near to you, not just home care but a wide variety. I wonder if you can just explain to the committee again what that has meant for so many of your members and why you're concerned that that be expanded to other health care services?

**Mr. Hurley:** Competitive bidding is hostile to the concept of integration, which is key to this bill. Jane Aronson from McMaster says that the competitive bidding model destroys the collegiality between health care providers. That's what it did in the home care sector, because people have to compete with one another to achieve the contract that's tendered by the CCAC. As a result, people are reluctant to share information etc. in terms of new procedures or whatever might enhance care.

In terms of the workforce, though, the impact has been devastating. You have people who've worked for an agency who lose the contract, who can never achieve more than 20 hours of work a week, because if they did, they'd have to receive benefits. They don't have any hope of having a pension. They've often negotiated wage cuts of an ongoing nature so that their employers can compete for services. They can't afford to subsidize the system, so you have a turnover rate of almost 60%. This is the labour market.

And who are these people? These are women; in the home care sector, these are primarily new Canadians, people of colour. This is a hostile labour market policy, from our perspective. The thought that you would extend it across the hospital and long-term-care sector is just totally unacceptable to us.

**The Chair:** Mr. Fonseca, please.

**Mr. Peter Fonseca (Mississauga East):** I'd like to thank you, Mr. Hurley, and CUPE for your presentation. In regard to some of your comments in terms of the minister's meetings with different stakeholders, the minister did meet with CUPE in the minister's office—that took place in October 2004—along with a number of workshops that have happened. He's actually consulted with well over 4,000 stakeholders. I was at a number of those workshops. There were his breakout meetings. It was all into bettering and making our local health integration network the best it can be.

We've also learned much from other jurisdictions, and from those other jurisdictions where they did have elected boards at one time, they did not work. They did not work throughout Canada, and they've reverted back to appointed boards, partially through the ministry and through the community. That is what has worked in other jurisdictions. So the minister has really looked, where we've had the opportunity, to see what has worked or what hasn't worked in other jurisdictions and to bring the best here to Ontario. That's what the minister is doing.

I know you mentioned the closure of hospitals. The minister, if you heard his remarks here, has said that under his watch, under this government's watch, no hospital would be closed in Ontario. His remarks were made here this morning. In your opinion, should we not learn from what has happened across Canada and bring the best to Ontario so that, as the minister said, we could put the patient squarely at the centre of health care here in Ontario? This is about the patient.

**Mr. Hurley:** What the minister has told us is that hospital procedures will be quantified, that a price will be set for them. There will be a tender, and the tender will be awarded to those who can deliver the services, who has the HR capacity to deliver the enhanced volumes. Over time, you're going to see the movement of many hospital procedures out of smaller communities and into large urban centres.

Is it a reasonable expectation for a woman in Kenora or Smiths Falls that she can give birth in her community? It will not be a reasonable expectation in the future. You have to ask yourself how it can be that one of the richest provinces in one of the richest countries in the world cannot contemplate a health care system where a woman has the right to give birth in her own community. We have the resources for that.

This is not a factory that we're setting up here. As you know very well, these are services that are vitally important to people. They need to be close to home; they're not going to be.

**1030**

**Mr. Arnott:** I appreciate your presentation this morning. I expect that we'll hear from Canadian Union of Public Employees representatives as we travel the province in the next few days, and perhaps even when we come back to Toronto next week.

I don't know if you were here for the minister's presentation this morning, but after he concluded it, he gave the clerk of the committee a copy of his notes. It was interesting to read some of the things that were scratched out. For example, on page 6 of the original draft, which perhaps his staff had prepared for him, it said, "We set out to craft a piece of legislation that would ensure that decisions would be taken in a transparent, accountable manner, based on priorities set in communities, after open public meetings and extensive consultation." However, the minister scratched out the words "and extensive consultation." I gather he assumed he was going to be criticized for the minimal, inadequate level of consultation with groups such as CUPE and didn't have the audacity to say that to the committee, but it was in the original draft. Would you care to comment on that?

**Mr. Hurley:** We met with the minister's staff, I think, the morning that Bill 36 was introduced. That does not constitute consultation, in our view. One thing that really disturbed us during the SARS crisis was the extent to which the Ministry of Health operated by issuing edicts to its workforces and not consulting with us, even though we have the specialization around infection control, hospital cleaning etc. which could have reduced the impact of that disease. Half the SARS cases were hospital workers, so this consultation thing is a huge issue for us, and there wasn't any.

I don't believe that there was any real consultation with the people of Ontario either. So you still have hundreds of people who want to appear before this committee to have some input, and they're being turned away. That is not right.

**The Chair:** Thank you very much for your presentation.

## ONTARIO NURSES' ASSOCIATION

**The Chair:** We'll move on to the next presentation, the Ontario Nurses' Association, please. You can start any time you're ready.

**Ms. Linda Haslam-Stroud:** Good morning. My name is Linda Haslam-Stroud. I am the president of the Ontario Nurses' Association. With me today are Lawrence Walter, our provincial government relations officer, and Jan Davidson, who is one of our managers and has dealt with the restructuring across health care over the last 30 years in the Ontario Nurses' Association.

I am a registered nurse and have worked for over 28 years in the hospital sector, so I've lived through more than my share of restructuring.

I wanted to comment to you that ONA is not resistant to change. We welcome integration, as the minister quoted from our 15-year-old document this morning. However, he also said that the consequences of not getting it right are very important. So I'm here today to tell you that the consequence of the present legislation as it's tabled is not getting it right.

We are not wedded to the status quo, but we support changes that we believe are going to assist us in providing quality care to our patients and support the registered nurses of Ontario who, we are told, are the heart of health care.

ONA represents 51,000 registered nurses and allied health professionals across Ontario. In the Toronto area alone there are over 18,000 registered nurses; that's region 3 in our structure. That actually covers all or part of five LHINs. We have members working in all sectors included under Bill 36: hospitals, community care access centres, community health centres and long-term-care facilities.

We also have members who provide public health services, which, as you know, are excluded from Bill 36.

As you can imagine, health care reform is of vital interest to our registered nurses in Ontario. It is our belief, however, that Bill 36 as currently drafted neither safeguards the professional interests of our members nor protects access to and the delivery of quality, comprehensive care for our patients.

Today, although we have many concerns with the bill, I am going to focus on a number of ONA's priorities in key areas. They include providing for a health human resource plan for quality care delivery and to protect the rights of health care professionals, including registered nurses; providing for consultation on, and input into, the development of the provincial strategic health plan; and ensuring that key health care providers are included under LHINs to facilitate meaningful integration.

Our vision to get it right—as Minister Smitherman says, "Pass the very best legislation"—starts with the premise that effective integration coordinates access to quality and comprehensive services in order to implement a seamless continuum of health care for our patients.

In short, we disagree with the government's conceptualization of integration set out in Bill 36. Concepts missing from Bill 36, but in our view fundamental to genuine integration of health care, are patient-centred care, including a focus on outcomes and access to high-quality, comprehensive care within a publicly delivered model; inclusion of all major providers of health care services; open and transparent integration decisions based on the public interest and based on public priorities; and health human resource planning.

Integration in Bill 36, however, is defined in section 2 in the blunt language of restructuring. Health care services can be transferred, merged and amalgamated. Services or operations can cease, dissolve or wind up. The reality is that hospitals could end up closing, because if there is a competitive model and if all the services are

being moved away from hospitals under the LHIN boards' decisions, hospitals are not going to be able to continue to function.

The registered nurses' vision in Ontario is much different. We believe this reform of health care should be all about better coordination to improve the patient care that we provide, not about rationing care or reducing services to achieve economic efficiencies. We are already seeing the loss of RN jobs in Ontario. We are already seeing the transfer of services out of hospitals to for-profit operations. Our vision is for an integrated system that coordinates services to implement seamless health care for patients in a manner consistent with the principles in the preamble to the Commitment to the Future of Medicare Act, which the minister referred to this morning.

Let me now turn to a review of three overriding concerns we have identified in Bill 36. If we agree that the purpose of the bill should be to implement seamless health care, then the exclusion of health care services from LHINs makes absolutely no sense to us. We believe that exclusion is a mistake. How can there be meaningful integration, we ask, without consideration of all health services? Of particular concern to nurses is the current exclusion of public health, independent health facilities and physician and primary care.

Public health services, in our experience, are an integral part of the integrated health care system. SARS—we've all lived through that—demonstrated the dangers of the currently fragmented and underfunded public health system, and their exclusion from LHINs will add more uncertainty during emergencies.

From the perspective of nurses, physicians seem to have been given a special deal once again, because they are excluded from Bill 36 and will continue to negotiate directly with the provincial government. Let there be no mistake: LHINs will not be the gatekeepers of this health care system. The physicians are the gatekeepers of the health care system, and they are excluded from this legislation. We are asking you and the government to take a hard look at that, because at the end of the day we need full integration so that all health care providers are included. We certainly believe that physicians and primary care should be part of the provincial strategic health care plan as well as be included in the integrated health service plans developed by each LHIN.

In addition, we do not believe that primary health care services should be treated differently—included in Bill 36 only if they are provided by a community health centre. We are extremely concerned that the coordination of transitions between primary, community and acute care will be inadequate, because primary care physicians will have little incentive to become a part of integration decisions. We have similar reservations regarding the coordination of, and input from, public health services.

We also believe that independent health facilities should not be excluded from Bill 36. We are concerned that this will mean that hospital services that are currently publicly delivered will be moved into privatized community clinics. Although we're saying that we're not going to have the patient pay anything, the reality is that there are many services we provide in the hospitals each and every day that are not covered under the Canada Health Act. As you move those services out of the hospitals and into the community, by virtue of the act, those patients are now going to have to start paying for those services. Physio might be an example of that.

**1040**

Already we have seen companies getting ready to operate private primary care clinics in Ontario as early as this summer. Let's look at what the best research shows. In the United Kingdom the results are in: There are fewer RNs caring for patients in Britain. For your information, if you are not familiar with the literature, Canadian literature shows that there is increased morbidity—in nursing lingo, "increased morbidity" means increased disease—and increased mortality, which means death. There is increased morbidity and increased mortality as you reduce the number of registered nurses caring for patients. This is a very major concern to us, obviously, for the quality of care that we believe our patients deserve.

As currently drafted, Bill 36 puts in place a framework for the consolidation of services and disruption in delivery systems that, if undertaken, we believe will undermine patient accessibility and quality care. Actively encouraging the transfer of services out of hospitals into independent health facilities is one such example where the bill fails to preserve medicare and prevent user fees. That was the example I just gave you.

Let's move now to the lack of provisions for effective input from employees and their representatives. First and most importantly, we are concerned about the lack of an open process to determine the provincial strategic health care plan. Let me give you a few details. The fact that there is currently no requirement or process for broad public consultation regarding the provincial strategic plan for the provincial health care system that the minister is charged with developing under section 14 in our opinion is one of the most glaring oversights of the bill. We believe this is a glaring oversight because it is this plan that will form the basis for local integrated health services plans being developed by each LHIN. We understand that the actual provincial strategic plan isn't even going to be out before the LHINs plans are available. We are therefore calling for a green paper on the provincial strategic health plan to be released well in advance, and to form the basis for broad public consultation.

I would now like to turn our attention to a topic that I feel very strongly about. I am absolutely mystified how the minister would introduce legislation that is essentially silent on the issue of health human resource planning. If there's one topic that nurses have been pressing, it is the crisis we face because there are not enough nurses to provide the care our patients deserve. Because of the training time required to educate new professionals, health human resource planning needs to be done many years in advance to ensure that the specific needs of each

community are met. Because Bill 36 jumps directly into restructuring without addressing the issues that impact on recruitment and retention, such as the need for ensuring the continuity of representational and individual rights, we believe it will create a health human resource disaster. No consideration appears to have been given to how restructuring will splinter employment between sectors, how it will undermine wages, pensions, benefits and job security. Maybe it does answer that question, because it is going to gut it. An example given by the minister this morning was about satellite dialysis clinics. I can tell you that those for-profit clinics have nurses working in them who do not have pensions, have lesser wages, have no job security, and they're moving in and out, through the system, trying to provide quality care to the dialysis patients. I'm a renal transplant nurse, so that is very much part of my heart in looking at the nephrology patients in Ontario.

In addition, no thought seems to have been directed to the impact of the integration decisions on current bargaining structures. You heard Michael Hurley speak of that as well. Central bargaining for nurses in Ontario in the hospital sector covers 45,000 nurses, and we predict that, since there has been no direction given regarding bargaining structures, this could actually lead to labour relations chaos. We will propose in our written submission, which we will be providing to you by the deadline, that Bill 36 be put on hold until a thorough consultation has been conducted on the impact of this legislation on health human resource planning issues.

Even if some health services are not defined as health service providers and therefore are not funded by LHINs, it is our view that PSLRTA, the Public Sector Labour Relations Transition Act, should apply to any transfers or integrations caused by restructuring that impacts on the employment of health care workers. Therefore, we will propose that PSLRTA apply to all health care restructuring, whether or not the successor employer is in health care. I'd like to hear you guys say that quickly. You're laughing at me. It's hard. In our view, this proposal is the only way to ensure that there is at least some attention paid to the rights of health care workers and registered nurses during this restructuring.

Further, we will propose the removal of restrictions on the application of PSLRTA. Without these amendments, we predict there will be extensive litigation at the labour board. We'll see litigation over whether PSLRTA should apply, inequitable treatment of the rights of health care workers, and extensive litigation under the successor rights of the Labour Relations Act. As you know, they're already under-resourced.

PSLRTA should apply to all health care restructuring unless the employer and the unions agree it does not. We will put specific provisions in our amendments, making the legislation retroactive as well, to cover the gutting and the restructuring we've already seen.

Health human resource adjustment plans should be promoted in the legislation. It should provide for a smooth transition of the affected employees and address the issues of the transfer of job security, portability of benefits, retention of terms and conditions of employment, and representation rights.

As you can tell, we do not believe that Bill 36, as currently written, provides a firm foundation to build an integrated health care system, and it does not include the key elements: Critical health services are excluded; it does not mandate public consultation for the provincial strategic plan; it does not focus on access to comprehensive care; it does not plan for health human resources.

Our amendments, we believe, will address Minister Smitherman's concerns regarding patients being the centre of care. Every dollar of our money as taxpayers should be provided to patient care. If competitive bidding in not in LHINs or foreseen, then put it in the legislation. Our patients do come first and our amendments, we believe, are needed to provide quality patient care to the patients of Ontario.

**The Chair:** Thank you very much for your presentation.

## SERVICE EMPLOYEES INTERNATIONAL UNION, LOCAL 1.ON

**The Chair:** We'll move on to the next presentation now. It will be from Service Employees International Union, local 1.on. I believe Cathy Carroll will be speaking on this. Ms. Carroll, please have a seat. You can start anytime you're ready. There are 15 minutes in total. Please proceed.

**Ms. Cathy Carroll:** Good morning. I'm Cathy Carroll and I'm secretary-treasurer of the Service Employees International Union, local 1. SEIU, local 1, represents 40,000 health care workers in hospitals, nursing homes, home care, retirement homes and community support services in Ontario.

The Local Health System Integration Act, Bill 36, in its present form, will radically alter the kind of health care service Ontarians receive, how these services will be delivered, who will profit from the services delivered, and who will lose as a result of the integration, amalgamation and devolution of health care services.

Contrary to the Orwellian language of Bill 136, or Bill 36—and we could get those mixed up quite easily—the legislation will remove any local control over health care and place the control of health services solely within the power of the Minister of Health and Long-Term Care and the Ontario cabinet.

The Minister of Health and Long-Term Care professes his commitment to the Canada Health Act, but this legislation is an attempt to further circumvent the principles of that act. At the very least, the preamble and section 1 of the bill must contain specific commitments to ensuring that the principles of the Canada Health Act are maintained.

As this bill now reads, every health care service not covered by the Canada Health Act will be subject to privatization. The government is moving this legislation forward without a strategic plan for the delivery of health

care in Ontario. A provincial strategic plan is needed to be put into place before the LHINs can even start to develop their plans.

SEIU asks that members of this committee delay third reading until the government has held broad consultations with all of its stakeholders. The strategic plan must also include a human resource plan. To have any legislation that's going to have broad, sweeping effects on a workforce without having a human resource plan in place prior to the legislation being adopted seems kind of like putting the cart before the horse.

The legislation is flawed and its premise is based on cost containment of health care and not on ensuring that Ontarians have equal access to quality public health care services. The real name of the legislation should be the Ontario balanced budget act for the 2007 election.

**1050**

Health care workers are now subsidizing their own wages, up to $900 per year, in a health care tax. Every hour a nurse works, 50 cents goes to the Liberal health tax. Apparently, the government believes that health care workers can sacrifice even more with the introduction of this bill.

LHINs are undemocratic. The boards are not elected. Sections 7 and 8 of Bill 36 must be amended to provide for the election of LHIN boards of directors. That the legislation gives greater control over health services to local authorities is just patently false. What chance would a small community have to decide what health services it wants when the community is lumped into a LHIN with larger metropolitan centres? Section 9 suggests that LHIN meetings are public, but what citizen would travel 200 kilometres or more to attend a board meeting?

Reconsideration of LHIN decisions, as outlined in sections 26 and 27, do not allow affected parties much time to appeal: 30 days. Will unions holding bargaining rights have the right to the reconsideration process? That's not clearly outlined. The very short time frame for any party to make a submission for reconsideration and to study the impact a LHIN board decision will have on a local health service suggests that the government wants to limit the appeal process.

Why does the government draw the line at the health care providers, as defined in the act? Why are independent health facilities, physicians, laboratories and ambulance not included? These independent health facilities could be operated as private clinics but funded by public health care dollars. Physicians are excluded from the legislation. We ask, how can doctors act in an advisory role without being part of the entire health system?

The legislation gives near-dictatorial powers to the Ontario Minister of Health and Long-Term Care. The Minister of Health will have greater control over the kind, type and amount of health care that's provided in each LHIN throughout Ontario. Section 28 of the bill allows the Minister of Health to order a health service provider that carries out an operation on a not-for-profit basis to cease operating, dissolve or wind up its operation, amalgamate with one or more health service providers, transfer all or substantially all of its operation to one or more persons or entities, and to take any other action necessary to transfer property. What the LHIN lacks in power, the Minister of Health can do.

Section 33 will allow the government to order health service providers to cease operating and transfer their property. This leaves the door wide open to greater privatization of the health care system. For example, a LHIN could require the transfer of health care services, such as chronic care, from a public hospital to a private, for-profit nursing home.

LHINs financing: The Ontario government promised it would deliver a balanced provincial budget before the election of October, 2007. This legislation will make that promise a reality—the only promise, apparently, that the government intends to keep. The only way this government can balance the budget is to take a big bite out of health care. No LHIN will be allowed to have an operating deficit. This legislation is not about building a better health care system, but rather how to control health care spending.

Even before the LHINs are operational, it is costing Ontario taxpayers millions of dollars in start-up costs. Democratically accountable district health councils were shut down, the hiring of 550 new bureaucrats to operate the LHINs will cost $52 million, and almost $200 million will be spent on setting up the bureaucracy. This will not add a single family doctor, medical specialist or direct, hands-on care provider to the health care system in Ontario. Add to this the fact that the government has funded the Hospital Business Services corporation in greater Toronto $42 million to eliminate full-time jobs at 16 greater Toronto area hospitals, and the HBS will devolve non-clinical services to for-profit providers. We're already seeing this. It is the exact prototype the government wants the LHINs to follow.

When we reviewed the Hospital Business Services model last year, we found no savings or any return on investment that could be achieved. If there is no community control over hospital services, why should citizens bother to volunteer, to raise funds or donate to specific hospital campaigns? If a LHIN has the power to move the service the community raised funds for, why bother with the effort?

Last summer, SEIU met with several Liberal MPPs to relay our concerns about the lack of nursing home standards, the quality and continuity of care in the home care sector, the private financing and construction of Ontario hospitals and also our concerns about the local health integration networks. Many Liberal MPPs told us that it was not the intention of this government to achieve health care savings on the backs of health care workers. Were we again mistaken? Clearly, the legislation will affect every health care worker's livelihood.

Home care workers continue to be subjected to competitive bidding. Bill 36 has the ability to extend the competitive bidding model to all health care service sectors. Everything is for sale, including our workers' livelihoods, and it is not what this legislation is supposed

to be about. Transferring public health care assets to private for-profit enterprises is not what the health system in Ontario was built on.

SEIU represents mainly service, clerical and home care workers in Ontario's health care sector. That's why we're very concerned about Bill 36's terminology: "non-clinical services." Any time there is a transfer of a service, a person or entity under an integration order, the transfer of all or substantially all of the operations of a health service provider and the amalgamation of two or more persons or entities under integration decision, the Public Sector Labour Relations Transition Act, 1997 will apply. However, if the successor employer is not a health service provider and the primary function of that entity is not the provision of services within or to the health care sector, then it will not apply. Non-clinical service transfers will be subject to the provisions of successor employer and sale-of-business provisions under the Ontario Labour Relations Act. PSLRTA will not apply where the Ontario Labour Relations Board issues an order declaring that it does not apply. In other words, the government wants to remove the protection of current collective agreements from health care workers.

Our members' jobs have been under pressure for years. Hospital service and clerical workers' wages average $33,000 to $35,000 annually. Nursing home workers average a few thousand dollars less. Most home care workers' annual incomes are below the poverty line.

Many health care workers are immigrants and women. Does the Ontario government really want to create a class of health care workers toiling for poverty level wages, with no benefits and no pensions?

Competition in the home care sector has eroded the continuity and quality of care. Competition in the rest of the health care system will do the same. You've already heard from the previous speakers on the competition and how it has devastated workers' wages and livelihoods.

Nothing in this legislation must override collective agreements or trade union representation rights. Health care workers must be assured that their jobs are protected, their wages and benefits are protected, and their pensions are protected. No integration decision should be made by the government to alter the terms and conditions of employment of an employee, including collective agreements, without their union's consent. The application of PSLTRA should not be subject to the discretion of the Ontario Labour Relations Board.

The integration of the 42 CCACs into 14 will have serious consequences, for both home care clients and service providers. The RFP process has subjected home care workers to second-class-citizen status in the province. They are not entitled to successor rights under the Ontario Labour Relations Act. If the 42 CCACs are integrated into 14 LHINs, they will be aligned to face this new reality. Contrary to Elinor Caplan's observation when she was doing the review on home care that competition is good in the home care sector, all the evidence leads to the contrary. The fundamental element of a home care delivery process must be continuity and quality of patient care. At the very least, a human resource plan based on this model must ensure that workers have successor rights within the industry.

The successful care agency in the RFP must be bound by any existing collective agreement with the union that represented the employees with the previous agency.

In conclusion, Bill 36 is a revolution in health care, and there will be a lot of carnage left on the battlefield if this legislation passes in its current form.

Bill 36 says nothing about the quality of care that the LHINs will deliver. The bill is about the bottom line, how to balance a budget, Ontario health care workers and consumers be damned.

**The Chair:** Thank you very much for your presentation, Ms. Carroll.

**1100**

## ONTARIO PUBLIC SERVICE EMPLOYEES UNION

**The Chair:** We'll move to the next presentation, the Ontario Public Service Employees Union, Leah Casselman, please. Any time you're ready, Ms. Casselman, you may start.

**Ms. Leah Casselman:** Good morning. How is everybody today?

**The Chair:** We're doing very well right now.

**Ms. Casselman:** Good. I'm glad. With me is Patty Rout, who will be presenting right after myself. So we will go through our presentations and then we'll open it up for questions, if that's acceptable to the committee.

**The Chair:** Terrific.

**Ms. Casselman:** As you know, I'm Leah Casselman. I'm president of the Ontario Public Service Employees Union. We represent just about 40,000 health care workers right across the spectrum of health care delivery. We are pleased to be here to have the opportunity to formally present our views before this committee. A more detailed written submission will be filed next week.

Sadly, it appears the LHINs are a fait accompli. It appears the minister first decided to set up the LHINs and is now making a plan for the system. It seems to me that you should first plan and not put the cart before the horse.

My union believes it is not necessary to create chaos across the health care system. We do not have to fix what is not broken. We need less fragmentation and more coordination. We do not believe that the proposed LHIN structure will accomplish that.

We first heard about the local health integration networks in July 2004, when many of our members and staff were on holidays, surprisingly enough. We heard almost by chance that the ministry had concocted a plan to restructure health care in Ontario. We were shocked and offended that plans of this nature were being rolled out in the midst of a summer vacation season while virtually no one was paying attention and without any public consultation. Our union raised the alarm then and has continued to be active in informing the public about

the LHINs. We also understand that Monique Smith was brushing her teeth at the time she heard our radio ads and dropped her toothbrush in the sink, because of course they thought no one knew what was going on and they could just kind of slide it through.

As time passed, we learned more about what this government had planned for health care workers. We learned that the government was planning to set up 14 unelected, unaccountable entities to control health care. We learned that these new bureaucracies would be able to open the door to competitive bidding right across the health care system. We learned that they would have the power to move services around within their regions, depending on who could provide the service of course at lowest cost. And we learned that jobs and patient care were at risk.

In November 2005, a coalition was formed by the four largest health care unions to step up the fight against these LHINs. We've held meetings this month in 17 cities for members of the four unions. We have listened to the concerns of our members—and there have been lots.

*Interruption.*

**Ms. Casselman:** There's not a message on there for me, is there, Peter?

**The Chair:** Please proceed.

**Ms. Casselman:** We will be hearing some of our members directly over the next few days, and I hope that you would pay more attention to their presentations, perhaps.

Also this month, 160 of our members of OPSEU in regional offices in the Ministry of Health were among the 300 workers who became the first casualties of LHINs. These workers have an excellent knowledge of the health care system in their regions, but they, along with their expertise, have been shoved aside to make room for political appointees. I understand there is one at the back of the room here.

Our members see this bill as opening the door to competitive bidding, while moving accountability and transparency out of our health care system. Our experience tells us that this is a mistake. Let's go back to the summer of 2004. That's when the Victorian Order of Nurses, beloved in the Niagara region, after 80 years of service lost its contract for providing home care services.

The VON lost this contract because the community care access centre awarded it to a lower bidder: a company with no previous local experience, a company with no staff, and a company with even no office. The community was up in arms when this news came out. No one could imagine that the Niagara region would be without the little red VON cars, sponsored by local businesses, zipping around and providing home care to patients. They even built a little park in one of the communities to celebrate the history of the VON. You could not open up a newspaper or turn on a radio in the region without hearing about the loss of the Victorian Order of Nurses.

These VON staff, also OPSEU members, were extremely upset by the loss of their livelihoods. One nurse said that she would rather sell doughnuts at the coffee shop than work for a private health care company. By the way, did I tell you that it was a private, for-profit company that won that lowest bid to provide services in Niagara?

Patients were upset too. Elderly and infirm people do not like change. They do not like it when a new person shows up instead of the person they know. They particularly do not like it when nobody shows up, which happened in a number of cases. So that's what happens with competitive bidding.

Concerned members of the community—OPSEU members, patients, the VON, the Niagara media—all asked Minister George Smitherman for a meeting. George Smitherman was very polite and basically said, "My hands are tied. The process is legal. There is nothing I can do. Sorry."

This, or a similar scenario, has played out all across Ontario since competitive bidding came in through the CCACs. The highly respected local chapters of the VON and other organizations with long-standing records of care and community service have been driven into bankruptcy by the Harris-Eves and McGuinty governments' policies. This is merely a continuation of those.

I want to ask members of this committee if you can imagine the hardships felt by patients who had interruptions in health care services as a result of the competitive bidding process.

Why are we talking about this in the context of LHINs? Well, the LHINs will open the door to competitive bidding, not just in home care but in hospitals, in long-term care and in many other aspects of health care. The bill may not state that explicitly, but the maintenance of the purchaser-provider model makes it inevitable. The LHINs bill will make it very easy to privatize a service and very difficult to get it back into the public sector.

I remind you that there is nothing innovative about private sector involvement in health care. There is nothing innovative or new about making a profit from people's emergencies, illnesses or injuries. This is not health care reform, as some would have it. True reform of health care is using the revenues of the province on a public, non-profit basis to provide proper health care for everyone in a time-tested model. It is not using taxpayer money to pay profits. Innovation is finding creative ways of looking after one another, not profiting from people in their time of need.

The system we have in place is not broken; it is underfunded. Ontario's hospitals are already very efficient. They have the shortest stays in Canada: an average of 6.6 days. Ontario hospitals treat more patients on an ambulatory basis than any others in Canada and are the most cost-effective. But some people say that the system is broken. They say that we need a regionalized care model even though some of our hospitals are already spread out over huge geographic areas.

**1110**

Our belief, and it is shared with our coalition partners, is that the LHINs are merely a smokescreen for the

minister so that he can avoid responsibility for unpopular decisions made in the regions across this province. Once again he will be able to say, "My hands are tied. The process was legal. There's nothing I can do. Sorry," but now on a much larger scale. This spreads right across, beyond home care.

Another related concern is that services will be contracted out of many local communities under the LHINs. The LHINs aren't local. Don't fall into that trap. The average LHIN is roughly the population of Saskatchewan or Manitoba. For that matter, the LHINs are not about integration. Many of the key parts of the health care system are not in the LHINs. How could you forget the gatekeepers of the system: primary care, family health teams and doctors? How could you forget drugs? Pharmaceutical costs made up 16.7% of health care expenditures in 2004. Drug costs are the fastest-growing expenditure in health care, yet pharmaceuticals are left out of the structure.

Members of the committee, I know that you too face competitive bidding for your jobs in 2007. Maybe you don't have any sympathy for the health care workers who have been laid off or those who are facing uncertainty, but remember: When health care workers leave their jobs or are laid off, there may be no one around with the same training and experience to replace them. Remember that when the next virulent disease hits our hospitals. Those who went through the SARS epidemic and know what to do may no longer be working there. Remember that sick and elderly people will suffer.

If you allow the LHINs legislation to proceed as written, this union and our coalition partners will be there to remind users of the health care system, and their families, why they have to travel that extra 100 kilometres for surgery. We will be there to remind families that many health care workers have left their communities, along with their salaries and the services they provide, because of the chaos this bill is creating.

Our members know the health care system. They care deeply about what happens to their patients. They are the experts. Please, as you travel this province, we would ask you to listen to their voices.

We are calling on the government to withdraw this legislation so that it can engage in a proper consultation process on a provincial strategic plan. If enabling legislation is required for that plan, it must include provisions for proper transparency and accountability, and provisions that uphold the fundamental principles of the spirit of medicare, not just the letter of the law. It must stop the transfer of services out of hospitals, which is being done to avoid the coverage of the Canada Health Act.

I will now ask Patty Rout, who is the chair of our health care division, to make her presentation. Then we'll open it up for questions, if we have time.

**The Chair:** You have three minutes left. Please proceed.

**Ms. Patty Rout:** Good morning. I am Patty Rout, a lab technologist at Lakeridge hospital in Oshawa and chair of both the province-wide health care divisional council of OPSEU and the hospital professionals division. I represent health care workers in all areas of health care, and as an OPSEU board member I serve workers in Haliburton, Algonquin Park, Barrie, Orillia, Oshawa, Cobourg and all parts in between. I have travelled this province two winters in a row to discuss the impact of the LHINs with workers whose jobs and patients will be affected. In this capacity, I have been able to hear the concerns of thousands of health care workers about these LHINs. I am pleased to be able to share the views of these workers with this committee.

We are opposed to the regionalization of care when it involves the movement of hospital services from public to private, and from near to far. We oppose keeping services in constant flux, jobs that move from one hospital to another, and the uncertainty and fear that these so-called integrations cause.

In my own region of Durham, I have already seen how amalgamations and regionalized care have threatened our services. The lack of multi-site funding for the hospitals has created huge difficulties for that region. Just take a look at their deficit budget. If you can't manage four or five hospitals, how are you going to manage it in 14 LHINs?

Just before Christmas, we received word that the pediatric unit at the Rouge Valley hospital in Ajax was being closed and that all services were being moved to Scarborough. For families in Ajax, Pickering and points east, this was going to be a huge hardship. The distances aren't large, but it's a major problem for many people. If any of you have driven on the 401, you certainly know what it would be like if you were having a baby and it was 7 o'clock in the morning in Pickering. Who knows? You'd probably have that baby in the car.

Second to that, not everyone has a car. Travelling from Ajax to Scarborough by public transit literally takes you most of the day. That just isn't an option for a sick child. Our hospitals are part of our community; our tax dollars went to build these hospitals; our tax dollars continue to provide service—full service—for hospitals. As a result of this belief, hundreds of patients and workers attended a meeting in December in defence of these services being available locally. Miraculously, the money was found, but the question is, for how long?

Our concern is that this is already happening across the province. Services are being rationed and moved around, such as nuclear medicine, physiotherapy, biomedical, social workers—I could go on and on. With the LHINs in place, this will happen more and more frequently as the LHINs are forced to ration and centralize services and contract out to the lowest bidder. My father used to say, "You get what you pay for." I don't believe that has changed. We can't have two-for-one sales in hospitals.

Ironically, the sector repeatedly targeted by the Minister of Health is hospitals. It is ironic because the hospital sector has been the star performer in Ontario's health care system. Ontario has fewer hospital beds per

capita than any other province. The Hay Group's March, 2004, study also said that Ontario hospitals are more efficient than others in Canada. The report shows that Ontario's hospitals have a lower potential for finding additional savings than others in Canada, which is a reminder of the efficiencies that they already went through.

Once again, our members are being asked to cope with the chaos that has been created when the whole system is amalgamated, merged, transferred—any way they can find to squeeze a dime out of the system. I have not even mentioned the effect of competitive bidding on hospitals; Leah has done that. But home care is simply not a career option anymore for most health care professionals, and that's thanks to the competitive bidding system put in place by Mike Harris.

We don't want to see the same thing in hospitals. We also wonder if this is truly integration or something else. While the government presents the LHINs as a solution to the integration problem within the system, key parts of the system remain outside, and Leah mentioned a few. Here are more examples:

—The ambulance service is outside the LHINs despite all the problems they're having now interfacing with hospitals.

—Public health is left out despite the lessons learned from SARS. My members will tell you that if you went to the Scarborough Hospital right now, it's in a worse situation than it was the day SARS happened there.

—Hospital laboratories are in the LHINs, but private laboratories are not. Strange.

—Psychiatric hospitals run directly by the ministry are out, but the divested ones are in.

—The independent health facilities, a growing area of health care, are run primarily by doctors. Those are out as well.

This government has just approved $20 million from the feds to go to the independent health care facilities who provide diagnostic imaging such as x-ray, ultrasound and nuclear medicine. Who are they accountable to? Will there be profit made when it should be used for better care?

Another example: The regional laboratory plan for eastern Ontario, known as EORLA, and other similar structures are also out of the LHINs, even though those hospitals provide care for patients and the lab work is done for those hospitals.

How do you integrate a system when you leave so many important services out of it? This inconsistency will mean more fragmentation to communities than presently exists, and ironically, the LHIN legislation actually encourages transfers to these organizations that are outside the LHINs. Was this the intention? I don't know. But for those workers affected, there are many huge questions that have not been answered.

In the last round of hospital restructuring, the Health Services Restructuring Commission recognized the need for a human resource adjustment plan to be negotiated with the unions. This time, there is no human resource strategy. I attended a LHINs workshop a year and a half ago. That was a priority in the Markham LHIN; it was also a priority in a number of the LHINs, more than not, and yet it was still ignored. There's already a huge retention and recruitment problem for all health professions and others, and this legislation is going to make it worse. We are already wondering who will be working for us when we're 65 or over. I don't think you want me with a crutch, pushing a stretcher down the hall. Constant chaos and threats of amalgamations and transfers do not help. Who is going to relocate—this is the big question—to a remote community when the rumour of having the service transferred to another centre is frequently rumoured? If you want proof of this, just look at what happened at Scarborough General, look at Sarnia with the palliative care, look at nuclear medicine in Oshawa. It goes on and on.

**1120**

The province needs to negotiate a human resource adjustment plan now. The government must be willing to substantially fund these plans, and this plan should have, at a minimum, layoff as the last resort, measures to avoid a layoff; voluntary exit opportunities; early retirement options; pension bridging; and retraining options. A transitional fund should be put in place, and a health service training and adjustment panel should be resurrected now, not later.

This legislation must not go forward without a human resource plan. Without health care workers, you have no health care.

**The Chair:** Okay, we have about nine minutes left, three minutes each, and I'll start with Ms. Wynne.

**Ms. Wynne:** Thank you very much for being here. I just wanted to make sure, and you've made a joint presentation, so I'm going to address both of you, and whoever wants to answer the question—I'm assuming that you are aware, both of you, of the meetings that have happened with the ministry in terms of the consultation. You've met with the minister a number of times and your organization has been asked for recommendations, so that conversation has been going on for some time. I think it's really important, because obviously you represent people who are on the front line and it's very important that we listen to you, which is why the minister has met with your organization.

I wanted to also make sure that you're aware of the open process that we're requiring LHINs to undergo when they have their meetings: that the meetings will be open in the community, that there will be access by the community to what the LHINs are talking about, what they're planning. There's a section of the bill that specifies community engagement. It's not as specific, perhaps, as some people would want, but what it does is allow for the LHINs to develop their community engagement processes. I think that's important, because each community is going to have to do that differently. You make a comment about the size of the LHINs—

**Ms. Casselman:** I'm assuming these are questions. Are these questions?

**The Chair:** Madame, please.

**Ms. Wynne:** I'm coming to a question. You've made a number of points, Ms. Casselman, and I think it's important that we make sure you understand the issues.

**Ms. Casselman:** I know that the minister's staff have given you some questions to ask, so I'm just waiting for them.

**Ms. Wynne:** No. Actually the minister's staff didn't give me questions to ask.

The last point I wanted to make is that you make a statement about not fixing what's not broken, and I guess it's a little surprising to me that you—especially people who are on the front line—wouldn't feel that there is room for improvement, that there's a need to improve the health care system in Ontario, especially people who have been involved in acute disease and epidemic, that you understand that there needs to be improved communication and there needs to be a plan. Could you let us know exactly what changes you would make in order to make the health care system more coherent?

**Ms. Casselman:** Yes. I think that's part of our presentation. I'll just start by saying, never open up a question with "assume," because we know what "assume" means, right?

On the consultation, we met with the minister himself and the ministry staff on a couple of occasions. The first time we met with the minister, we said, "Okay, where's your human resource plan?" He said, "My what?" and we went, "Uh-oh." We actually came back on a couple of occasions with the good, the bad and the ugly of Bill 36, what worked, what didn't work, and then we found out from subsequent meetings that that side of the equation had been moved over to the Ministry of Labour. Yet we see very little of it in the legislation, even though, apparently, the Ministry of Labour was involved in the drafting.

On the openness piece, I guess it depends on what kind of openness you're talking about. I'm not quite sure what kind of openness there would be for the folks in Peterborough when they're connected to a LHIN in Scarborough. I think they're kind of outnumbered. On the information and openness of the meetings, whether or not the mostly retirement community could travel to wherever that LHIN is going to be that's attached to Scarborough, it may be a little difficult for the constituents in that area.

What's not broken? If we, God forbid, have another SARS in Toronto, where does the public health department go to? To which of the four or five LHINs that they're now connected—where do they go to find out how they coordinate an attack on whatever that disease will be, because of course there will be another one. You had district health councils where communities and municipalities had a seat. You had Ministry of Health offices. If you just wanted to make sure you were devolving more authority or responsibility away from the central ministry, you could have beefed up those areas, because they were already in the communities, already staffed with qualified folks who knew the health care system—

**Ms. Wynne:** And many of those will be involved with the LHINs.

**Ms. Casselman:** Now you're hiring guys in from London who are over here, I guess, for a reason: to look at our health care system. Having been in England in September, we don't want to duplicate what they're doing over there.

**The Chair:** Ms. Witmer, please; three minutes.

**Mrs. Witmer:** Thank you very much for your presentation. It certainly is very honest and frank, and I have to compliment you on the courage to come forward and express those concerns.

**Ms. Casselman:** I've never been shy.

**Mrs. Witmer:** I know that, Leah, and I do appreciate that.

Maybe you want to expand on the fact that the LHINs are not local. That's a concern that I've certainly had. You've pointed out that the average size is going to be the population of Saskatchewan or Manitoba. What impact do you think that's going to have on decision-making?

**Ms. Casselman:** I think it'll be totally left in the hands of whoever is being appointed by the minister and whoever they end up hiring. I don't believe—whether there are open meetings. And we still don't know how open they're going to be and what kind of input local folks can have when you're travelling from Timmins to Sudbury to Wawa. If you've got issues with the health care being provided in your community, whether it's aboriginal health care services because the population is higher or whether—again, I come back to Peterborough and Scarborough. Give me a break. What are the connections between Haliburton and Peterborough and the health care requirements in Scarborough? So having the size and the volume when you already had district health councils with local communities involved and that kind of stuff, and you had Ministry of Health offices in those communities—I think we're losing an opportunity here to really make a health care system that is going to work for local people.

**The Chair:** Thank you. Ms. Martel.

**Ms. Martel:** Thank you very much, both of you, for being here today. Let me focus on local control, because you referenced that it was your staff who have become the first casualty of LHINs. Yet the minister would like to say that the LHINs are all about input and consultation at the community level. If you look at the legislation, it's clear that it's cabinet that creates, amalgamates, dissolves and divides the LHINs. It's cabinet that appoints the LHIN board members; they don't come from the community at all. They serve at the behest of the ministry. They're even explicitly defined as agents of the crown in the legislation. Each of the LHINs has to enter into accountability agreements with the ministry, and if they can't agree, the minister can set the terms of those agreements. They're funded on the terms and conditions that the minister considers appropriate. The list goes on and on.

So in terms of community involvement, these folks—the cabinet, the minister and the LHINs—have even more

control than what we saw before with respect to, for example, the Health Services Restructuring Commission. I think they're going to be a front for government decisions, negative ones, in the same way that the Health Services Restructuring Commission was. I wonder if you want to comment on that.

Secondly, can you comment on how your own members who were at the Ministry of Health doing health planning, who were involved in the community, feel now that basically their jobs have been lost to the LHINs?

**Ms. Casselman:** Well, I have to make a pitch for successor rights, because this government has promised to give back what the Tories took away, and we're still waiting. So maybe they would have had an opportunity to move their skills and ability to the LHINs. I don't know whether that would apply. If they had had successor rights they would have been able to at least stay in the ministry. So that's now lost to us as citizens, their work, because those folks are gone; they don't have the ability to stay.

In relation to, again, the local control and input, we don't see it. That expertise is lost to us as taxpayers from those folks who are gone, and the fact that these appointments are made by the government. It's merely—as I'm known to say—a prophylactic protection for the minister in regard to very difficult decisions that they're going to be making in cutting and moving health care services out from under the protection of the Canada Health Act. The more they can divest and devolve out of hospitals and the communities, we're going to see more and more competitive bidding set up, as we see in the home care sector under the community care access centres. And the fact that these are appointed and are not accountable to the communities where they live, I think, is going to be a real disservice to us as taxpayers for our Canadian health care system, our medicare system.

**The Chair:** Thank you for your answers and your comments.

**Ms. Casselman:** Thank you very much.

## CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 815

**The Chair:** We'll move on to the Canadian Union of Public Employees, local 815.

**Mr. Perry Levac:** Good morning, ladies and gentlemen. This is actually my first time ever doing anything like this, so I'm kind of beyond myself here. My name is Perry Levac. I'm a steward with CUPE local 815. I'm an electrician at the Oakville and Milton hospitals. I'm here regarding Bill 36, or as some people have been calling it, the LHINs. I'm going to try to keep this simple and fast, basically a brief outline. The main thing is that I wanted to come out and make a point so that you people are aware that there is a lot out there that people don't know, that they should be made aware of.

**1130**

There are a lot of people out there who don't know anything about the LHINs or how they will affect them. I was one of the lucky ones who had the opportunity to find out about Bill 36, and I've been telling everyone I can possibly find.

How can you think of putting through such an important bill that affects so many people, and yet the public has so little input? I've been doing a lot of reading about Bill 36, and to be frank with you, it scares the pants off me. From what I understand, a lot of jobs will be affected in order for this to work. And yes, I will be one of the people who lose their jobs, but not right away.

The part that scares me the most is the whole set-up, with the lowest bidder getting the work. I have been in construction for over 20 years and I am sure it will end up, just like the construction industry, with shortcuts and many secrets in order to save money and time and will in the end, result in careless errors, which in turn hurt and cost lives or more money. You can't have a good health care system if every two years you put part of your operation out to tender to keep the price down. This will mean many changes to staff and loss of knowledge for that site. I know that I would not appreciate the lowest bidder doing surgery on me. Would you?

There is a lot to know about LHINs, and there are many questions that need to asked and answered. There is a lot here, and this whole process has gone way too fast, and too secretively, for it to be a good thing.

Quick; simple. Thank you very much, people.

**The Chair:** Thank you. Just wait there in case there are any questions for you. Next would be Mr. Arnott, please. There is lots of time.

**Mr. Arnott:** You did a great job on your first presentation to a standing committee. I hope you'll come back again in the future if you have concerns about legislation. You were concise and straightforward and your point was made loud and clear. We appreciate your input.

**The Chair:** Madame Martel.

**Ms. Martel:** Thank you, Mr. Levac, for coming this morning. You're an electrician?

**Mr. Levac:** Yes.

**Ms. Martel:** In which hospital?

**Mr. Levac:** I'm the electrician for the Oakville and Milton hospital sites.

**Ms. Martel:** And you've been doing that for the past 20 years?

**Mr. Levac:** No. I've been in the construction trade for the last 20 years. I've been in and out of the Oakville and Milton hospitals, doing work for the last 15 years. I've been employed by Halton Healthcare for the last three and a half years.

**Ms. Martel:** Halton Healthcare—correct me if I'm wrong—has been expressing concerns about their financial ability to manage a number of sites and whether or not they're receiving appropriate funding to allow them to do that. Or do you know?

**Mr. Levac:** I don't quite understand the question.

**Ms. Martel:** It was in the back of my mind, because you're working at a couple of different sites and working for Halton Healthcare, that they actually manage—not manage; run, operate, oversee—a couple of hospital sites.

At previous public hearings they have come before us to suggest that their need to have to manage a number of sites is not taken into account by the government, that the money they get to do that doesn't really cover all their costs, so they are continually looking for ways and means to cut services in order to balance their budgets. I don't know if that is the case, if we've got the right health care group or what the situation is in terms of the hospitals that you're working in now with respect to both deficits and cost-cutting measures, and how much of that would actually be shared with staff like yourself, for example.

**Mr. Levac:** I really can't answer that question. The only thing I can really talk about is past experience working at the two hospital sites. The workload for me: There is one electrician for two hospitals, so I'm constantly bouncing back and forth from site to site. But as far as the money aspect, ever since day one that I've been down there, I have been asking for another electrician. Finally, down at the Milton site they are going to be losing a plant technician and getting another electrician to help me out down there. That's about the best way I can answer that question.

**Ms. Martel:** All right. Thank you.

**The Chair:** Ms. Wynne, please.

**Ms. Wynne:** Mr. Levac, thanks for coming.

First of all, I just wanted to give you a piece of information, and then I had a question. One of the reasons we're having seven days of hearings rather than two or three or four is that we wanted to get as many people to be able to talk to us as possible. I just wanted to make that clear. There was a large number of people who wanted to speak to this bill, so we've tried to accommodate as many as possible.

You made a comment about losing your job as a result of Bill 36. Have you been told you're going to lose your job?

**Mr. Levac:** No, I have not been told that I will be losing my job. It is just an assumption, but since I am part of the support staff at the sites, it only makes sense that the support staff would be contracted out.

**Ms. Wynne:** I think that's part of what's going on here, that there are people spreading that kind of information that is not based on anything that's in this bill, particularly. So I think we need to be clear, as the government to a citizen, that it's not our intention that you would lose your job; it's our intention that health care would be better coordinated in the province. That's what this bill is about. So to the extent that we can make that happen and you can keep your job, then we will be successful.

I just want to be clear that there are different stories going around, and it's in the best interests of people who are opposed to change and opposed to rationalization and coordination of the health system to get people like you worked up about losing their jobs, when that may not at all be what's going to happen. And I hope it's not what happens. So I just want to make that clear.

**Mr. Levac:** Well, the losing my job part is actually the smallest part of it all. It was more or less the subcontracting. Unfortunately, I'm not a very healthy person and my wife is not a very healthy person. The one disadvantage—let's say I did happen to lose my job, or somebody in a situation like me who doesn't have half-decent benefits, where they have to dish out more money in order to even pay for their medicines. I don't think that's a proper thing. I think there are a lot of things that haven't been answered.

I read the bill as much as I can. Unfortunately, I don't know that much about politics to understand the bill properly, but there are certainly a lot of questions in there that I think really do need to be answered.

**Ms. Wynne:** There's nothing in the bill that would instruct any organization to contract out your service or set up a situation where you would lose your job. I hope that doesn't happen. Thank you for coming.

**The Chair:** Thank you very much for your presentation.

## ONTARIO FEDERATION OF UNION RETIREES

**The Chair:** We'll be hearing the last one before the break for today, and that is from the Ontario Federation of Union Retirees. Joyce—please have a seat, both of you. Good morning.

**Ms. Joyce Cruickshank:** Good morning. The last name really isn't as difficult as it looks. It's Cruickshank. With me is Orville Thacker. He's the president of our organization.

**Mr. Orville Thacker:** The reason Joyce and I are appearing here this morning is that we're very concerned about health care. I think the various levels of government have given us enough reasons that we should be very concerned. Not even two years ago, the Prime Minister of the day and the Premiers met, and they were going to cure health care for the next decade. The Premier of Ontario was a party to that group.

We just went through a federal election campaign, and the main thing in those discussions was the deterioration of our health care.

Joyce and I are both volunteers. I'm the president of the federation of union retirees, and Joyce is the secretary. We're not appearing here because we're going to lose our jobs. We're concerned about people who may be losing their jobs, but overall we're concerned about health care and the condition it's in in this province.

Joyce is going to present our paper, and we'll be available to answer any questions you have at the end.

**Ms. Cruickshank:** Good morning, everyone. Our particular organization has affiliations in Ontario from over 35 organizations, which represents, of course, thousands of retired union members in the province of Ontario. Our affiliates come from many union organizations across the province: Steelworkers Organization of Active Retirees, also called SOAR; the Canadian Union of Public Employees; auto workers by the hundreds, that's for sure; Communications, Energy and Paperworkers; COPE, the Canadian Office and Professional Employees; and the list goes on and on. We are directly

affiliated with the Canadian Labour Congress and with the Congress of Union Retirees of Canada, also called CURC.

**1140**

Our constitution has a number of things that it mandates us to do and, of course, one of those is to secure and protect Ontario retirees' mutual welfare, benefits and all those things that accrue to their families by whatever means we can. We believe that there are legitimate aspirations of those who work very hard for a living, and you've heard many of them today.

Our health care system is the cornerstone of our existence. As seniors and retirees, you can probably understand that. We're committed to informing you of our concerns around Bill 36. We believe very firmly in the five principles of the Canada Health Act: accessibility, affordability, public funding, public administration and not-for-profit status—we can't say that strongly enough. We strongly support the Ontario Health Coalition's position regarding Bill 36. I understand that they're presenting to you this afternoon in a great deal of detail, so rather than reiterate all of their points, we'll refer to some and then try to relate it to our own particular experience as citizens, retirees and former union members.

We feel that the bill is a health restructuring bill at heart, no matter how you look at it, but without the checks and balances in place needed to make it responsive to Ontario citizens' needs in health care. In the last round of restructuring, we got hit pretty hard as well. There were hospital closures in a lot of places, staff layoffs, funding shortfalls—we had an awful time. I guess you've heard this from a lot of communities here.

Although we're a provincial organization, most of our experiences that we would relate to you today would come from Waterloo region. Our population is nearing the 500,000 mark and it's growing in leaps and bounds. During the time of the hospital restructuring, we had three acute care hospitals. Down came the mandate that one of them would close. That was St. Mary's Hospital. The time, the energy and the resources committed to trying to keep that hospital open were just phenomenal. Just think of what they could have done if they'd been able to direct that towards improving things at the hospital instead of trying to convince the government that it was a wrong-headed move in the first place.

In our region, in regard to seniors' services, the lack of long-term-care beds and nursing home beds means stressed-out caregivers, and most of these, of course, are women; they're just right at the bottom. I know one of these ladies personally, and when I see her several times a week, I just look at her face and I can see she's had, as usual, about three hours' sleep a night. She's waiting for a long-term-care bed; she said that they told her it would be a year. That kind of stress on ordinary people is just unbelievable, and they're doing this at a risk to their own health and well-being; they're carrying the burden. Is this the kind of end you'd want for your own parents? I can honestly say I would think that you wouldn't.

In Sudbury, some seniors are being sent as far away as Parry Sound for long-term-care placement, which is completely unworkable. How can family members visit at such a distance, even supposing they have their own transportation? How are their doctors going to see them, or are they just shifted off to somebody else who doesn't really know them? How are their ties to their home community maintained? If they refuse this distance placement, does their name go back down to the bottom of the list and they start all over again with the wait?

We do not agree with the centralization of power towards Queen's Park, with the LHINs reporting directly to the minister. Any organization that controls the health system in an area should be responsible not only to the government but also to the citizens that live in that particular area. I understand that members of LHINs are going to be appointed by and responsible to the government. There is a definite lack of democracy there. Who said that they should be picked in that manner? There should be some other way to do it.

Political appointees do not necessarily have the best interests of their assigned community at heart. We saw that in the decision to close St. Mary's. As well, the tendency to appoint those with little or no background in public health care delivery is dangerous. Business appointments are, by their very nature, inclined to look at the bottom line of dollars and cents, profit and loss, and that makes perfect sense to me, but not to a health care system.

We find it difficult to reconcile this mentality with a system that is supposedly designed to answer the health needs of its citizens, heal them, cure them, rehabilitate them and maintain their good health. You may be saying, "Trust us to do the right thing," but we have a problem with that in Waterloo region. A funding promise made to Cambridge Memorial Hospital by the former Conservative government was broken by the current Liberal government. The hospital's need for immediate funding for a new roof and boiler replacement were only the most pressing problems. Many individuals and organizations in the community were outraged and again had to put tremendous time, effort, energy, money, talent and dollars into reversing a stupid decision. Yes, they did reverse it, but talk about effort and energy—wow. It was crazy. The people did it, but they shouldn't have had to.

The fact that LHINs will be able to meet in camera at the discretion of the cabinet flies in the face of what should be an open, democratic process. Decisions about our health care system are far too important to be made in secret, with no input from the public and no right to appeal those decisions by either patients or community members.

In the area of privatization: Again, we do not want our publicly funded health care system to be privatized—not any part of it. We only have to look south of the border to see what a market-driven health care system looks like and to see the millions of ordinary Americans without any health care at all. Ontarians need and want a system that's not-for-profit, where the bottom line doesn't decide

whether or not you even get treatment, how much treatment, how long, what type. We need a healthy population in Ontario, and moving toward a money-driven system is not really the way to go, in our opinion.

Competitive bidding: We did have a flourishing local Victorian Order of Nurses office and group in our community, but they were drastically downsized by the competitive bidding. Although they paid their nurses a reasonable wage, they were underbid by a for-profit company. Turning every facet of service delivery into dollars and cents consideration means that service providers look only at how much they can make out of a contract, or a contact, not how well the person is recovering, healing or being rehabilitated. Again, health care is too important a public service to be left to business and government.

Competitive bidding for hospitals means that the hospital that provides a service for the least price would get the approval to provide that service. That makes prefect sense, but that's not the way to go. Such consolidation of services may be a cost saving for the system, but the distances people would have to travel to be able to have certain procedures performed would be prohibitive, even supposing they have the ability to get there. The years of fundraising efforts to make sure services are available locally would be absolutely wasted.

In our area, for many years, we have had a lack of mental health services and beds. For a number of years we had a revolving-door system. Patients would go into our only schedule 1 hospital, be assessed and diagnosed there, shipped off to London, turfed out of London after maybe a few days, weeks or months, popped on a bus and sent back home to Kitchener with no real connection to their community. They came back to a community in which they had no job, no home, precious little in the way of resources and maybe some very overstressed family members. Very soon, they would either break the law or wind up back in the crisis clinic and back down to London again. So they just went around and around the system for years and years.

Well, about seven years ago, they started looking at ACTT, which is an assertive community treatment team. We finally did get one, and just this last year we got dollars for a second one. Now, you recall I said that Waterloo region has 500,000 people, or close to it. London's got about six of the darned things. Why? They have the psychiatric hospital there to be able to refer people to.

In Cambridge, they didn't have any kinds of mental health beds for years, and they were promised them in the latest round of restructuring. Of course, part of that funding was for mental health beds, but they're still waiting. They haven't broken the ground for that particular area yet. So we're quite familiar with the idea of essential services being located 100 kilometres away. They just don't work.

**Mr. Thacker:** Five minutes.

**The Chair:** Three and a half.

**Ms. Cruickshank:** I've got about three paragraphs.

Geography: I know that you've heard we were watching in the overflow room about geography from some of the other people. It's crazy to lump our huge—I shouldn't say "huge"; not in terms of Toronto—our large metropolitan area in with some very, very rural areas, and the distances are just incredible. I don't think our health care system can survive another restructuring. Establishing networks to make the system better and healthier, but making the kind of changes you're suggesting, raise some really, really bad questions.

Health care, like water and hydro, is far too important to be left alone in the hands of business and the government. It has to remain with those five principles of the Canada Health Act.

**The Chair:** Any additional comments?

**Mr. Thacker:** That completes our presentation. How many minutes did you say we had?

**The Chair:** We have about three minutes that we can allow the members to ask questions, if you want to.

**Mr. Thacker:** Well, I suppose that may be the most productive way to go, if we could field some of your questions.

**The Chair:** Okay, terrific. Could we start with Madame Martel, please? One minute each.

**Ms. Martel:** Thank you for being here today. The LHIN area that I come from is excessively large: through most of northeastern Ontario and then heading down into southern Ontario. The concern of many of my constituents is that when the minister talks about rationalization or consolidation, he's not just talking backroom services like HR; he's talking centralization of important health care services at one hospital. In our neck of the woods, it would probably be the Sudbury Regional Hospital. I live in Sudbury. One would think I'd be happy with that, because I could benefit from that, or our community could, but there are already people from across northeastern Ontario travelling three and four hours to come for cardiac care, neonatal care, cancer care. The last thing they want to do is have to come for other operations as well because services are rationalized at that single hospital in order to cut costs and everybody just travels to there.

**1150**

You said you didn't want to talk very much about geography, but I can tell you that it has lots of significance and lots of resonance in my part of the world in terms of where this is going to take us and what the ministry is really trying to do, which many think is just to find a way to rationalize services and cut some costs. Maybe you want to describe again, from your part of the world, why people would be concerned about travelling perhaps even more than they already do.

**Mr. Thacker:** That's one of our concerns. If you have business people running these LHINs and they're only concerned about the bottom line, they're going to limit services in certain areas and you're going to have to travel a longer distance to receive them.

I can sympathize with the people in the north. For too long they've been travelling too far for their services, but

even in—if we're used to getting our health care in Kitchener, we see no reason why we should have to travel even to Guelph to get the same services, because it doesn't make sense. You're clogging up very dangerous highways, to begin with. You've got people who are driving on highways under stress. It really isn't a good situation.

That's our main concern: We don't want to see these things run as a business and as profit-motivated.

**The Chair:** Thank you very much. Ms. Wynne.

**Ms. Wynne:** One of my and, I know, the minister's concerns when we were first elected was the fact that some of the district health councils did a lot of planning. Certainly the Toronto District Health Council had a pretty good idea of what the services were and what was needed, where the gaps were in Toronto. But nobody really listened to the district health councils, and that was a huge problem.

If you look at the objects of the local health integration network, including "to identify and plan for the health service needs of the local health system in accordance with provincial plans and priorities and to make recommendations to the minister about that system," do you think, at the core, it's a good thing to have a planning body that has some clout in terms of its ability to fill those gaps or make rational something that's not rational in an area?

I take your point about geography. I understand that. Every file in this government, because of the size of Ontario, deals with that issue. I've spent a lot of time in education. Some of the boards in the north are huge. We have that problem in Ontario. That's a given. But given that, is it a good thing to have a planning body that actually has some clout in terms of monitoring and making changes that will provide better service?

**Ms. Cruickshank:** As a former member of the district health council in our area, and I chaired it for about three and a half years—

**Ms. Wynne:** And nobody listened to you.

**Ms. Cruickshank:** —I describe them as toothless bears. They could rage and prance around their cage and show their teeth, but that's all, because there was no legislation that they could point to and say, "Do it, or else."

The bulk of the people on those planning bodies—I shouldn't say the bulk of the people. They did a really good job, but they had a really good understanding of the health care delivery system. Many of them either worked or were former workers within the health care system, so they had some of this understanding. Yes, we need some planning in place and we need the ability to carry out those plans, but I don't think what they're describing here is what Ontario needs.

**The Chair:** Thank you. Mr. Arnott.

**Mr. Arnott:** Thank you very much for your presentation. As you know, I represent a big part of the rural part of Waterloo region, part of the city of Kitchener, of course, and much of Wellington county. I want to thank you very much for giving voice to some of the concerns that I hear in my constituency, and especially for your effort to highlight the issue of the Cambridge hospital, because I would agree with you. After a great deal of community response—including a massive petition, trips to Queen's Park by a huge number of people from the Cambridge area, work by the mayor and council and of course the good work of MPP Gerry Martiniuk and Elizabeth Witmer, our health critic—in the end, the government has allowed the hospital to move forward to some degree, although not really the full approval we need.

The fact that you've raised that issue, I think, is something that needs to be brought to the attention of the committee and the government. As we move forward with Bill 36, whatever rationalization and improvement of health care will be taking place, surely we would look to the future with a view to preventing that from happening again in Cambridge.

Do you think this bill should be withdrawn?

**Mr. Thacker:** First of all, not many citizens of the province know very much about the bill. It was kind of pushed through neat and tidy. I suppose if there wasn't a bit of an uproar from the opposition, we wouldn't even be having these hearings. It probably would have been history by now. I think that's the main problem: that most of the citizens of the province are not aware of what's in this bill or what's going to culminate as a result of this bill.

**Mr. Arnott:** Yet it would appear that if this bill passes in its current form, there will be a massive change in our administration of health care, and if people don't know about it, they're not going to be able to offer an opinion or provide input.

**The Chair:** Thank you very much for the presentation and your answers to the questions.

We are ending the first part of the day. We are going to go for a break. We'll be back at 1 o'clock.

*The committee recessed from 1156 to 1302.*

## NOOJIMAWIN HEALTH AUTHORITY

**The Chair:** Good afternoon and welcome to our afternoon session. The first presentation this afternoon is from Leslie Cochran. Is Leslie here? Would you please have a seat. You will have 15 minutes to make your presentation. You can start any time you're ready. There are 15 minutes in total, and if you spend less than 15 minutes, there will be an opportunity to make some comments or ask some questions.

**Ms. Leslie Cochran:** My name is Leslie Cochran. I'm a Trent graduate; I graduated in 1999 with honours in native studies. Currently, I'm working as a policy analyst for Noojimawin Health Authority in Toronto. It's a health authority that is funded by the aboriginal healing and wellness strategy. We have a staff of three. We cover the province. We're unique because we're the only health authority mandated to articulate the aboriginal urban and rural health priorities at both the regional and provincial levels. Our activities focus primarily on policy analysis,

aboriginal health research and methodologies, communication, and coordination of services.

Our board is composed of the Ontario Metis Aboriginal Association, the Ontario Native Women's Association, the Metis Nation of Ontario, the Ontario Federation of Indian Friendship Centres, and Anishnabe Health Toronto, which is one of two aboriginal community health centres in the province.

I just want to begin by thanking the committee for opening up public consultation and also acknowledge their support staff for coordinating this series of meetings. I also wish you safety as you travel across the province so that you can return home safely to your families.

My reason for being here today is just to stimulate reflection and further inquiry about Bill 36 as it relates to aboriginal health. As individuals involved in policy development and analysis, we have an important responsibility to ensure the legislation is equitable; specifically, that urban and rural aboriginal people enjoy the same access to health services as the general population and also enjoy equal opportunities with regard to health planning processes and representation.

We know that equal opportunities do not equal the same results, and for this reason we acknowledge that sometimes different processes or treatment are required to achieve the same results. It's this notion of equality that is embedded in the Canadian Charter of Rights and Freedoms.

The health status and health service needs of aboriginal people differ from those of the general population in many ways. While I am conscious that I always try to present a healthy image of aboriginal people, it needs to be said to this committee that differences in life conditions, ongoing systemic discrimination and historical trauma contribute to unbelievable disparities in the experience of health and well-being.

The development, implementation and evaluation of health policies that affect aboriginal people must take these differences into account; if it does not, your analysis is incomplete and unintended impacts will occur.

For this reason, I just want to share with you a health-impact statement with regard to Bill 36 as it relates to urban and rural aboriginal health. First of all, we see that limited consultation processes have effectively shut out some provincial and territorial organizations; effectively, non-status Indians. The effects of the proposed legislation on aboriginal health outcomes, health services and health planning processes have not been identified and addressed. Links have not been made between Bill 36 and existing policies and strategies such as the New Approach to Aboriginal Affairs, the blueprint on aboriginal health, Ontario's aboriginal health policy or the Canada Health Act. Insufficient consideration has been given to the resources needed for addressing aboriginal health in various regions of Ontario and little has been said about how we will retain services in the north. A proposed complementary aboriginal-specific policy or strategy with respect to local health integration networks has been ignored.

My question to this committee then becomes: How do these outcomes meet or hinder the Ontario Liberal government's values, objectives and policies? I don't think people mean to exclude and people don't mean to do a bad job, because when they want to, they do their best. So I'm just here with some reminders that we need to take care as we move forward.

This past summer, the McGuinty government announced Ontario's New Approach to Aboriginal Affairs, which proclaimed this new, constructive, co-operative relationship with aboriginal people, one that was based on mutual trust and respect. It also states that the government is committed to creating a new and positive era in the province's relationships with aboriginal people in all their diversity, and this includes urban and rural. Yet the first real opportunity Ontario has had to demonstrate this new approach, to actually turn it into a practice, has missed its mark.

The preamble in Bill 36 recognizes "the role of First Nations and aboriginal peoples in the planning and delivery of health services in their communities," and then it's never mentioned again. So I question: What exactly is the role of First Nations or provincial-territorial organizations when the government is approaching them only after the fact? The consequence of working in this way continually undermines this relationship we're striving for that was described by the Liberal government in the New Approach. Not only is it frustrating and stressful for government, political staff and aboriginal leadership, but it's inefficient. We are not using our talents to the capacity that we have. It's costly and it's time-consuming. It becomes a scramble for the finish line, to come up with something that is somewhat acceptable to First Nations and aboriginal communities.

The role, if it were truly valued, would be a common thread woven from beginning to end throughout the entire policy process and not merely an afterthought, add-on or additional subsection. There would be an awareness at all levels of government of the importance of aboriginal health as an organizing principle, as a way of conceptualizing information.

If this were the case, Bill 36 would look a lot different. I would actually have confidence that the minister's provincial strategic plan would include aboriginal health priorities; I would have confidence that the performance agreements would inherently include indicators of success—

*Feedback from the public announcement system was heard.*

**Ms. Cochran:** Is this normal?

**The Chair:** Yes, go ahead.

**Ms. Cochran:** I would have confidence that the performance agreements would inherently include indicators of success around the number of aboriginal community consultations and how they were conducted. I would be confident that the reporting from the LHINs that's being required would have aboriginal-specific data that would let me do my job a whole lot better. I would be confident—

*Feedback from the public announcement system was heard.*

**Ms. Cochran:** What is this?

**The Chair:** The technicians are working on it. If you are able to continue, go ahead; otherwise, wait, and we'll—

**Ms. Cochran:** What is it? Feedback?

**1310**

**The Chair:** If I knew, there would be no problem. I'm told it's outside.

**Ms. Cochran:** Okay.

I would also have confidence that aboriginal health professionals, both regulated and non-regulated, would be included in committees, but to date the legislation is quite exclusive.

Ontario has recognized in the New Approach the importance of programs delivered by aboriginal service providers in Ontario. Furthermore, it commits the province to continue partnering with them to support and improve the delivery of these programs, yet there is no clause in Bill 36 which guarantees or protects aboriginal health services from integrating or ceasing to exist.

*Feedback from the public announcement system was heard.*

**Ms. Cochran:** Is everybody listening? I don't think you're hearing me.

**The Chair:** We are trying to fix the problem. It's outside. So we have two choices: one, we wait; or, if you choose, you can continue. Unless somebody objects, you can continue. It's up to you.

**Ms. Cochran:** Is everybody listening?

**The Chair:** Yes, we are listening. We are able to hear you.

**Ms. Cochran:** Okay.

Despite the importance the Liberal government has put on partnering with aboriginal health, there is still no clause in this bill that guarantees that aboriginal health is still going to exist and that you support it.

Shifting gears a little bit, I gave you a copy of the Blueprint, which is the most recent document, which describes a 10-year transformative plan, agreed to by the First Ministers and leaders of national aboriginal organizations, intended to close the gap in health outcomes for aboriginal people.

What I want you to understand is that the Blueprint incorporates three distinct frameworks, as well as commitments to urban and aboriginal concerns with respect to health. It's intended to guide your decision-making, and it's also intended to be implemented at the regional level. All parties, and this includes Ontario, have endorsed this population health approach that focuses on determinants of health, including those outside the formal health sector. In doing so, Ontario has agreed to work with aboriginal organizations and leadership to ensure that the interests of their constituencies are reflected in the health care system, and still there is no clause to guarantee this in Bill 36. I'm just wondering if maybe you can make the connection as a committee to ensure that this is there.

Aboriginal health services in Ontario in urban and rural areas are tailored to the diversity of that community, and they are responsive to the needs of that community. They are specific and effective.

The Blueprint speaks out against pan-Indian services. This is a potential reality under the LHIN structure: that all aboriginal services might get lumped together or that they may somehow be integrated with non-aboriginal services. We need specific services in communities where we have actual nations and populations identified and specific health needs that have been identified. Part of me is wondering if the Blueprint, because the Premier has adopted this, precludes LHINs from even requiring aboriginal health service providers to integrate. Does it supersede this bill? These are the questions you need to answer as a committee.

Alternatively, if we look at it in a positive way, LHINs have a really unique opportunity to implement the Blueprint, to be leaders, to be the first people who are doing this, because we're moving so slowly on this.

When aboriginal communities lack participation, resource support, influence over decision-making and involvement in health-planning processes, programs and services become inappropriate for aboriginal people.

I just wanted to touch on the fact that participation is a difficult thing, because we only have X number of aboriginal professionals who are able to participate at various different levels of health planning. Resource support: How do we get to these meetings? One district reported that a hospital had 72 planning committees. So how do I, with an office of three, try to attend these and influence these? So resource support becomes very important.

The Aboriginal Health Policy, which I've also provided you a copy of, is probably the least-known and most underutilized document in the government at the moment. The Aboriginal Health Policy provides the Ministry of Health with strategic directions when it comes to planning and representation. As long ago as 1997, it recommended a strategy to facilitate First Nations and aboriginal communities' representation and participation on governing bodies for health programs and services to ensure that communities are involved in health planning activities at local, regional and provincial levels. It made recommendations that the representation must be proportionate to the First Nations–aboriginal population or to the aboriginal population being served, whichever is greater. Let's look at the structure of the LHINs right now. Who are our CEOs? Who are our board members? It's not our community. We have communities that are coming close to 51% aboriginal. This needs to change.

It recommended that the Ministry of Health and First Nation–aboriginal communities develop a strategy to support nominations and appointments of aboriginal people to public boards. What happened? Front-line workers were not allowed.

It recommended that a strategy be developed to address and remedy racism and discrimination in public boards. What are we in, 2006, nearly 10 years later?

We have learned a lot from the Bill 36 experience. We've learned a lot about processes and how we fumble through them. We've learned a lot about inclusiveness and the need for it. So the question then becomes: If we're looking for real alternatives for government and aboriginal people, what are our options with this bill? How do we move forward in a way that's mutual?

If the real purpose of this act is to provide for an integrated health system to improve the health of Ontarians through better access to health services, co-ordinated health care and effective and efficient management, from my perspective we've got a long way to go. Effective management. Efficient management. I know that people do their best, but we can do better.

I want to leave you with some key messages today—and I hope you can hear me over the feedback.

Aboriginal health service providers need to be protected from integration orders and protected from ceasing to exist. Communities rely on health services as an integral part of being in that community, and they're a tremendous support towards well-being.

Performance standards for LHINs must include aboriginal community engagement, and it must be deemed useful by the community. I would even argue that those engagement processes should be designed by that community and approved by that community. Where is that in the legislation? If we're really moving forward and uplifting aboriginal health and we're going to change the way we think about it and uplift it so it's a current, concurrent system, these are the ways we can empower each other.

Inclusion of aboriginal leadership throughout the policy development process would lead to more effective and efficient management of the LHINs. Those are the outcomes you've identified. You want efficiency? Then start including people and get them working for you. It's simple.

LHIN representation needs to reflect the constituencies they serve. This is mandated in the aboriginal health policy, and Bill 36 breaches that policy. So I need you to look at the new approach, which I'm sure you're all familiar with. I need you to review the aboriginal health policy, specifically section 3, which talks about planning and representation, and then you need to find out from your Premier which is more important, Bill 36 or the Blueprint, and how these interface and intersect, because that's going to be a big one for you.

I was only here to help you as you move forward in your clause-by-clause reading. I want you to read with a filter, and ask the questions: Is this inclusive? How does this protect aboriginal health? How does this reflect the values of the government that's in power at the moment? Be rigorous. Dare to change and think and act differently. We're on the cusp of a new era. I think this committee has a lot of potential to swing us into action and to move forward in a different way, not because you have this moral sense of obligation but out of an impulse that you want to move towards good government.

**1320**

**The Chair:** Thank you.

**Ms. Cochran:** Just one more comment. I realize that I'm the first speaker from an aboriginal organization; you'll be hearing from my peers over the course of the next four to eight days, I guess. I've left specific amendments up to the PTOs to put in your ear, but I just really want this committee to think about process and how we can move forward in a better way so we can achieve—there is a common goal here: that Ontarians be healthy and have good access, and this includes urban and rural aboriginal people.

**The Chair:** Thank you for your presentation. Sorry about the technical problem we're having.

**Ms. Cochran:** That's okay. It's not your fault.

**The Chair:** We've never had this in the two-plus years that I've been here. I don't know what the problem really is. But we could hear you, and I suspect that people also were able to hear what you were saying. Your presentation has been appreciated. We certainly went over six minutes because of the noise. Unless there is a strong will to ask questions, I think we can move on to the next presentation. Would that be okay? Thank you again.

## ONTARIO PUBLIC SERVICE EMPLOYEES UNION, LOCAL 333

**The Chair:** I'll ask the next presentation, the Ontario Public Service Employees Union, local 333, from Oshawa.

**Ms. Maureen Whyte:** Good afternoon. My name is Maureen Whyte. I am here today as a representative of OPSEU local 333, and as a concerned citizen. I am employed with the Ministry of Health and Long-Term Care in the claims payment branch. I am responsible for processing doctors' claims submissions for payment, providing customer service to the public on questions of coverage and processing out-of-country medical expenses for patients.

I am here today to voice my adamant and vociferous opposition to the passage of the LHIN legislation, Bill 36. I have several issues with this legislation and the way the government is implementing it.

First of all, I am highly suspicious and very cynical of the implementation process that is unfolding before us. Why is the government so intent on rushing this legislation through? It was introduced just before the Christmas break, when people both in and out of the government are distracted by other issues.

*Feedback from the public announcement system was heard.*

**Ms. Whyte:** Fortunately, I talk loud.

**The Chair:** Could someone go and speak with someone, instead of just sitting here and hoping someone fixes the problem?

**The Clerk of the Committee (Ms. Anne Stokes):** There are people working on it.

**The Chair:** So you know they're working on it.

**The Clerk of the Committee:** Yes.

**The Chair:** I guess you have the same choice as the prior speaker. I can hear you properly. Unless somebody has a problem, I think you can proceed.

**Ms. Whyte:** Carry on? Okay. The bill has gone through second reading and there has yet to be any serious discussion, debate or consultation in the house or with many of the stakeholders, our unions among them. I attended one of the public forums that was held to inform communities about this initiative. I dare say that I, along with many other participants, left with more questions than answers.

The LHINs are charged with implementing the government's strategic plan for health care, which has yet to be developed or unveiled. Is this not a case of putting the cart before the horse? Further to this, the LHIN boards were established before there was any framework, guideline or legislation that would provide them with their mandate.

The government has also deemed it necessary to totally disband the district health councils, which the LHINs are replacing. Is this not throwing the baby out with bathwater? Would it not have made more sense, and been more cost-efficient, to build on the experience, expertise and success of an already existing structure?

And for an initiative that is supposed to reduce health care costs, thus far it is doing anything but. By the government's own figures, it is costing twice as much to administer the LHINs as it did the district health councils. This year $40 million is being allocated for the administration of the LHINs versus $18 million to $19 million for the district health councils. It's also costing somewhere in the neighbourhood of $20 million to dismantle the district health councils.

The necessity of creating such an unwieldy and expensive bureaucracy is something else I question. Many of the things that LHINs are charged with doing under Bill 36 are being done elsewhere, without the creation of an additional and unnecessary layer of bureaucracy. The consolidation of many of the payment and accounting systems within the government, and bulk purchasing agreements by hospitals—just two examples—are already being implemented in areas outside the LHIN jurisdictions, and it didn't involve the creation of huge appointed, unaccountable bureaucracies. So why is it necessary to create this expensive and unaccountable layer of red tape here?

My, and many other people's, feelings are that it's an attempt by the government to remove itself from the inevitable fallout of unpleasant political decisions made by the LHINs, which leads me to my next objection: The LHINs are being given massive decision-making authority and almost two thirds of the provincial health budget. The legislation states that they will be accountable to the Minister of Health. These are unelected, appointed positions spending the taxpayers' money with seemingly no accountability to anyone but the Minister of Health.

Under the legislation, the LHINs are given a mandate to integrate, amalgamate, consolidate etc. I have to wonder if many of the savings that will supposedly be realized by the LHINs won't be eaten up by legal challenges under the Charter of Rights and the Canada Health Act. This would occur as the inevitable centralization and regionalization of health care under LHINs leads to reduced accessibility, one of the principles of the Canada Health Act. Or will the LHINs circumvent the Canada Health Act by introducing competitive bidding and private contractors which are outside its jurisdiction?

In addition to the huge cost of implementing and administering the LHINs, the larger social cost and economic impact on many communities must be considered. In their zeal to integrate, amalgamate and rationalize, the government must realize that the health care sector is the cornerstone of many communities' economies. If this sector is devastated by job and wage cuts, in some communities the ripple effect to other businesses could destroy their economic health and vitality.

In closing, I would like to say that until there has been full disclosure as to the intent and mandate of the LHINs, until there has been real consultation and collaboration with all stakeholders and until the necessity and the real cost and viability of the LHIN model have been explored, this approach should be stopped. As taxpaying citizens in a democratic society, we are entitled to complete and comprehensive information, including total costs, so that we may make an informed decision on whether this is necessary and/or even a viable option.

I believe that such a fundamental and far-reaching initiative that represents such a massive sea change in the way health care is delivered requires far more input and far more debate from all those affected. At the very least, I think opinion polls and focus groups should be conducted and maybe even a referendum considered. Legislation such as this that has such potential for adverse impact on people's jobs, lives and their communities requires far greater scrutiny.

**The Chair:** I'm sorry for the noise that we're all experiencing. We have about four and a half minutes left, one minute and a half, each. Ms. Wynne, please.

**Ms. Wynne:** Thanks, Maureen. On the issue of the district health councils: You talked about their existence. One of the concerns about district health councils is that they were bodies that did a lot of planning, but they really didn't have any teeth; there wasn't any way of their plans being put into operation. If you read the objects of the LHIN under section 5, I think it's clear what the purpose of the LHIN will be: "(a) to promote the integration"; "(b) to identify and plan for the health service needs." There are 12 items there, actually, under part II, section 5.

I guess my fundamental question is, is it a good idea to have a body in place that will be doing the planning, the kind of thing the district health council was doing, but on a broader basis, and will be able, then, to fund and to bring together disparate services and integrate them in order to provide the best service to patients? Is that a good idea at its base?

**1330**

**Ms. Whyte:** It may be. The big issue I have with it is that the government has not been terribly forthcoming with information about the LHINs. The consultation process seems to be kind of after the fact. From participants—

**Ms. Wynne:** Sorry to interrupt you, but those 4,000 people who took part in the open houses and were able to attend meetings at the beginning of this process—you don't think they got information? Certainly people in my community got information. They brought it back to my seniors' council and we were talking about what they had heard.

**Ms. Whyte:** The feedback I've gotten is that many of those public meetings were a bit of a waste of time. The one that I attended, although it did provide some information, I don't feel it provided enough information to make an informed decision. The real issue I have is the fact that these are appointed boards. They are unelected; they are being given two thirds of the health benefit, to my understanding. Who are they accountable to? The Minister of Health.

**The Chair:** Thank you. Mr. Arnott.

**Mr. Arnott:** Thank you very much for your thoughtful presentation. You mentioned the administrative costs that are going to be incurred by the government because of the disbanding of the district health councils and the establishment of the new LHINs. You indicated that you feel the establishment of the LHINs is really an effort by the government to create a political buffer so as to insulate the minister from—

*Feedback from the public announcement system was heard.*

**The Chair:** Please proceed.

**Mr. Arnott:** I certainly concur with you that that is one of the reasons, it appears, that the government is coming forward with this legislation.

The thing that strikes me as being most problematic is the fact that the government proceeded to establish the LHINs in the absence of any legislative authority to do so.

**Ms. Whyte:** Exactly; precisely.

**Mr. Arnott:** One might argue that that demonstrates absolute indifference to the Legislature and the role of the Legislative Assembly.

**Ms. Whyte:** Exactly.

*Feedback from the public announcement system was heard.*

**The Chair:** I wonder if somebody can go and tell those people that there's no need to waste more time telling us. Can somebody do that, please? Ted, sorry; go ahead.

**Mr. Arnott:** Would you care to respond?

**Ms. Whyte:** I would agree wholeheartedly with you. That is exactly my fear, that they're circumventing the entire democratic process. I want our elected officials to be accountable for the money and the decision-making process. That's why I vote; that's why we elected them; that's why we have a democracy. I don't like the idea of huge amounts of money being placed in the hands of people who are appointed, who are not accountable to the taxpaying citizens. We don't even know what their mandate is. How can I make an informed decision about this? There's no legislation; there's no framework; there are no guidelines. When these people were chosen and this was set up, they didn't have a job but they were being paid. The system is backwards.

**The Chair:** Ms. Martel.

**Ms. Martel:** Thank you, Maureen, for being here today and for trying to operate over the fire alarm system.

At the start, you said it was interesting that the mandate of the LHINs is to implement the government's strategic plan, which hasn't even been developed yet. It is astonishing to me that this can be a mandate when we have absolutely no clue when the government is going to get around to implementing its own plan: who is participating, what the process is for that, etc. There's something a bit backwards about all of this.

I should have asked Leah Casselman earlier, but you said you had attended some of the meetings. Do you have any sense that OPSEU, for example, which represents thousands of workers in this sector, has been asked to participate in the making of a strategic plan at the provincial level? Do you have any sense of what's happening with that, what the process is, who is involved?

**Ms. Whyte:** My counterparts in the union who I have talked to—this has been one of the major complaints—have not had any real involvement in the process up until this point. They have tried to make their concerns and their issues known to the government but they have been largely ignored. Their issues and concerns have been ignored and they have not been invited to participate in the process. That's my understanding in talking to my colleagues. I have not had an opportunity to participate in those meetings, but that is what I've been told.

**The Chair:** Thanks very much. For those of you who are worried that we won't be able to appreciate what you are saying, that level of noise does happen in the House sometimes, so we are used to it.

## CENTRAL LHIN HOSPITALS

**The Chair:** Can we have the next presentation, the Central LHIN from Richmond Hill, Mr. Weldon, please? That doesn't happen in Richmond Hill; I know that.

**Mr. David Weldon:** Mr. Chairman and members of the committee, thank you very much for taking the time to hear from us. My name is Dave Weldon. I'm the chair of the board of York Central Hospital. I'm here today to speak on behalf of the nine hospitals that are located within the boundaries of the Central LHIN. Those hospitals are Bloorview Macmillan Children's Centre, Humber River Regional, Markham Stouffville Hospital and the Uxbridge Cottage Hospital, North York General, Shouldice, Southlake Regional, St. John's Rehab, Stevenson Memorial and York Central.

We are thankful that we have this opportunity to present to you today as part of this consultation process

and we are mindful that consultation is the hallmark of the democratic society we live in.

We are the boards and management of the Central LHIN hospitals, and we applaud the Ontario government's commitment to improved health care through better access, coordination of care and effective and efficient management. We look forward to participating in the Central LHIN, and more specifically to working co-operatively with other hospitals and health care providers: to facilitate care across the continuum; to improve patient access to services; to provide care in the most appropriate and cost-effective setting; and to reduce overlaps and duplication of services.

We support the overarching principles of Bill 36, and the acknowledgement that a community's health needs and priorities are best developed by health care providers and the people they serve. We endorse the government's commitment to:

—enable local communities to make decisions about their health system;

—work together with communities, health care service providers and LHINs to better co-ordinate health service delivery across the province;

—equity and respect for diversity in communities;

—public accountability and transparency;

—govern and manage the health system in a way that reflects the public interests and promotes efficient delivery of high-quality service;

—ensure that access to health services will not be limited to the geographic area of the LHIN in which one lives; and

—deliver the health service that people need, now and in the future.

We support the key principles of the Canada Health Act and the work of the health quality council. We actively participate in the development of hospital accountability agreements for our member hospitals.

A little bit of background about the Central LHIN hospitals: We have a tradition of accountability and efficiency. The Central LHIN hospitals proudly participated in many initiatives which demonstrate leadership in public accountability, including:

—voluntary participation since 1998 in the balanced scorecard, a joint initiative of the Ontario Hospital Association and the Ministry of Health and Long-Term Care;

—a tradition of community stewardship and accountability through their hospital, foundation and volunteer association boards; and

—support of the multi-year funding guidelines and hospital accountability agreements and the continuing work of the joint policy and planning committee to develop an improved funding formula for hospitals.

Central LHIN hospitals have embraced measures to reduce waiting times for key surgical and diagnostic procedures, demonstrating the ability to become some of the province's top performers in several areas. In the material that has been circulated, there are a number of graphs, the first being hip surgery, demonstrating median wait times in October and November 2005. Of the five hospitals that are involved in hip surgery in our LHIN, three are below the Ontario average in wait times; for knee surgery, three of the five are below the Ontario average; and three of the six that provide cataract surgery are below the average. We are working very hard and very productively in keeping wait times low.

Some key facts about the Central LHIN: It has the largest population of any of the LHINs in Ontario. It represents 12.5% of Ontario's population. Currently, a total of a little over 1.5 million people live in the Central LHIN. It has one of the highest growth rates. The graph on page 5 indicates our growth rate at 14% projected between 2007 and 2012, and historically, certainly over the last 10 years, it has been the highest in the province. The provincial average projection is 10%, so we're 40% higher than the provincial average. It has the highest proportion of immigrants—new immigrants and visible minorities—in Ontario, almost double the average. Central LHIN has about 45% of its population in that category. It has one of the lowest localization index scores in the province, indicating that a high number of our residents are seeking health services outside of their LHIN. The percentage in our LHIN is around 60%; the provincial average is around 80%. It has one of the highest proportions of low-income households in Ontario. Despite some of the perception that parts of our LHIN are amongst the wealthiest, we have one of the highest proportions of low-income households in Ontario, second-highest to the Toronto central region.

**1340**

The map attached to our presentation sets out the boundary of our LHIN, and you can see that it is quite large. Forty-four per cent of our population lives in the city of Toronto, and 56% in York region and parts of Simcoe county. An estimated 40% of the patients served by the Central LHIN hospitals live outside of the Central LHIN boundaries. Our age-weighted growth rate is higher than most in Ontario, and the York region proportion of that is significantly higher than the Central LHIN average. Most of the growth in the Central LHIN is taking place in York region. York region continues to grow at a rate faster than that of any other LHIN.

There are a number of service providers in the Central LHIN: nine hospitals; 42 long-term-care facilities; 43 community support service agencies; 27 mental health organizations; seven addiction organizations; four community health centres, with one to be added in Vaughan; two CCACs; and three other acute providers. There are 125 health care organizations in total. Some of them are represented in more than one of the categories listed above.

As I said at the beginning, we generally support the provisions of Bill 36. We do have six areas of major concern.

The first is, in our minds, the need for population-based funding. There is a need to include consideration and recognize population size and characteristics in planning for health service needs of communities served

by the LHIN. Currently, hospital funding is based largely on historical capacity and funding and it does not address physical capacity, human resource and funding restrictions which may be creating unacceptable wait times, or causing residents to seek care outside of their LHIN. This approach is particularly problematic for high-growth communities that have been historically underfunded in both operational and capital funding. Therefore we strongly recommend that the funding formula for both hospitals and the entire LHIN be directly linked to growth.

Secondly, funding and planning mechanisms to recognize cross-border patient traffic. Currently, the legislation empowers LHINs to allocate and provide funding to providers of services in or for the geographic area of the LHIN on terms the LHIN considers appropriate. A significant proportion, up to 40% for community hospitals such as Humber River Regional, North York General and Markham Stouffville, and higher for specialty hospitals such as Shouldice and St. John's Rehab, of the hospital service areas lie outside of the geographic boundaries defined by their LHIN.

The legislation should articulate guiding principles regarding funding to providers, which include: (1) equitable access to the continuum of care and meeting health care needs; (2) effective, high-quality care; (3) overall cost containment; (4) operation efficiency within the context of value for money; (5) equitable and transparent allocation of funds; (6) stability and predictability in provider operations; (7) consistency with the IHSP and provider roles; and finally, provincial standards.

The legislation should also clearly identify how these principles will transcend the geographic boundaries of individual LHINs to respect patient choice and preserve access to care. We firmly believe that there needs to be something in the legislation that will help us all understand how that will work.

Thirdly, the selection of LHIN board members and clarification of criteria for in camera board meetings is a concern. There is a lack of clarity in the selection criteria for the LHIN boards to ensure appropriate skill-based local representation from within the LHIN boundaries. In keeping with the overarching principles of bringing decision-making and accountability closer to the point of service, there should be explicit direction within the legislation to ensure appropriate local representation on LHIN boards by those who either reside or work within the designated LHIN boundaries and have appropriate and clearly identified skill requirements. Further clarity is also needed in specifying the process by which board members are appointed.

Although the need for LHIN board meetings to be open to the public is specified in the legislation, there are no specifically defined parameters for in camera discussions. Clarifying these parameters within the legislation would ensure transparency and create confidence in the integrity of the board and its decision-making processes.

The next item is criteria for integration decisions and appropriate appeal mechanisms. Our concern is the need to more clearly define the criteria for integration decisions and the mechanism of appeal regarding these decisions. Integration decisions should be evidence-based, consistent with the provincial and/or LHIN plan and shown to be in the public interest.

Currently, there are no clearly defined criteria for integration decisions, and appeals are heard only by the LHIN board that issues the decisions. Appeals, in our view, should be heard and ruled upon by an independent third party that is outside the political or bureaucratic realm of influence. This would ensure proper recourse and redress for integration decisions made on incorrect information and safeguard against inappropriate interference in the process.

The next item is the preservation of foundation independence and donor privacy. The proposed legislation expands the reporting requirements of hospital foundations to include the LHIN to which their affiliated hospitals report. Currently, only the hospital foundations and hospital boards receive these reports from foundations and have the ability to influence how the funds will be directed. Quite frankly, sometimes we don't. We get a number of people who make donations to our foundations, and those donations are made for specific purposes that they themselves want to see enhanced. As separate legal entities, foundations do no fall within the scope of the LHIN. Therefore, the subsection of Bill 36 that speaks to this new reporting requirement and amends the Public Hospitals Act to recognize this reporting relationship should, in our view, be deleted. This amendment to the proposed legislation would help preserve both foundation independence and also donor information included in their reports.

There also needs to be a clear definition of "public interest." There is lack of clarity with regard to the definition of "public interest" in the bill, in our minds. The LHINs and the minister must consider the public interest when issuing integration decisions or orders, but the legislation does not provide a definition of "public interest," as does the Public Hospitals Act, PHA, and the Commitment to the Future of Medicare Act, CFMA.

The PHA definition includes the quality of the management and administration of the hospitals; the proper management of the health care system in general; the availability of financial resources for the management of the health care system and for the delivery of health care services; the accessibility to health services in the community where the hospital is located; and the quality of the care and treatment of patients. After all, that's what this is all about.

I'm almost done. The CFMA definition includes clear roles and responsibilities regarding the proper management of the health care system. The details of that are included in here. A clear definition within the bill would help to ensure due consideration to patient and community health care needs.

**1350**

In conclusion, we would like to reiterate our support for the aims and principles of Bill 36. We believe that LHINs have the potential to improve the integration and

delivery of health care services while meeting the unique needs and priorities of the communities they serve, if the legislation includes:

—population-based funding for both LHINs and their member hospitals;

—funding mechanisms to recognize the provision of services to patients from other LHINs;

—clearly articulated selection criteria for board members;

—clearly articulated criteria for integration decisions and an appropriate appeal mechanism;

—an amendment to preserve the independence of hospital foundations;

—a clear definition of the public interest.

We appreciate the opportunity to be here. We believe that Bill 36 recognizes the value of local hospital governance and builds on the strength and experience of local health care providers. We offer our recommendations to help ensure that this made-in-Ontario model of health care fulfils its promise. We look forward to working with you in that regard. Thank you very much.

**The Chair:** Thank you very much for your presentation. There is no time for questions, but thank you.

*An address from the public announcement system was heard.*

**The Chair:** This should be the last announcement. I understand that a contractor cut the wires, but there are some trucks outside and they should be fixing it. So maybe we won't have to hear that again.

**The Clerk of the Committee:** We may. Every 15 minutes, they have to, until it is fixed.

**The Chair:** Okay. So until it's fixed, every 15 minutes we're going to hear an announcement.

## BRAMPTON HEALTH COALITION

**The Chair:** Having said that, we can move on to the next presentation, from the Brampton Health Coalition. Again, our apologies to those of you who are having difficulty properly listening to what the presenters are saying.

**Mr. Ed Schmeler:** Good afternoon, Mr. Chairman. Thank you to the standing committee on social policy for hearing our presentation. We're Ed Schmeler and Dora Jeffries from the Brampton Health Coalition. As members of a local health policy advocacy group, the Brampton Health Coalition, the authors of this presentation took part in the public consultations related to the Central West Local Health Integration Network. We attended the initial central west community LHIN workshop held in Orangeville in November 2004 and worked on the development of integration priorities for the Central West LHIN. Our initiative on transparency, community involvement and the creation of a LHIN community advisory group was developed in a team with six other participants at the workshop and was chosen by a vote of all workshop participants as one of the top 10 integration priorities of the Central West LHIN.

The authors were also members of the Central West LHIN steering committee, which worked with the staff of the Halton-Peel District Health Council and consulted with the local community members and organizations to complete the summary report of the Central West LHIN and submit it to the Ontario Ministry of Health on February 14, 2005. Again, on December 16, 2005, the steering committee met with the staff, board and CEO of the Central West LHIN and briefed them on updates to the priorities contained in the summary report.

The question is, what is the rationale for community involvement and transparency in LHIN operation? The LHIN vision, as outlined in LHIN bulletin number 1, states that it "engages communities in health system transformation." As participants in the creation of the Central West LHIN summary report, we met and interacted with many dedicated, passionate and hard-working members of the health services community. What struck us, however, was that there was very little participation and input in the process from front-line health workers and those most affected: the users of the system, the people of the community. It seemed to us that there was a need for transparency in the operation of LHINs and a mandate for community input and participation in LHIN decisions. This does not appear to be present in the proposed Bill 36.

What is it that we're proposing? First, legislated provision of a community advisory group, or CAG—one per LHIN. The CAG would consist of representative community members who would provide input to the LHIN board.

Second, we want to see legislated requirements for the provision of transparency in LHIN operations and decisions.

What's the rationale for transparency and for community advisory groups? Transparency in LHIN operations and the provision of community advisory groups would serve to integrate the grassroots needs of our communities and individual service providers on an ongoing basis. The engagement of the public by LHIN boards in their planning, priority setting and budgetary activities would help us ensure that board decisions reflect community health needs and priorities. If the introduction of LHINs into the provincial health system is proposed as a transformation that will improve citizens' lives and health, then health care workers, clients, patients and families must be part of the proposed partnership of equals.

There are legislative precedents in Ontario for health care community advisory groups; they already exist. The first one is the Toronto Board of Health—local health committees, or LHCs. In early 2002, the Toronto Board of Health mandated the creation of local health committees to assist the board of health in determining and setting public health policy on a broad range of local health issues and to raise health determinant awareness and its impact on Toronto communities. The terms of reference covered mandate, roles and responsibilities, composition, term of office, remuneration, meetings,

quorum and committee member qualifications. The medical officer of health for Toronto at that time was Dr. Sheela Basrur, who is now Ontario's chief medical officer of health and assistant deputy minister of health.

The second act is the Accessibility for Ontarians with Disabilities Act—the accessibility advisory committees that are set up under that act. The act requires municipal councils to prepare an annual accessibility plan and either seek advice from the AAC it establishes or consult with persons with disabilities and others on the identification and elimination of accessibility barriers to persons with disabilities.

The third existing legislation is the Community Care Access Corporations Act—the community advisory councils. In respect to the boards of directors of community care access corporations, the act mandates, "Each board of directors shall establish a community advisory council as a committee of the board."

What legislative precedents are there for transparency? Let's look at the Municipal Act, 2001. The Municipal Act provides that, with only certain specific legislated exceptions, all meetings shall be open to the public, and records and minutes, subject to the same exceptions, must be made available to the public. Furthermore, before holding a meeting or part of a meeting that is to be closed to the public, a municipality or local board or a committee of either must state by resolution the fact of holding the closed meeting and the general nature of the matter to be considered at the closed meeting.

We developed this information as part of community consultations. What did we learn? The first thing we learned was that in order for LHINs to succeed in achieving their stated vision of community engagement, they must practise openness and transparency and hold open board meetings. Community consultation works; the research on methods and benefits has already been done. Third, it's not necessary to reinvent the wheel to provide openness, transparency and public input in LHLN operations. Provincial and municipal legislative precedents that can be adopted already exist.

Finally, I'd like to say that there's a reference study on community consultation, Towards More Meaningful, Informed, and Effective Public Consultation. We've provided an electronic copy to Ms. Stokes, clerk of the standing committee, and she can make it available to any members of the committee or to the research people who would like to see it.

Now I would like to pass it over to Dora Jeffries. She'll be speaking on the second part, which is on LHINs and privatization.

**Ms. Dora Jeffries:** As members of a local health policy advocacy group, the Brampton Health Coalition, the authors of this presentation have been opposing the P3, public-private partnership, financing model of the new Brampton hospital since it was arbitrarily introduced to our community in 2001 by former health minister Tony Clement. We continue to oppose this funding model, which has introduced a level of privatization previously not a part of Ontario's health care system. Our group, as part of the Ontario Health Coalition, has been involved in a court case for three years now to force full disclosure of the details of the secret Brampton P3 hospital deal. We do know that the present value of the difference between public and private financing is $175 million. In Brampton we know, from our experience and the well-documented experiences in the United Kingdom, that more privatization is not a better or cheaper way to deliver quality health care. Therefore, we are alarmed by the opportunities for increased privatization in Bill 36.

**1400**

The minister may, under Bill 36, order any non-profit health service provider that receives funding from a LHIN to close down; this does not apply to for-profits. The minister may amalgamate non-profit health service providers; they cannot amalgamate for-profits. The minister may transfer all of the operations of any non-profit health service providers to other non-profits; this does not apply to for-profits. The minister may transfer property of non-profits or any other actions necessary to carry out these things; this does not apply to for-profits. These are in part V, sections 28 and 29 of the bill.

Privatization: The legislation facilitates privatization in several ways. The LHINs may move funding, services, employees and some property from non-profits to for-profits. Cabinet may order the wholesale privatization or contracting out of all support services in hospitals. The minister may close or amalgamate non-profits, but not for-profits. With all of this power in place, it is not difficult to foresee a shrinking set of non-profit providers while for-profits grow and gain new market opportunities as the system is restructured. This is in part V, sections 28 and 29.

To conclude, the residents of Brampton have been part of an experiment in increasing the for-profit involvement in our health care system through our P3 hospital. This hospital was introduced into our community with no public consultation or proof that this financial model would be beneficial to the taxpayers. Because of our experience, we are extremely sensitive to the alienation caused in a community when public consultation is ignored. We are also acutely aware of the increased costs and loss of control, loss of transparency and accountability when a private for-profit consortium can enter into secret deals with our government.

**The Chair:** We have about three minutes available, one minute each. We'll start with Mrs. Witmer, please.

**Mrs. Witmer:** Thank you very much. You indicated here that the difference between public and private financing is this $175 million. Was that for the Brampton project?

**Ms. Jeffries:** Exactly. That's in present dollars. If you put that over the 25-year life of the contract, it's actually more. That is just the slightly over 1% difference in borrowing from the public sector, and then handing it over to the private sector and having them go out and raise the money. That's the private financing model that is prevalent in the United Kingdom, which is costing so much money and which is costing us more. That is only a

small part of the deal that we know. We are in court to find out what other costs are there in the deal. We still don't know.

**Mrs. Witmer:** I was going to say that my belief was that that information had not been made publicly available. It's pretty well still in the dark.

**Ms. Jeffries:** Most of the deal is.

**Mrs. Witmer:** Yes.

**Ms. Jeffries:** This information, this borrowing cost differential, is available, but as you are saying, most of the financial information is still secret.

**The Chair:** Ms. Martel, please.

**Ms. Martel:** Earlier this morning you weren't here, but the minister made some comments about the bill. He said that there were a number of critics who were making baseless attacks and spreading deliberate misinformation about the bill. In his response, he said he disagreed that LHINs are going to open the door to privatization and two-tier health. I'm glad that one of the focuses of your presentation had to do with privatization and the sections in the bill that allow for that.

Outside of the sections in the bill where that's clearly articulated—this may sound like a silly question—what is the concern that you have as an individual taxpayer, but also as a coalition, about increased privatization in terms of where money goes when it should be going to patient care?

**Ms. Jeffries:** As I said, the secrecy of the deal alarms us, and we feel that the competitive bidding model used for home care and the creation of internal competitive markets, which is the British system, which seems to be what this is modelled on, will increase privatization, which actually costs more. In the United Kingdom, they're about 10 years ahead of us in this kind of model, and there is ample proof that this system costs more. In fact, the Economist is even calling for a moratorium on the increased privatization in the British system, the PFI—Private Financial Initiatives. So it really worries us to see all the opportunities in this bill for increased privatization.

**The Chair:** Thank you. Mr. Fonseca.

**Mr. Fonseca:** Thank you very much for your presentation. As the minister brought forward this legislation, and being patient-centred, he was looking at the 12 million people in Ontario and to really address the regional inequities that happened for so long, especially addressing high-growth-needs communities like Brampton and the Central West LHIN. So what the LHIN legislation actually does, and allows the ministry to do, is to address those needs. In a previous presentation, we saw in their graph that the Central West LHIN does have many needs that have not been addressed: This will help address those needs.

In regard to the LHIN boards and in terms of the local community, the LHINs are actually required to establish a process to identify candidates from that community who will make up a portion of that board. That is in play right now through the LHIN executives who are coming up with those criteria to address some of your needs. Do you think it would be a good process to be bringing in the local knowledge and skilled people who will help in terms of being at the table for that community?

**Ms. Jeffries:** As we said in our presentation, we don't think it's sufficient; we do not think it's enough.

**Mr. Fonseca:** Okay. But it is moving in a way that you would like to see it move.

**Ms. Jeffries:** When we read the legislation, we do not see the power going to the community. It seems to me that it's very centralized, that this is a centralization of power in order to restructure the health care system and make decisions that are not going to be popular.

**The Chair:** Thank you very much for your presentation.

## FRIENDS OF AJAX/PICKERING HOSPITAL

**The Chair:** We'll go to the next presentation, the Friends of Ajax/Pickering Hospital. Good afternoon. You can start any time you are ready, please.

**Mr. Fred Parrott:** Chair and members of the committee, on behalf of the Friends of Ajax/Pickering Hospital, my colleague Bill Parrish and myself, Fred Parrott, thank you for this chance.

First, we'd just like to recognize two other members of our Friends: Peter Mawby and Lynne Childerhouse, who did the spadework in this presentation. We'd like them to get credit for that.

The Friends of Ajax/Pickering Hospital is a volunteer patient advocacy group concerned with health care issues affecting the communities of Ajax, Pickering, Whitby and west Durham. The main focus of the group has been the erosion of services from the Ajax and Pickering hospital since the amalgamation in 1998 with Scarborough Centenary Hospital to form the Rouge Valley Health System. Recent public forums organized by the friends have attracted over 1,700 people, providing invaluable opportunities for community input. Two of our members attended the first central east LHIN workshop in December, 2004.

Here are our concerns: (1) The key word, "integration," is in fact very misleading regarding many of the potential activities suggested by this legislation. "Integrate" is defined in the act as:

—"to coordinate services and interactions...,"

—"to partner with another person or entity" to provide services;

—"to transfer, merge or amalgamate services, operations, persons or entities,

—"to start or cease providing services,

—"to cease to operate or dissolve or wind up the operations of a person or entity."

The English language takes exception to that definition since there's a second word, "disintegrate," to define the actions of the last three: "cease," "dissolve" and "wind up." When disintegration begins to occur, the electorate will react and could feel misled by the emphasis on integration. We have seen strong evidence in our community of this sort of reaction.

(2) Provision in Bill 36 for community, as in public, input on health issues such as mergers, amalgamations and integration and disintegration of services etc. is non-existent. As specified in the act, the engagement of "the community of persons and entities" on topics including integrated health service plans and setting priorities means the engagement of the people within the relevant health service area. The public is not part of this process.

**1410**

The Minister of Health shall develop a provincial strategic plan for the health system that includes a vision, priorities and strategic directions. The bill does not provide for any public input into this plan. No public appeal process is provided.

The LHIN boards should be prime sources—

*Feedback from the public announcement system was heard.*

**Mr. Parrott:** The LHIN boards should be prime sources of communication with the public.

*Feedback from the public announcement system was heard.*

**The Chair:** You can proceed.

**Mr. Parrott:** Those LHIN boards—prime sources of communication potential. However, cabinet will decide by regulation which LHIN meetings will be public, with no requirement for a public process of consultation. A minimum of four board meetings is required in a calendar year, which is a very pitiful number, given the scope of their responsibilities. These and committee meetings are at the discretion of cabinet as to whether they should be open to the public.

Regarding integration—or disintegration—decisions, notice will be given to the health service providers of the decision, with copies to the public. Because of the geography of many LHINs, all decisions should be posted on a website for improved public access. The only appeal process is by health care providers party to the decision, and this is only after the decision is made. Public input is limited to the polling booth at the next election, which is far too late to have any positive impact on the health of people's lives.

(3) The development of the regulations will be handled as follows: The public is to be informed about the proposed regulations by notice in the Ontario Gazette and by other means the minister deems appropriate. The involvement of persons and entities who may be affected will be sought. However, here again public input is hardly encouraged, and even the health care providers will find that there are some circumstances where their input is not required.

(4) Through the processes of strategic plans and accountability agreements, the minister awards contracts to health service providers and implements them. No public input is required or public appeal process provided. Health service providers have the only appeal process of 30 days against the decisions of the LHINs.

Furthermore, the bill does not specify measurements of service levels, public satisfaction experiences or goals to be achieved other than those specified in the accountability agreements. Thus it is feared that the lowest-bidding health care provider, private or public, will win out most often.

(5) The LHIN boards and staff will assume control over most of the health care providers in Ontario. These boards of directors, duly appointed to their position, may pass any bylaws and resolutions for conducting and managing the affairs of the LHIN, including establishing committees. Where are the controls for the regulations they may determine necessary for the operation of the LHIN?

The LHIN will create an additional level of bureaucracy that will impact our health system. The LHIN boards are to "consist of no more than nine members"; 14 LHINs times nine is equal to a possible 126 paid positions. As well, each LHIN "shall appoint and employ a chief executive officer." Now we have 140. Furthermore, the LHIN may employ other employees that the network considers necessary for the proper conduct of the business of the network. Even if this were to be only one other person per LHIN, we are now looking at additional salary costs, a further drain to our health care dollars, of 154 people.

(6) How can we achieve an integrated health system without including the major providers of primary health care?

At the outset, the legislation includes hospitals, certain psychiatric facilities, long-term-care facilities, home care, community mental health and addiction agencies, community health service providers, community health centres and others by regulation. It does not include family doctors, chiropodists, dentists, optometrists, independent health facilities, laboratories, public health and certain corporations of health professionals.

How can we achieve an integrated health system without including the major providers of primary health care? Leaving family doctors out of the LHINs is a serious mistake.

We therefore make the following recommendations: To achieve meaningful and extensive input from people governed by the LHINs, Bill 36 should be amended as follows:

(1) The provincial strategic plan for the provincial health system be published and widely circulated, with public input invited before the provincial strategic plan is adopted by the minister.

(2) Before any LHIN board makes any decision to integrate, merge, amalgamate, partner etc. any health service affecting any community, it must first publish the details of the plan with the rationale. The public must be given at least 90 days for comment and input before any final decision is made.

(3) Any decision of a LHIN that affects the health care of the people in a community must be subject to appeal. Any person or group should be able to appeal the decision of a LHIN with at least 60 days' time after the LHIN has published its decision to do so. First appeal goes to the LHIN board. If this is denied, then an appeal to the minister and then to the Ombudsman.

(4) All the details of how the people should be involved in the LHIN board decision-making must be spelled out in Bill 36 before it is passed and not left to regulations.

(5) Any order by the Minister of Health and Long-Term Care to order a hospital to cease operation or cease to offer services must include public notification and public hearings before any final decisions are made. This directive must also be subject to an appeal process, as mentioned earlier.

(6) All the reports being considered or studied by a LHIN board must be made available to the public on a website before the report is adopted.

(7) Minutes of LHIN board meetings must be made available to the public on a website or on request.

(8) Finally, if the Legislature and the government do not amend Bill 36 to provide for major public input and involvement at the LHIN board level, the people who pay 100% of the costs of their health care system will have lost all input and control. The minister will have achieved complete centralized power over our health care.

The LHINs may have been conceived with the greatest intent for our health system, bringing, as Minister Smitherman said previously, "capacity that's in the same place, closer to the action, in local communities, with people dedicated to their communities." In actuality, the health system is being redesigned, in our view, to provide the cheapest health care services without regard for where the patients and their families live, as well as creating another level of bureaucracy at the expense of our health care system. Thank you very much.

**The Chair:** Thank you very much for your presentation. We have run out of time, so there's no time for questions. But thank you for your presentation.

## ONTARIO ASSOCIATION OF COMMUNITY CARE ACCESS CENTRES

**The Chair:** The next presentation is going to be the Ontario Association of Community Care Access Centres. As you come in, gentlemen, you have 15 minutes. Whenever you are ready, you can start. There is some disturbance, as you may have heard, so if that's the case, you may wish to proceed or stop, as you choose.

**Mr. Ross McCrimmon:** As long as you can hear us, we can continue.

**The Chair:** We are able to hear you, yes. So please start whenever.

**Mr. McCrimmon:** Good afternoon. I'm Ross McCrimmon. I'm the chair of the Ontario Association of Community Care Access Centres. I'm here with Jim Armstrong, our chief executive officer. It's a pleasure to have the opportunity to speak with you this afternoon.

The Ontario Association of Community Care Access Centres is a voluntary organization that represents Ontario's 42 CCACs. As the provincial voice for CCACs, our mission is to represent the interests of our members, to act as a vehicle for the development of common policy and shared services, to provide leadership in shaping health care policy, and to promote best practices on behalf of the people served by their community care access centres.

**1420**

Each year, CCACs provide coordinated access to health and support services to approximately half a million clients. Through our case managers and care coordinators and our information and referral processes, CCACs play a significant role in promoting independent living, helping people to navigate the health care system and providing a bridge to other health care services.

Over the past two years, the government has made a significant investment in CCACs in recognition of the contribution of CCAC services to a broad health system transformation.

CCACs are working at the local and provincial level:

(1) To support the development of family health teams and build formal relationships with other primary care groups to promote service integration;

(2) To support hospital service plan development and implementation;

(3) To provide comprehensive and compassionate end-of-life care;

(4) To develop strategies to improve the management of chronic conditions; and

(5) With home care providers, to improve and simplify the service procurement process and to implement the other recommendations of Elinor Caplan's review, once approved by the minister.

Finally, over the last year, the OACCAC and our members have been engaged in ongoing discussions with the Ministry of Health and Long-Term Care regarding the proposed plan to align CCACs within the LHIN boundaries and consolidate CCACs within each LHIN.

Let me begin my comments on Bill 36 by stating our support for development of local health integration networks, for the principles underlying the Local Health System Integration Act and for the objects outlined for LHINs in section 5 of the bill.

We believe that the linkage of responsibility for community-based planning, funding and accountability provides great potential for the development of a system that fosters collaboration and innovative approaches to service integration and is responsive to local conditions.

We also believe that subsection 17(2), which creates the potential for LHINs to retain a portion of any savings generated through efficiencies to reinvest in services, is an important step forward. Historically, there have been few incentives for health care service providers who realize savings through efficiencies only to see that these savings are recovered and lost to service enhancements at year-end.

Section 16 addresses the responsibilities of the LHIN to engage the community in planning and priority setting. Further, clause 36(1)(f) provides for regulation-making authority regarding the nature of the engagement process. We support this approach, but we caution against including provisions in the act binding the LHINs to a specific process for engagement that may prove to be

inadequate or unworkable over time. As an example, the CCAC act included a specific requirement for CCAC boards to convene community advisory councils. In many communities, these councils were not an effective mechanism for community engagement, and this requirement is being removed through the complementary amendments in Bill 36.

We believe that any provisions setting out specific requirements or processes for community engagement would be better addressed in regulation, to more easily facilitate development and improvement of the process over time. We would, however, encourage broad consultation on any regulations dealing with the community engagement process.

Subsection 16(2) also sets out a specific responsibility for the LHIN to establish a health professions advisory committee consisting of representatives of the regulated health care professions. It is important to recognize that a significant portion of health care services are provided by unregulated health care workers, including personal support workers and volunteers. We would encourage recognition of their valuable contribution and input into the advisory process to the LHIN.

Subsection 20(2) deals with patient mobility and prohibits the LHIN from entering into agreements or arrangements that restrict access or prevent individuals from receiving services based on geography. Subsection 20(3) provides an exception for agreements between LHINs and CCACs, recognizing that CCACs provide services within an approved geographic area. We recognize the need for this exception, given that our services are primarily provided in our clients' homes, and have no problem with the clause. We do, however, want to identify that there are circumstances in which CCACs coordinate services to clients who live outside a CCAC's geographic boundaries. Two key examples include facilitating placement in long-term-care homes for clients who live outside a CCAC's geography and facilitating discharges from hospitals to home that cross geographic boundaries. It will be important to ensure that accountability agreements between the LHINs and the CCACs recognize these circumstances.

The remainder of our comments relate to the complementary amendments to the CCAC act under part VII of the bill and the proposal to amalgamate CCACs and align them with the LHIN boundaries.

Under the current provisions of the CCAC act, CCAC boards and executive directors are appointed through the Lieutenant Governor in Council. In addition, the minister is responsible for fixing the salary, benefits and other remuneration for the executive director. Our experience has been that this framework created dual, and often ambiguous, accountability relationships that diminished the board governance. This approach has also created a corresponding increase in the government's obligation in administering a massive appointment process. There has been a high degree of uncertainty and instability for CCAC board members and executive directors, with long delays for new appointments and with reappointments often occurring within days of the expiration of the term.

We are, therefore, very pleased with the proposed amendments that would return CCACs to the status of non-profit corporations under the Corporations Act, with the power to elect their board of directors, retain and set employment terms for chief executive officers and create bylaws to govern their structure and operations. These amendments are consistent with recommendations that we brought forward to the Ministry of Health and Long-Term Care following a motion ratified at the annual general meeting of our membership last June. We believe that these amendments will provide a framework for greater stability and clearer accountability in our sector.

As mentioned earlier, the OACCAC and our members have been engaged in extensive discussions with the Ministry of Health and Long-Term Care over the past year in relation to the proposal to amalgamate CCACs and align our boundaries with those of the LHINs. While not universal, there is a significant level of support among CCACs for consolidation and alignment. Concerns remain about the impact of creating larger, more complex organizations serving diverse populations and geography. Our members have identified the need to ensure equity in service distribution across regions; sensitivity to regional diversity, including local representation; and an adequate time frame for implementation. It will also be essential that the transition process ensures the fair and equitable treatment of staff affected by the proposed change, continuity in local partnerships and agreements with our service providers and, above all, stable services to our clients. However, our sector remains committed to working with the ministry to ensure a smooth and seamless transition that provides stability of client services, assuming the plan goes forward.

Finally, the Minister of Health and Long-Term Care, in his remarks to the Legislature, indicated that the government is considering a broader role for CCACs in the future. The power in the bill to make regulations contains provisions that would allow the Lieutenant Governor in Council to support an expansion of the CCAC role. We believe there is considerable potential to further build our care coordination, experience and resources through these partnerships with family physicians, hospitals and other community agencies to facilitate access, improve service integration and support clients as they navigate their way through the health system. This in no way diminishes the significant roles our health care partners play in providing access to services, nor should it impede or complicate people's ability to gain entry to the health service system through a variety of portals.

On behalf of the CCACs and our association, we are grateful for the opportunity to share our views on this important piece of health care legislation.

**1430**

**The Chair:** Thank you. There are three minutes; one minute each. Ms. Martel.

**Ms. Martel:** Thank you for being here today. Let me go to page 5, where you say you're pleased that the

government is bringing in proposed amendments to "return CCACs to the status of non-profit corporations under the Corporations Act, with the power to elect their board of directors, retain and set employment terms for chief executive officers and create bylaws...." What would you say if some of those principles were actually applied to the LHINs?

**Mr. McCrimmon:** Jim, do you want respond?

**Dr. James Armstrong:** We haven't been addressing that question in terms of the LHINs. We've only been focused on the access centres and what we see as desirable for the services.

**The Chair:** Ms. Wynne.

**Ms. Wynne:** Thank you very much for being here today. I want to go to your point about unregulated health professionals. You were talking, I think, about part III, subsection 16(2), where there's a health professionals advisory committee. Is your suggestion that that committee should include unregulated health professionals, or are you suggesting that there should be another advisory committee of unregulated health professionals?

**Mr. McCrimmon:** Either way, but we do think there should be some method whereby they have the opportunity to input to the LHIN organization.

**Ms. Wynne:** Okay. It's a very interesting point. Thank you very much.

**The Chair:** Mrs. Witmer.

**Mrs. Witmer:** I was going to ask the same question as Ms. Martel. However, I guess what you see in all of this is that the minister has made some commitment to expanding the role of CCACs in the future. That may well take place at the expense of the hospitals. Have you considered that probability? The minister's chief of staff said the other day at a conference I was at that hospitals don't speak to community needs. Do you see your organization, then, assuming some of the responsibilities?

**Mr. McCrimmon:** I think we're basically looking at other expansion, whereby our case managers can perhaps provide a service to other ministries.

**The Chair:** Thank you for your presentation, gentlemen.

## ONTARIO HEALTH COALITION

**The Chair:** The next presentation is from the Ontario Health Coalition. Good afternoon.

**Ms. Natalie Mehra:** Good afternoon.

*An emergency alarm sounded.*

**Ms. Mehra:** Okay?

**The Chair:** Any time you're ready.

**Ms. Mehra:** Okay, great. I was sitting here thinking that Jean-Paul Sartre wrote a play about how hell is a meeting in a very hot room that never ends. Even he didn't think of adding a fire alarm. I do thank you, and I'm sure it's been just an insufferable day for you here.

I would like to start with some comments about the response of our members across Ontario to the introduction of this legislation. As you know very well, the province isn't a blank slate when it comes to health restructuring. We have actually been through significant health restructuring over the last decade or decade and a half, or longer. That experience, I think, colours many people's approach to new legislation to provide powers to restructure the health system. A lot of our concerns flow from the experience of health restructuring over the last several years.

Like the hospital restructuring legislation brought in by the Conservatives, this bill increases government powers over health providers in order to facilitate restructuring. Like the Conservatives' restructuring, there are few checks and balances to ensure that the process can't go awry, and where there are, they're inadequate. We believe that the lessons learned by community members, health care providers and staff in the last round of restructuring are very important to take into consideration when looking at this new piece of legislation.

Certainly, it appears in this legislation that a lot of thought has gone into how the power system will work: how the minister will achieve his powers, how the transfers of property will take place and how the mergers and amalgamations will take place. But it appears that less thought has gone into what checks and balances will be in place on that power and how the public will interact with the directions of the health ministry, and in fact, how the health minister's ideas about the health system interact with the civic-minded individuals who have spent the last several generations in their communities raising money to build local community hospitals and to improve local access to comprehensive health care services.

In this legislation, a full system of centralized power or centralized planning, sometimes referred to as a kind of command-and-control structure, has been set up. But any kind of central command structure for any public service, as we've learned from history, requires democratic input. It requires proactive seeking of democratic input. It requires a feedback loop. It requires checks and balances. It requires clarity of principles and direction of restructuring.

In the last round of restructuring, if I can refresh your memory—there is no official evaluation of it, but what happened, ultimately, was that 9,000 critical, acute and chronic care hospital beds across the province were ordered closed and 26,000 full-time-equivalent hospital worker positions were laid off. The care that was moved out of hospitals into the community and the new capacity that was built in the community in long-term-care facilities and in home care were overwhelmingly privatized and remain that way to this day. The incredibly expensive hospital building program that was ordered by the restructuring commission was privatized through P3s and continues to be privatized to this day. The balance of not-for-profit and public delivery of health care, compared to for-profit, private delivery of health care, was changed, possibly forever, in the health system.

At the end of the day, important hospitals services—like physiotherapy, rehabilitation, chiropody, other types of hospital services—were cut from hospitals and have

never been replaced in the public health care system. You can't get them for free, and certainly not in a timely fashion, in many communities across the province.

At the end of the last round of hospital restructuring, what we learned was:

—that restructuring geared to cutting costs or to finding budget efficiencies simply leads to offloading;

—that the facilities off-load services and they're not picked up anywhere. You don't need to delist things from OHIP; they're just cut, and they never return;

—that restructuring done badly can drastically increase costs without improving the health system. In fact, the costs in the last round of restructuring, according to the provincial auditor, escalated $2.8 billion over projected amounts;

—that restructuring can create vast new market opportunities for the for-profit health industry;

—that the destabilization brought about by restructuring can take years, and millions of dollars, to undo.

We believe that the principles that guide any restructuring in the health system must be more specific and more protective of the public interest than simply including the term "public interest"; that the principles of the Canada Health Act must be incorporated into Ontario legislation regarding restructuring; that meeting population need and moving comprehensive health care services as close to home as possible—these types of principles—must be front and centre; and there must be democratic checks and balances.

We find that the unequal treatment of the for- and non-profits in the legislation is indefensible. We note in the legislation that the LHINs already have the power to transfer funding and services out of not-for-profits into other not-for profits and into for-profits or into third-party, contracted-out agencies, whatever they may be. Why, then, does the minister need the additional powers to order the closures of non-profit agencies? Why would this legislation set up a dichotomy in which the property and services of not-for-profits, which have been built by local communities and people who are civically engaged out of the goodness of their hearts and out of the concern for their communities, are treated with less respect than property and services that are run for the purpose of seeking profit?

Furthermore, while this government obviously trusts itself with the increased powers that it gives itself in this legislation, would this government trust another potential future government with the powers in this legislation? For instance, if the Conservative were to win the next election, would you support the minister having the unilateral power to order the closure of the not-for-profits in the health system, to order the mergers and amalgamations of the not-for-profits etc.?

**1440**

In terms of democracy, as we say, this is really the set-up of an extended central planning system, but without a kind of glasnost, without a kind of openness in the health system. You should know that many health care workers are covered by gag orders and not allowed to speak out about poor practices in their facilities or in their particular health sector. The LHINs boards that are appointed by cabinet and can be replaced at cabinet's will etc. are clearly centrally controlled, and cabinet is given the inexplicable power to exclude "any persons or classes of persons" from LHINs membership, which seems to be a set-up for discrimination. There are no protections in the legislation to prevent a revolving door, for instance, between the for-profit health industry and the LHINs boards, and we have deep concerns about that.

We're concerned about why the democratic protections in this legislation are so different than those in other provincially set regional governance structures; for example, municipalities and school boards, both of which are creatures of the province, both of which have much stronger protections against in camera meetings, both of which have the right for public deputations, for public submissions, for public appeals, all kinds of procedural protections in their legislation. Why is it, then, that the health system's restructuring legislation is so inadequate in comparison? I will append to our submission the sections of the Municipal Act and the Education Act that limit in camera meetings and call for democratic processes.

In terms of privatization, I think you've heard from other groups that we're extremely concerned about the powers to close the not-for-profits and not the for-profits. We're also concerned about the part of the legislation that gives cabinet the power to order the contracting out of all support services in hospitals. We clearly object to that.

I've heard that in the minister's comments he raised questions about the concerns about competitive bidding in the health system. I don't think this is a problem of interpretation. In fact, competitive bidding has already been introduced in the hospital system through the wait time strategy for cataract surgeries. Hospitals are bidding on a price basis, and those hospitals that meet or come below the ministry's target on a price basis for those services will get those services. This has already been announced. It's on the record. There is no question about whether or not that is happening; it is happening. In addition, the ministry is on the record as being supportive of the findings of Elinor Caplan's review supporting the continuation of competitive bidding on home care. So we have good, concrete reasons to be concerned about the extension of competitive bidding, which we believe has been extremely damaging to the health system and which also, I believe, puts your government at odds with all of the civic-minded people who have been trying to build local access to community health services.

I should also note that in no jurisdiction the size of Ontario has either the attempt to specialize hospitals in this way or the competitive bidding system been tried. It has been tried in Catalonia, as I understand, which is a small area of Spain. It has been tried in Britain. Well, you can fit Britain four times into the province of Ontario. The Northwest LHIN can fit the entire geography of Spain, Portugal and France into it. It costs $700 to fly

from Kenora to Thunder Bay. There is no train. It's a six-hour drive, as some of you will know.

So the kinds of geography and population demographics that we're talking about really preclude specialization in hospitals in this province, and we urge you to look extremely carefully at the strategic direction of the ministry regarding competitive bidding.

I'll conclude with the labour issues. This legislation includes a significant portion on labour issues. I can't talk extensively about it, but we are deeply concerned about the different treatment that doctors, for instance, in the health system are getting in order to buy their support for transformation of the health system versus the women, for example, who work in hospitals in the support services. The ability for the government to order the wholesale contracting out and potential privatization of their jobs is offensive to all of us, and we hope that you'll take that out. Thank you.

**The Chair:** Thank you very much for your presentation. You used all of the 15 minutes, so thank you again.

## ONTARIO PUBLIC SERVICE EMPLOYEES UNION, LOCAL 311

**The Chair:** The next presentation is from the Ontario Public Service Employees Union, local 366. Good afternoon.

**Ms. Connie Ferrara:** Good afternoon. It's 311 now.

**The Chair:** Okay. Thank you. Please proceed any time.

**Ms. Ferrara:** Hello. My name is Connie Ferrara. I'm a pharmacy technician employed at the Rouge Valley Health Centre in Ajax. I have been a pharmacy technician for almost 36 years. I know my job and I do it well. This is because if I'm not doing my job well, it could have serious repercussions.

Throughout Canada, there is a shortage of pharmacists. Technicians now perform a vital role, and more and more tasks are delegated to us because of the shortage. Downloading the pharmacy services to the community would put patients at risk.

Community pharmacies employ technicians who do not have the same scope of practice that hospital technicians have. For example, in the community, the technician counts the pills or pours the liquid medication from one bottle to another under the supervision of the pharmacist. Sometimes, and a lot of the times, the front-store cashier is called to help count the meds or pour the liquids when the pharmacist and pharmacy staff are very busy.

In hospital, the technician screens the doctor's orders, we look for incompatibilities such as drug allergies, heights and weights of patients, and we also do order entry for certain medications. Technicians check orders after they are filled and before they are delivered to the nurse's station. We prepare IV medications, chemo and compound special orders. We dispense narcotics and maintain files. Technicians provide a responsible quality of service that community technicians are not trained to do.

If pharmacy services were downloaded to community pharmacies where pharmacist shortages are prevalent, who would fill these orders—the front-shop cashier or the cosmetician? If the cosmetician gets the order wrong, maybe she can offer her other services to the funeral parlour.

But kidding aside, each and every hospital needs an in-patient pharmacy. We have stat orders on a constant, daily basis. Medications are delivered to the emergency department, to the ICU and to the OR within minutes in a serious situation; off-site services would cost lives. Health care is something we take for granted. That is because it has been available to us and we don't miss something until we lose it. Health is very precious; this you find out the hard way.

Years ago, I had a very ill child. He faced a life-threatening disease that devastated our whole family. Initially, he was in Sick Kids Hospital, where, after two weeks' stay, I was presented with a hospital bill totalling $93,000. It clearly stated that if I did not have OHIP, I was responsible for payment. Luckily I did, and at that time to help my child, I would have done anything. His treatment took a long three years.

Three years ago, I had a minor stroke, and now I have developed diabetes. I am at the point in my life where health care is essential. I too took it for granted for a long time, but when you reach a certain age, you have worked for so many years, you have paid your taxes and you are expecting to eventually retire and enjoy life, guess what? You find that your health isn't what it used to be. What I do expect is that health care will be there for me, that the people elected will ensure that this service is protected, that a private company has not decimated the system for profit.

We all have aging relatives who require health care in one form or another. How is the community going to provide for them? What would your reaction be to your parent or grandparent having to travel to a distant city for treatment? What if their pension isn't enough for the expenses they would incur? Personally, for my family and me, this type of expense would wipe me out financially. I have worked since my teens, not only one job but, at times, three. I have raised four children on my own since my husband became disabled after a fall from a second-storey roof. I would need to sell my house to pay for expenses that I would incur if we needed to travel.

When I hear a candidate running for office promising to cut taxes, I tune that person out. Cutting taxes is not the answer; ensuring that our taxes are used appropriately is. The government should be ensuring that those tax dollars are used for services, not setting up LHINs without the proper consultations. You need to include us; you need to slow this process down and ensure that each and every step taken is the right one. We are the caregivers; we have the answers for you.

People are not stupid. We have past examples that are not easily forgotten. I personally hate the fact that my tax

dollars helped build the 407, only to have it sold to a private company which has raised the price for its use so that I can't afford to use it. The LHINs won't be forgotten or forgiven either if you don't put people first.

**1450**

The last government's cuts to hospitals left us hurting. Budget cuts have deteriorated services. One example in my hospital is that after amalgamation between Centenary and Ajax, dietary services were cut. The cafeteria hours in Ajax were cut when they opened a Tim Hortons in the building. Next, the CUPE members lost their jobs as the Tim Hortons employees now also run the cafeteria and prepare the patients' trays.

I can still see what Ajax hospital looked like 15 years ago and the state it is in now. Did we not learn anything from SARS? Did we quickly forget the price we paid for SARS and lies? Health care workers died. They did their jobs. How will the community serve in a pandemic? We know that that time will come. How will you defend your decisions then?

In my community of Ajax, when there was an immediate threat of closing pediatrics and maternal newborn services, the municipalities threatened to withhold funds to the hospital. These are tax dollars that people expect to be used for their needs, not for private companies looking to make a profit. If a publicly held hospital cannot meet their needs with their current budget, how would a for-profit company run it? The answer is obvious: Cut services and replace qualified staff with unqualified workers. Would you allow your child to be treated by unqualified staff? There is no way to guarantee that if a service is located at one site across the region, the patients from other areas will have timely access. For instance, Lakeridge Health has rehab and palliative care beds that first go to patients from their sites, shutting out Durham residents at the Ajax site. At Ajax, we have not had a patient admitted into one of these beds for years. The senior management at Rouge Valley does not consult with staff as to program needs and direction. They are out of touch with what is happening at the ward level. They have misinformation which they will be passing on to the LHIN, because paternalistic father knows best, and children—the staff—should be seen and not heard.

Senior management eliminated discharge planners at Rouge Valley and gave this work to social workers in order to save money. Social workers are now hard pressed to meet the social and emotional needs of patients and families when trying to explain why a family member has to be transferred to Scarborough for treatment. Now patients may need to travel even further abroad. There is no real concern for the emotional needs of patients and families at present, although the hospital mottoes are "We care" and "Family-centred care."

Also at present, senior management is unable to manage more surgeries being performed than beds available to accommodate at the Ajax site. Current practice is to scramble internally to find a bed. If a post-surgery service is no longer available internally, a patient will have to be placed on a waiting list at another site, blocking beds. Presently at Rouge Valley mental health, we have a three-month day treatment group therapy; a three-week day hospital—support after being in hospital and to prevent hospitalization; a crisis service for the emergency room, not 24 hours and not on weekends; and in-patient treatment for the severely and persistently mentally ill. All of the above programs will be cut except for the day hospital and crisis service. The impact will be that the people normally attending these groups would have to find the equivalent in the community.

In the 1970s, the Ontario government began closing psychiatric hospitals, stating that patients will be cared for by services in the community. The community services did not exist. Scarce community services currently exist to meet social and emotional needs of patients. For children and adolescents in Ajax to see a child psychiatrist, they need to go to Lakeridge Health in Oshawa or the Centenary Shoniker Clinic. Our biggest concern is that if we combine services, what would stay and what would go?

I won't go into other examples. I'm sure that you will have heard and will hear a lot more than I could go into. I just want to leave you with a thought that this is a very serious process that you must decide. You need to remember that your constituents afforded you their faith and trust to act on their behalf and make decisions that allow them a certain quality of life. Rushing in this legislation without consultations and input from all of us will have serious repercussions.

Thank you for the opportunity to speak.

**The Chair:** Thank you very much for your presentation. We have about two minutes each. We'll start with Ms. Wynne, please.

**Ms. Wynne:** Thank you very much for coming here today. I have a couple of questions. First of all, you talked about the need for input. I guess one of my basic questions is, wouldn't a LHIN—a community-based organization, more local certainly than the ministry—be more accessible to the public than the minister's office or the ministry? What's happening in this legislation is that powers and planning authority are really being devolved to the 14 LHIN offices. I'm just a little confused about the sense that the minister's office or the ministry is more accessible than the LHINs will be.

**Ms. Ferrara:** I attended two LHIN meetings and I think I'm more confused than you are. With every single question that was asked at those LHIN meetings it was, "We don't have the answers. We don't have that information." So I can't tell you what would be better. All I can tell you is that since there is no information, how do I know what's going to benefit myself, my community, my children and my hospital?

**Ms. Wynne:** I guess what we're trying to say is that with this legislation we're bringing more clarity than there was before the legislation was brought into place. We're saying there will be a provincial plan that is in the process of being produced now, there will be consultations on that provincial plan, and then it'll be up to

the LHINs to have a local plan that fits in with the provincial plan. That's where the interface between the community and the needs of the community happens.

The private-public discussion is a parallel one, but the need for a plan that will allow for sustainability over the long term—you talk about the future. That's what we're trying to get at: a plan that will allow for health care in the future.

**Ms. Ferrara:** But we need to see that plan. I have no idea what's in that plan.

Secondly, how can someone like our chairperson, who is from the northern part of our LHIN, hundreds of miles away, know what we experience, what our needs are without having input from us? I can't see us being part of this process.

**Ms. Wynne:** So that community engagement piece is very important, is what you're saying.

**Ms. Ferrara:** Before everything is in place.

**The Chair:** Mr. Arnott.

**Mr. Arnott:** The government talks about the need for a long-term health care plan that is sustainable. I think all of us in Ontario would agree that that's needed. But some of the points that you've raised today are very important ones in the sense of issues that I've seen over the years in health care. When the government is contemplating a major change in health care direction, they don't often enough consult with the front-line health care workers. This is something we see time and time again. So your input has been very helpful in that respect.

Would you agree that Bill 36 is yet another example of where the government has not consulted adequately with front-line health care workers prior to its implementation?

**Ms. Ferrara:** Yes. I feel that perhaps, rather than starting up a new LHIN, we should have just expanded the services of our district health councils and maybe go back to the basis of why they were formed to begin with. The amalgamations were supposed to cut costs. Instead, we ended up with several tiers of a management system that just took away funds from where they should have been put.

**The Chair:** Ms. Martel.

**Ms. Martel:** Thank you for coming here today. I'm always interested when I hear the government say that this bill is all about powers and planning being devolved to the community. I hope the government members will read two legal opinions—one that's been put out by Sack Goldblatt Mitchell and the other by Cassels Brock—that just list page after page, section after section, how LHINs are controlled by the government, the erosion of local control, then the direct ministerial and cabinet control over local health service providers in a manner that is now unprecedented, even more than when the former government, for example, brought in the Health Services Restructuring Commission, or Bill 26.

There's nothing here about local control. The LHIN board members, for goodness' sake, are themselves appointed by government. They serve at the behest of government. They are agents of the government. They can't even claim to be representative of the community because they're not even elected by the community, and they don't serve at the request or the behest of the community. So I find it a little hard to hear again and again how this is all about devolving local power.

The other interesting thing to me is that the LHINs are mandated to put in place this plan that the government has for health care across the province. We haven't seen the plan, we don't know who's involved in the consultation and we don't know where that's at. So the whole process really is about more central control. Health care is a function of how much money there is for the system, and the minister and the government make those decisions. Who gets health care, when and in what timely fashion is a function under the control of policies of the government with respect to who's going to get those services, where they're going to be located etc. The LHINs are going to do nothing about that. They have no power, no control and no say over any of those services.

If you'd like to say anything else, you go ahead. That's my speech for the day.

**Ms. Ferrara:** Well, that's just it. I'm totally confused.

**The Chair:** Thank you for your presentation.

**1500**

## WELLESLEY CENTRAL HEALTH CORP.

**The Chair:** The next presentation is from Wellesley Central Health Corp., Dr. Bob Gardner and company. You may want to introduce your friend, please. Good afternoon.

**Mr. Richard Blickstead:** Good afternoon. Thank you, Mr. Chair. I'm Richard Blickstead. I'm the CEO of Wellesley Central. Wellesley Central, as you may know, is the successor organization to Wellesley Central Hospital. We are an organization that deals in research, capacity-building and public policy, as well as the redevelopment of the Wellesley lands. We look at health promotion and urban health from the social determinants of health perspective, particularly in the world of housing, income distribution and social exclusion. We've worked with the LHINs from their inception, and what we want to bring to your attention is that one size does not fit all, that there is a need for an ability of the LHINs to recognize that neighbourhoods are different, and that, having come to Wellesley from the private sector, we really need to listen to our customers more than we need to listen to our administrators. Bob Gardner, our director of public policy, will speak directly to that, and then we will be happy to answer any questions following.

**Dr. Bob Gardner:** In many ways, what we want to emphasize speaks to the question that Ms. Wynne raised: how community engagement will actually work. We want to talk about some possible amendments to the legislation and some incentives that could be built into the structure of Bill 36 that can allow for real community engagement.

We do think that LHINs have great potential. The idea of regional health planning and greater integration of

services and greater coordination has a real opportunity to create a much more seamless and equitable access to a full continuum of care on the ground. We agree with the principle and we agree that it's a very ambitious project. But the LHINs are only going to be able to succeed if they really do effectively reflect the diversity of the communities they work with. As you know, some of them are so huge and some of those communities are so diverse that that will be an incredible challenge. They'll only be able to work effectively if they develop priority-setting and resource allocation that really do reflect those community needs and really do result in a seamless continuum of care.

We want to talk a little bit about the mechanisms that would actually make that happen. We want to talk about some mechanisms that could allow the LHINs to foster innovation on the ground, and then to be able to share those successful pilot projects and experiments across the province. Really, our emphasis is that the LHINs legislation needs to be altered to ensure that the planning really is community-driven. One of the problems with health reform is that it has to look at the incentives and drivers that actually make health care work on the ground and in the institutions. So we're going to be making some concrete recommendations on the particular sections.

For example, we think that there need to be very clear expectations on all the LHINs to involve communities, very clear requirements that communities have to be involved in the planning and priority-setting. We think there are two key ways in which this can be done. One of them is to get much more specific about requirements for community participation in planning and priority-setting in the actual legislation. So we're recommending that section 18 be amended so that specific requirements and indicators for community engagement are built into the accountability agreements between the ministry and every LHIN.

I talked earlier about incentives. We think that subsection 17(1) needs to be amended to require that specific lines or envelopes are put in the LHIN budgets to support community engagement. In fact, allocation of that money is tied to successful attainment of targets for community engagement.

We also think, as Mr. Blickstead was mentioning earlier, that there's a tremendous challenge in reflecting the huge diversity of needs within the LHINs. The LHINs are very, very large. They need to find a way of integrating the region-wide planning with much more locally based and more neighbourhood-based planning. So we're suggesting to amend subsection 16(1) to require that each LHIN create local neighbourhood or community advisory committees, that those committees become the planning forums in which neighbourhood and local priorities and discussions are set, and that then there are mechanisms to feed that up into region-wide planning.

I know that the ministry and members have looked at the experience of other provinces, and you will know that all the other provinces that have had over a decade of experience with regionalization have created this kind of more local or neighbourhood-based advisory or planning committee. Again, back to the main point: One size won't fit all. Quite what form these committees would take really will vary region by region. The ministry has the delicate balancing act of making sure that requirements are built into the legislation so that every LHIN does set up these committees but then be quite flexible on how particular regions and neighbourhoods do decide to organize themselves.

The other thing we think is that there's a tremendous amount of strength in the health care system at the moment. When the LHIN initiative was just starting, the ministry did some research and found over 1,000 examples of existing service and coordinating networks. They really should be built upon. We suggest amending subsection 15(1) so that one component of the integrated health service plans that each LHIN will be producing is that they specify very concretely how they will be building upon all of the existing networks in their region. We think that one starting point they should all have is to actually do an inventory of what already exists in their regions.

We also think that innovation has to be a very explicit part of each LHIN's mandate. Again, there's the same sort of balance of building that in too, so amend section 18 to require that the accountability agreements actually have very concrete expectations that the LHINs will fund and encourage pilot projects and experiments all through their regions. Also, amend subsection 17(1), the funding formula, so that's there's money for that and that, in fact, getting that money is tied to meeting targets in incubating and encouraging successful experiments. The province and the ministry, of course, have a responsibility as well to create an infrastructure, both a technological and a working culture infrastructure, that is able to share the innovations that are developed in particular regions across the LHINs and that can scale them up when appropriate.

We would echo some of the colleagues you heard from earlier that one of the more important issues is the question of funding and competitive bidding and what kind of mix of providers will work best. There has certainly been considerable research from Britain, if the government is looking for that kind of split purchaser-provider model, that there are problems with higher administrative costs, fragmentation and quality concerns among the commercial providers. There has been some concern about the experience of CCACs here in Ontario.

Luckily, the LHINs aren't going to be funding services for some years anyway, so there's time to hold a significant public debate on what the best mix of funding and service options is. Perhaps that's a role for this committee. It's something that the ministry certainly should do. We think the province should in fact issue a report with its own analysis of the pros and cons of different funding models. If it concludes that the British or some other model will work here, then lay out exactly what the costs and benefits of it might be.

As Mr. Blickstead said earlier, the main focus of Wellesley Central is on the social determinants of health. There's a huge amount of evidence, which I'm sure you're all familiar with, that poverty and inequality and poor housing and inadequate childcare are crucial factors in ill health for far too many. What does that mean for the LHINs? Obviously, a particular LHIN is not going to be responsible for ending homelessness in the province or in the country, but they certainly can be responsible for working with homelessness activists and housing providers and advocates in their region to try and do effective partnerships arrangements and innovative local experiments that would actually build addressing housing into improving health care delivery. For example, here in Toronto, Street Health and other outfits: We actually fund their research to provide really good primary care and supportive health care to homeless people.

The LHINs certainly should be accountable for that. They should be accountable for building into their plans how the social determinants of health will be addressed. So again, amend subsection 15(1) and amend subsection 13(1) to include that kind of requirement in the LHIN legislation. We actually think that section 5 should be amended to include addressing the social determinants of health as part of one of the core principles of this bill.

We'd like to stop there. We hope there's some time for questions. This is part of a much broader project that Wellesley has been doing. We have a great deal of material on our website. Your caucus researchers and your legislative research can look at that. Thank you very much.

**1510**

**The Chair:** Thank you. We have four and a half minutes available, one and a half each, and I'll start with Mrs. Witmer, please.

**Mrs. Witmer:** Thank you very much for your presentation and your recommendations regarding these sections. I think what I heard was that one of your biggest concerns was the fact that the LHINs in Bill 36, as presently structured, were not community-driven in the way they should be to reflect the needs of local individuals and local communities. What do you think the priority for this government is in amending the bill in order to ensure that that community input is reflected in all decision-making?

**Dr. Gardner:** Well, one thing, this committee may decide that it needs more extensive hearings to hear from more people. I expect that you've been quite overwhelmed with response.

We have made some specific recommendations on various sections in the bill that should be amended. We argued in our larger paper—and we invite you to take a look at it—that each of the LHINs should build into its own planning cycle very concrete consultations and priority-setting exercises with its communities. We think that each LHIN, for example, should have a very large community conference with its local region right away. We know there have been delays in setting them up. There's a base that they can build that on already. We were involved in the local integration priority-setting exercise for the Toronto Central LHIN back about a year and some months ago. Mr. Blickstead was actually the chair of that. So there is already a list of people who could be invited to come back and say, "Okay, the LHINs are just getting rolling. What are the main priorities? What are the issues?" Perhaps one of the main things there is, what are unresolved issues that providers and advocates are hearing in their communities that the LHINs have to address? I would say that those kinds of planning conferences have to become part of an annual routine cycle, and also the neighbourhood planning forums that we've talked about that build up towards the priority-setting, the budget-setting and the reports that the LHINs will be making to the minister.

**Mr. Blickstead:** I'd like to add just one thing, if I could, very briefly. Over a year ago we met as a group, and I recall we had to write our report very quickly, work through the Christmas holidays at that time. I estimated that the amount of input was roughly $250,000 of time. That was so that the LHINs could get community involvement. You know, you can't even get a meeting with the LHINs right now. It's easier to get hold of the Pope than it is to get hold of the LHINs and to speak to the LHINs about community issues and about listening to your customer. I think, unless you put that into the legislation, you will be in a very difficult position in terms of listening to customers. It's very, very disappointing to see the speed of change. Perhaps I'm speaking out of turn, but I think it's important that unless you put this into the legislation, it won't work as well.

**The Chair:** Ms. Martel, please.

**Ms. Martel:** I don't think you're speaking out of turn. That was very interesting. You can tell us more about some of your conversations, too, if you want.

I'm going to focus on competitive bidding. I've been an opponent of competitive bidding for a long time. I think it has been a total disaster in home care. Earlier this morning the minister, when he was talking about what opponents and critics would come to say and what kind of deliberate misinformation they were going to spread—those are his words, not mine—said that competitive bidding doesn't appear anywhere in the bill, so we should assume from that that competitive bidding is not going to be the way that LHINs purchase their goods and services. I'm assuming that you folks have read the legislation because you referenced a number of sections. It might not be in the bill; that doesn't mean it's not going to happen.

You also referenced some British examples, and it would be great if you would like to give us some titles so we can have some more research on this. I think this is exactly where we're going to end up because the government has done nothing to stop competitive bidding in home care, despite the upheaval in the system that we experienced under the Conservatives. I think that's exactly going to be the model. Maybe you can, with your references from Britain, give us some ideas about why that wouldn't be such a good idea.

**Dr. Gardner:** We're happy to send the available research to your research officer.

As you say, the bill is vague or permissive, depending upon one's perspective. But the danger there is, yes, we don't know exactly whether competitive bidding or what other combination of funding and service provider will drive it. That's why we would recommend that the government make that very clear and make it very clear right now. If it is going towards a particular model, be it the British or any other, then it presumably has done a great deal of internal research on the pros and cons and the relative cost benefits. We presume also that there has been a great deal of study of the history of the CCACs here in Ontario. There has been a great deal of program data for a number of years now. That data could be analyzed by the government and released. The work that the Honourable Elinor Caplan did reviewing the CCACs did not really go into any depth in the comparative quality or costs or consumer satisfaction with for-profit versus not-for-profit. Essentially, we would say that until the case is made, we would recommend that the government make it very clear that it will not be endorsing or allowing any for-profit provision until and unless it can make a strong case.

**The Chair:** Thank you.

**Mr. Blickstead:** I would just add to that, very briefly—I'm sorry—competitive bidding is not as much the problem as value. The issue is, the criterion has been price, not quality. So quality to the people of Ontario is what's important, not necessarily price.

**The Chair:** Thank you. Mr. Leal, please.

**Mr. Jeff Leal (Peterborough):** Through to Dr. Gardner, I'm just going to read a statement from Dr. David Naylor, who is the president of the University of Toronto and former dean of the faculty of medicine; I'll get you to comment on it.

Dr. Naylor said, "Community-based care reflects the needs of each community and is best planned, co-ordinated and funded in an integrated manner in that community. LHINs would engage their communities to involve Ontarians in a broad conversation and debate about their health care."

Can I just get you to comment on Dr. Naylor's statement? He's looked at this legislation; he's the leading expert in health care in the province of Ontario. I'd like to hear your comment on his observation.

**Dr. Gardner:** He has indeed, and he certainly is a leading expert. I think essentially he is saying what I opened with, that the LHINs have great potential, that if they do successfully engage our communities and do successfully integrate planning and service delivery, they really could make a difference to a seamless and an equitable continuum of care on the ground. But perhaps he didn't get, later in his statement, to some ifs and success factors. This is what we've been emphasizing: that the LHINs will be successful only if they do the kind of serious community planning that we have been outlining in our papers and if they do build in the kind of requirements and funding incentives that we have been talking about.

So I certainly don't disagree with Dr. Naylor. I would imagine he would say exactly the same thing. The whole history of academic and practitioner comment on regionalization in the other provinces is that it's a good idea that almost worked, but it needed to have a wider scope and more funding at times and it needed to engage its communities more seriously.

**The Chair:** Thank you.

*Interjection.*

**Dr. Gardner:** I'm not sure I exactly said that, sir.

**The Chair:** Thank you very much for your comments and answers. We just went a few minutes over the time, but thank you.

## PETERBOROUGH HEALTH COALITION

**The Chair:** I will have the next presentation from the Peterborough Health Coalition, Mr. Roy Brady. You can start any time you're ready, Mr. Brady.

**Mr. Roy Brady:** I want to thank the entire committee for giving me an opportunity to come here this afternoon. I think I have something to get you thinking. My name is Roy Brady. I'm the chair of a citizens' watchdog group in Peterborough and it's a chapter of the Ontario Health Coalition, which has very acute concerns regarding the local health care scene, as well as the provincial and federal levels.

I'm going to provide some general analysis of problems I see with Bill 36. This should lead to some serious amendments on your part. Secondly, I want to get into the Peterborough health care situation, because I feel that the lack of influence locally has retarded health care improvement.

The text you have in front of you would be about 90% of what I have to say.

Statements from political officials and health care administrators have praised LHINs as a long-awaited, necessary systems reform. Applying the concepts involved arguably may be very helpful for Ontario. However, in our view, the legislation, Bill 36, as it stands, will not improve the system and it appears to us to potentially create the opposite of what these officials praise.

**1520**

One rationale provided is to bring health care decision-making into the community. This is puzzling. The legislation clearly contradicts the intent to "allow decisions how health services are delivered to be made locally." There is no accountability for a LHIN or the health minister to the various communities within a LHIN; barely any local decision-making at all. LHIN board members are political appointees, meaning that no elected or community governance exists. The skills that were advertised for these positions were almost entirely managerial, financial and communications, which likely support political cost-cutting priorities but are hardly designed to effectively meet the health care needs in communities.

The process used to establish LHINs was undemocratic. Yes, some local health providers were involved,

but these people knew they had better co-operate while jobs would be streamlined and accountability and performance agreements would be signed. Unengaged were patients—who, by the way, received very little recognition in Bill 36 at all—and proven, responsible community groups. The consultations were held distant from the public, with very little notice. In my case, I found out about the Central East session in Markham through the Ontario Health Coalition. Otherwise, I would never have known. That was December 9, 2004. And yes, we have these committee hearings here, but isn't it pure irony that Central East citizens had to travel to Toronto to appear—and there were quite a few of us who applied—an indication, perhaps, of the travel dislocation LHINs may create to obtain health care services. So there was no real public process, no democratic requirements. You have to believe that that was intentional.

Instead, Bill 36 will restructure our health care delivery to provide incredibly new powers to one health minister and the provincial cabinet. We feel this is inexcusable. The minister will issue a strategic plan for the health system, a plan without public input. All LHINs must follow that plan. The legislation overrules all other related legislation, and its instructions are backed by court order. It demands accountability agreements to be signed by all LHINs, and when negotiations are unsuccessful, the agreements shall be politically imposed.

LHINs shall fund health care services according to what the minister considers appropriate, with a finite amount for one entire geographical area, hardly allowing for the flexibility required to solve unanticipated problems or needs within a very large, diverse geographical area. The Central East LHIN to which I belong includes Scarborough, the eastern section of the GTA, the Peterborough and Lindsay areas, and all kinds of stretches of rural areas. It's going to be difficult.

The minister, through a LHIN, will fund and restructure, but the scant appeal process does not apply to a community, or to patients for that matter. Non-clinical services in the legislation are defined very broadly, and that has created a direct threat for existing employee groups. Why would you want to do that?

Most important in the legislation is the ultimate power given to one minister or the cabinet to dissolve, divide, transfer and amalgamate service agencies that are not-for-profit. But the power will not apply to for-profits. These politicians can order the contracting out or privatization of hospital support services without community input. Undemocratically, the minister can determine who can and who cannot serve on a LHIN board and also which LHIN board meetings are public or closed, with just a notice provided. These are incredible powers within a citizens' health care system, but nowhere can I locate in the legislation powers or process for input that is local, as in "local health integration network." In addition, there is no accountability at all for the minister or cabinet.

We can readily see that the legislation is not regionalization or the local direction of health care delivery, but pure centralization. If centralization is your goal, state it. LHIN boards and CEOs are accountable to the minister and not at all to the communities, toward whom there is no political accountability. All decision-making, in reality, is at Queen's Park, because LHIN directions will be based upon the minister's strategic plan. Central East local service delivery will be determined in Ajax, and we can expect disconnection rather than a more accessible continuum of care.

The primary purpose of the legislation appears to be cost-cutting—that should be publicly stated. If health care expenditures are politically burdensome, attention should be redirected instead to the spiralling cost of drugs and technology and the creation of a new expensive LHIN administration.

Bill 36 is actually only the enabling legislation. Imagine: The regulations are to follow. Bill 36 enables far too much.

I would like to raise some concerns from the local level—Peterborough and area—which perhaps apply to other communities as well. Provincial funding decisions, or non-decisions, lead us to believe that future restructuring will leave our communities ill served. Peterborough has not been well served under the minister's current strategic plan. Right now it's centralization, without local voices being understood. Why do we need a bill to enable just that?

(1) The restructuring in Bill 36: we've gone through this before. The Sinclair commission in 1999 identified the need for 483 hospital beds for Peterborough and area. St. Joseph's Hospital was closed, leaving one Peterborough Regional Health Centre. This single hospital has 379 beds, 40 of which are unfunded—104 fewer than we're supposed to have; 144 if you include the ones they don't pay for. The provincial government's two-year deficit elimination edict demanded—yes, demanded—$8-million and $12-million cuts, which led to a range of proposals cutting services and positions, which led to deep community outrage; in particular, pulling the women's health care centre out of the hospital jurisdiction. That was fought off. Jeff Leal, our MPP, helped us with that.

Peterborough awaits a second balanced budget plan formulated and negotiated in secret. That was covered in an opinion piece in the Toronto Star this morning. The sad Peterborough Regional Health Centre situation, with the highest emergency ward overload per capita in the province and a severe family doctor shortage, has been virtually ignored by the provincial government. This situation was all over the Peterborough media on the weekend because of the terrible conditions that sprang up once again: not enough beds, and for a long time, the province hasn't helped us.

The Peterborough and area hospital system has been restructured from without, but health care improvements did not follow. In our view, the Ontario government has restructured Peterborough into this deplorable situation.

(2) To assist with deficit elimination, our hospital, like others, was urgently encouraged to transfer services from

the hospital setting into a less costly community setting. Peterborough Health Coalition has agreed with this transfer concept, but only if the transferred service is sufficiently funded. For example, Peterborough had a stroke rehabilitation day hospital downtown that was funded one time through the summer months, ending on September 30. The program was transferred from the hospital, but the funding mysteriously dried up, despite community care access centre attempts to arrange promised funding and continue the program. It seems, at best, to be on life support at present, and we credit the access centre with continuing to revive the program with alternative delivery models. Where's the funding? The hospital did its side.

(3) The policy of transferring services from a hospital to a community setting will likely continue. According to Bill 36, the Peterborough community will not be able to decide the process or delivery. That will be done by the LHIN in Ajax, overseen by the ministry, of course. Local health care boards and community supports will lose the ability to make such strategic decisions.

(4) The Canada Health Act protects public delivery of, and access to, medically necessary services in hospitals and with physicians. When services are transferred out of hospitals or from physician care, the danger is provincial delisting of these services, which might lead to out-of-pocket expenses or revenue generated from other sources.

Provincial downloading continues as a public policy. Our local health unit, not the province, funded two nurse practitioner clinics for a few months to alleviate the effects of the family doctor shortage. The county municipality and the VON fund a similar clinic in rural Keene. Peterborough Health Coalition believes that as long as funding gaps created by the province can be filled by local revenue sources, which really is downloading, the minister or cabinet, through a LHIN, will accelerate the policy of transferring services from the hospital to municipal agencies, and unfortunately the funding may not follow.

(5) Family health teams, though in our view not as promising as community health centres, have the potential to serve more patients who don't currently have a family doctor; that's their purpose. However, these teams—and there are five in the immediate Peterborough area—are unfortunately, in our view, likely to become dumping grounds for the provision of services that have been transferred from the hospital or from the two clinics I mentioned previously that have been closed for lack of funding, which left 2,000 patients to scramble to a family health team barely in operation yet, or to the emergency ward. Such decisions would be made in Ajax. Certainly, in our estimation, Peterborough health care providers and citizens would not use family health teams this way.

A further general fear is that because LHINs are not actually regional health authorities that directly provide health services and labour, a LHIN will contract out the services to for-profit and distantly located companies. The latter will have less attachment to the community than locally proven agencies and would be subject to less community input. Also, a competitive market system, rather than furthering integration, would create fragmented contracts driven to make profits that are forwarded to out-of-community head offices and would actually discourage information sharing and co-operation among providers in the interests of protecting their private information. Yet coordination is the alleged LHIN goal.

**1530**

We have at present a centralized system with enough empathy for our community. Why would we want centralization with excessive executive powers and decision-making out of the community? We don't look forward to more centralized, top-down decisions enabled by this bill, which over the last two and a half years, at least, have not understood and funded our community health care services adequately. Share the power with the community, which realizes its citizens' needs. We're going to be doing that in Peterborough a week from Wednesday: holding a public meeting and inviting all kinds of people, including our MPP, Jeff Leal. We're going to have all points of view there, and we're going to come up with recommendations. All political parties have been invited.

In conclusion, Bill 36 must be seriously amended, particularly regarding excessive executive power and the potential to displace community input and service delivery. At these hearings and in all Ontario communities there are groups, including our coalition, and individuals willing to help, but only if you stop, wait and listen more.

**The Chair:** There are 30 seconds each. Ms. Martel.

**Ms. Martel:** Maybe just a point, then: I'm glad you raised centralization of control. I referenced earlier today, and I'll do so again during the public hearings, some of the legal opinions that show very clearly that instead of devolving control to local communities, the government is actually centralizing that even more with respect to what cabinet can do, what the minister can do and then what the LHIN members can do. I remind you that the LHIN members are of course appointed by the government, not by the community. Thank you for pointing that out again today.

**Mr. Brady:** Can I just make a comment?

**The Chair:** Yes, quickly.

**Mr. Brady:** What I find regrettable is that it's a large bill and a lot of people haven't read it. The media in particular have not read it. They're reading the press releases and spouting them out. In Peterborough, we're trying to get that word out, and we've actually convinced a few people: "Hey, look a little further. This is centralization. It's not into the community."

**Ms. Wynne:** Two quick questions: First, do you think it's a good idea for the provincial government to have a plan for a sustainable health care system; and second, how did you get to the conclusion that the strategic plan was going to be developed without public input? I've been told, and my understanding is, that a process for public consultation is being developed as we speak. I'd like that information from you.

**Mr. Brady:** Okay. I'll answer the second one first. A strategic plan: You've had two and a half years. Other countries, other jurisdictions have delivered white papers which suggest where you're heading. That hasn't been done.

**Ms. Wynne:** So your answer is yes, there should be one.

**Mr. Brady:** There should be one—

**Ms. Wynne:** Okay, that's the first question.

**Mr. Brady:** —with public input, which has not happened so far.

**Ms. Wynne:** So how did you get to the conclusion that there's going to be no consultation?

**Mr. Brady:** I see no evidence that there is going to be. I tried to point out earlier that health care providers in the community were invited out, but the public was not.

**The Chair:** Mr. Arnott.

**Mr. Arnott:** Mr. Brady, I want to express my appreciation to you for coming in today. I don't know if you heard the minister's presentation this morning, but you have offered a very effective rebuttal to almost every point he made about what they're trying to do with this bill. You've highlighted very effectively, I think, the fact that this bill would appear to further centralize decision-making authority, really the opposite of what the minister indicated this morning.

**The Chair:** Thank you very much for your presentation.

## AUDITOR GENERAL OF ONTARIO

**The Chair:** The next presentation is from the Office of the Auditor General of Ontario. Jim McCarter, please. Good afternoon. You can start anytime.

**Mr. Jim McCarter:** Thanks, Chair, and good afternoon. I've got just a one-page handout. I hope you have it. What I'd like to do is read a very brief statement into the record and then throw it open to questions, if that's okay.

Essentially, my comments relate to subsection 12(1) of the bill, which proposes that the Auditor General perform the annual audit of the accounts and financial transactions of each of the 14 local health integration networks.

We're concerned that the resource requirements of conducting these 14 audits, essentially across Ontario, would probably require a reduction—very likely a significant reduction—in the amount of value-for-money audit work that we currently conduct, especially now that we have been given the mandate to conduct such work in broader public sector entities such as hospitals, school boards, universities and community colleges.

Given that the LHINs are located in different geographical areas throughout the province, we believe it would be more practical and cost-effective for the board of each LHIN to appoint its own private sector financial statement auditors. Our research indicates that the legislation in seven other provinces covering regional health care organizations allows an organization's governing board to appoint an independent financial statement auditor. Several other provinces allow for the appointment of the Auditor General to conduct the annual audit, but none require this.

I'd like to suggest that subsection 12(1) of Bill 36 be amended by removing the reference to the Auditor General and replacing it with a subsection requiring the board of each LHIN to appoint their own financial statement auditor. Although the Auditor General has audit access rights under the Auditor General Act, I believe it would be worthwhile to reiterate our audit access rights in the amended wording. Our suggested wording for the amended audit clause for subsection 12(1) would be the following:

"The board of directors of a local health integration network shall appoint an auditor licensed under the Public Accounting Act, 2004, to audit the accounts and financial transactions of the local health integration network annually. The Auditor General may audit any aspect of a local health integration network's operations."

I do not believe that accountability to the Legislature and oversight by my office will be impacted because, under the Auditor General Act, I would still be able to examine the accounts and activities, both from a financial and, probably most importantly, a value-for-money perspective, of any LHIN at any time should I consider it necessary.

I communicated the foregoing concern, together with our suggested amendment, to the Minister of Health and Long-Term Care by letter on January 3, 2006. The minister recently replied to me—it was late last week—and indicated that the government is prepared to propose an amendment to section 12 during the clause-by-clause review that would address my concern.

Although I am hopeful the government will remedy my concerns with respect to Bill 36, as an officer of the assembly, I did want to bring my concerns directly to the attention of the members of this committee and provide you with the opportunity to raise any questions you might have.

This concludes my presentation. I'd be happy to take any questions you might have.

**The Chair:** Thank you for your presentation. Two minutes plus for each. I'll start with Ms. Wynne, please.

**Ms. Wynne:** I'm just going to make a quick comment, and then my colleague Mr. Delaney's got a question. I just wanted to make sure it was on the record that the minister has said that he's open to an amendment, and whether or not it will be the exact wording is not clear at this point.

**Mr. McCarter:** Yes, the minister has written back to me and essentially said, "I hear where you're coming from, Auditor. I'm prepared to accept your suggested wording." My understanding is that it may not be the exact wording, but essentially he's onside with basically changing the act to have the local board appoint a local financial statement auditor to do the annual financial statement audit every year. So in Thunder Bay, they would probably take a firm from Thunder Bay; in Mr.

Leal's riding of Peterborough, they would probably appoint a local firm in Peterborough.

**Ms. Wynne:** And then you would have oversight of those audits.

**Mr. McCarter:** We have oversight to go in at any time to have a look at the audit. We would also have the ability at any time to go in from what we call a value-for-money perspective to any LHIN, to look at a number of LHINs for, say, best practices. We have the right under the Auditor General Act—because they would be basically recipients of public money—to go in at any time should we so desire. Quite frankly, we feel the time required to conduct 14—these are financial statement audits, where if they say they've got $10,000 cash, do they really have $10,000 cash? We feel our resources will be better utilized doing more broader public sector value-for-money audits or going into the LHINs and doing a value-for-money audit.

**The Chair:** Mr. Delaney. A quick one, please.

**Mr. Bob Delaney (Mississauga West):** You've actually answered most of the question, but perhaps you'd like to elaborate on it. Given that you expressed concerns on the resource limitations in your office, could you describe or perhaps elaborate a little bit more on how you'd set up a clear and consistent basis on which the 14 separate and independent audits could be conducted year to year on a consistent and repeatable basis?

**Mr. McCarter:** Within our office?

**Mr. Delaney:** Yes.

**Mr. McCarter:** Basically, we would have a team of auditors go into Thunder Bay or Peterborough and audit the LHINs. We'd have to do it annually; we'd have 14 audits. However, what would happen is, because we have staff going out and doing those financial statement audits, I know for sure it would mean I would have to reduce the number of value-for-money audits that I'm doing. We have the mandate now. We can go into hospitals and long-term-care facilities. There are hundreds of organizations we can go into that are getting hundreds of millions of dollars. I guess our preference would be—not telling tales out of school, but we are going for a fairly significant resource increase, hopefully, with the Board of Internal Economy. Notwithstanding, we would much prefer to use our resources doing more value-for-money audits as opposed to doing financial statement audits. That being said, if we had concerns about a financial statement audit, we would be in there pretty quickly.

**1540**

**The Chair:** Thank you. Ms. Witmer, please.

**Mrs. Witmer:** Thank you very much for coming to this committee, Mr. McCarter. I certainly support the amendment that you have put forward, and you can be assured of our support. Hopefully the minister will see fit to word it in the way that you have suggested.

You mentioned that in the other provinces, seven of them, the case would be that they would currently be in a position where they could allow an independent financial statement audit.

**Mr. McCarter:** All of them require, I think, an annual financial statement audit, but they allow the board the authority to appoint, to make that decision. What would typically happen is that the board would probably give us a call and say, "Do you have any suggestions, Auditor?" We would suggest they go out for an RFP, basically put it out to public bid.

**Mrs. Witmer:** Okay. Thank you very much.

**The Chair:** Ms. Martel, please.

**Ms. Martel:** Thanks, Jim. As a member of the public accounts committee, I'm far more interested in your value-for-money audits than I am in your financial statement audits, whether it be of LHINs or any other transfer payment agency.

How did it happen, though, that you folks appeared as the auditor, not essentially of choice, for the LHINs? Did you see this before the legislation was introduced? Were you asked about it by ministry staff before then, or did you see it after it was introduced?

**Mr. McCarter:** To be honest, we were not consulted about it. We saw it in the draft bill. I'd have to say, though, that this has happened before, you know, "We have the Auditor General. We'd better make sure we get the Auditor General in there doing the annual audit." So I think it was just something, you know, they were drafting the bill, and there's typically an audit clause. They could have looked at other legislation like the LCBO act or something, where it said, "Appoint the Auditor General" and picked that up without giving us a phone call.

**Ms. Martel:** How many agencies, boards and commissions have the Provincial Auditor, or the Auditor General's office, doing the financial statements?

**Mr. McCarter:** There are probably between 40 to 50 where we're named. What we found, though, for the out of town ones is that it's probably more cost-effective for us to contract that out. For instance, I think of ONTC in North Bay. What we found is, when we get the firms in around the table—I don't say this too loud; it used to be with Arthur Andersen on the other side of the table—they sharpen the pencil pretty good. We actually got the audit for close to what we were paying for hotel, meals and transportation costs. We just feel it's a very cost-effective strategy to have the local firms do the audit, with some oversight from us.

**Ms. Martel:** I don't want to make comments about Andersen. I think I'll stop there.

**The Chair:** Thank you.

## ONTARIO PUBLIC SERVICE EMPLOYEES UNION, LOCAL 431

**The Chair:** The next presentation is from the Ontario Public Service Employees Union local 431. You can start any time.

**Ms. Sheryl Ferguson:** Thank you. My name is Sheryl Ferguson. I'm very grateful for the opportunity to come and speak to you today.

I have many roles in health care in Ontario. I'm a patient, I'm a family member, I'm a provider, I'm an advocate for health services and I am a union representative. All of these roles are what bring me here today. I

am president of OPSEU local 431. We are the workers at the former Kingston Psychiatric Hospital and, since 2001, Providence Continuing Care Centre Mental Health Services. There are 604 members of our local. We are unique in health care in that we have one collective agreement covering all of our workers.

I'm also the communications coordinator of OPSEU's mental health division. This division of OPSEU is unique, as we have member locals from both the broader public service sector, where you will find most hospitals and community agencies, and the Ontario public service, where the two remaining provincial psychiatric hospitals are. At Providence Continuing Care Centre, I am a rehab officer. I work on the forensic unit, where I support the patients of the service in meeting their work and educational goals. I also have a large number of clients that I function as a case manager for.

I have many concerns about how this proposed legislation will impact on the members of this local, health care providers in general, my clients, my family and me.

When we look at overall health care spending in Canada, we see that we rank second to the United States due to large parts of our system that are presently being privately delivered. When private health care costs are calculated, Canada spends 10.7% of the GDP on health, still well below the 16% the US is forecast to spend. However, it is a cautionary statistic, particularly when we consider that the LHINs legislation opens the door to further private, for-profit delivery of health care. The fastest-growing expenditure in health care is actually outside the medicare system. If we wanted to make health care more sustainable, the logical conclusion, to me, would be to bring it more into the publicly funded, not-for-profit domain.

The local health integration networks are being presented as the solution to many of the difficulties Ontario is experiencing within its health care system. In fact, Ontario's health care system may not be so broken as to require such a massive, costly reorganization. The real cost drivers in the system are not addressed by this reorganization. For example, pharmaceutical costs made up 16.7% of health expenditures in 2004. Drug costs are not covered in this structure. Similarly, the shift to privatization has been a consistent cost driver. In home care, where the sector has undergone a massive shift from not-for-profit to for-profit delivery of care, costs have increased by 21.3% from 1980 to 2001. This has not been matched by a consistent service increase. When Ontario enacted a one-year funding freeze in 2001, service to patients was cut by 30%.

Ironically, the sector repeatedly targeted is the hospital sector. It is ironic because the hospital sector has been the star performer in Ontario's health care system. They have the shortest stays in Canada: 6.6 days, on average, down from eight days in the 1990s. Ontario hospitals treat more patients on an ambulatory basis than any other in Canada. They are the most cost-efficient. Ontario also has fewer hospital beds per capita than any other province in Canada. While funding to hospitals has exceeded the inflation rate, much of that funding has been targeted to specific initiatives. When core funding is distilled, in 2004-05 most hospitals received increases of 1% to 1.8%. That's from the OHA; not a group I would normally quote from.

According to an independent report in March 2004 by the Hay Group, Ontario's hospitals are more efficient than any others in Canada. The report shows that Ontario's hospitals have a lower potential for finding additional savings—a reminder of the efficiency measures that are already in place.

While local health integration networks have been touted as the solution to the integration problems within the system, key parts of the system remain outside the model. Physicians are left outside the system despite their role as the gatekeepers. Ambulance is left out despite the problems they face interfacing with hospitals. Public health is left out despite the lessons learned from SARS. Hospital laboratories are in; private labs are out. Psychiatric hospitals run directly by the ministry will be out; divested ones will be in. This cleaving of the health care system in fact creates more disconnect within certain sectors, such as mental health, than presently exists.

The weekend paper had this following headline: "A Health Care Quest." It's the description of one woman's 20-month search for a family physician in Kingston, and a family physician's description of how he is unable to retire because there are no family doctors in Kingston to take his place. I know this struggle well. Recently, I had to find a new family physician. I spent three months doing that, and I'm very fortunate. I happened to overhear a conversation of a new doctor in town and got in to him. My patients are not so fortunate.

There are approximately 40 outpatients registered with the service I deal with. Of all of them, I think there are approximately two who actually have a GP on the street. Otherwise they are using walk-in clinics, emergency rooms, and when all else fails, they use the family physicians contracted by the hospital who provide services to the in-patients. What this means is that my patients don't have ongoing preventive health care, they don't have a record and they don't have consistency in their care.

By leaving physicians out of the local health integration networks, many needs of the users of the system will not be met. I have many members who are forced to use our company doctor, and we find ourselves questioning, "Who is that doctor really accountable to? Is he accountable to us, to the patients he is seeing or to the employer who is paying him? Does our employer own our health records, do we or does the doctor?" That being said, my members have to go there because they don't have doctors and they need the services.

By going to the purchaser-provider model such as the CCACs, there will be no incentive to share best practices, given that facilities within any sector may face competition. My personal fear is that the integrated services that are common in mental health services will be carved out. Outpatient support teams such as ACT, case management and intensive community treatment may no

longer be able to provide the wide range of encompassing services they do now. Will cost efficiency mean that these teams will not have dedicated recreational specialists or vocational specialists, trained professionals who support, educate, mentor and, when necessary, handhold clients so they can meet their goals?

**1550**

The emphasis on making the system more sustainable suggests that the public is about to pay a price for this. The oft-cited example is of a number of hospitals transferring cataract surgery to a single factory-style clinic, yet when it is suggested that other services could follow the same route, we are called fearmongers. Under fiscal pressure from the government, the LHIN could very well rationalize many health services under the integration plan, forcing patients to travel hundreds of kilometres for services they presently receive in their community. While this may be efficient from a delivery standpoint, this is not efficient from a user standpoint.

Who pays for the flights, the hotels and the time off work to assist patients to travel to distant cities for treatment? For those who cannot afford these substantial expenses, are we creating a two-tier system? What is the difference between charging user fees and creating conditions whereby access to health care is dependent on substantial personal expense?

The clients that I support cannot afford to travel outside of their home community for treatment. Just because they have a serious and persistent mental illness doesn't exclude them from suffering other health issues; actually, they're more likely to suffer other health issues. Medications often lead to weight gain and the health conditions related to obesity, including type 2 diabetes, high cholesterol and heart conditions. Many medications cause the need for ongoing monitoring of livers and kidneys. Many of my clients are hepatitis-positive. They will all need specialists in their lives, and if that access is not available in their home community, who will get them to and from their appointments? Who will provide the support after their procedure? Not their family physicians, because they don't have them.

In Prince Edward county, which is very close to Kingston, rationalization of services at the local multi-site hospital led to doctors announcing that they would relocate to other communities, worsening an already existing shortage of physicians. This also included the one and only surgeon at Trenton hospital. It would appear, though, that the hospital has been somewhat successful in recruiting more doctors—not enough to meet their needs, fully stated, but there are some coming, and there is another part-time surgeon coming to Trenton.

I am aware of at least five family physicians leaving Kingston in the last few months. That has left thousands and thousands of people without a primary health provider. It has also added to the already 20,000 people in the larger area who didn't have primary health care.

Kingston continues to struggle to recruit specialists. The hospital I work for has actively been recruiting a clinical director for the program I work for, for over a year. Lo and behold, in this weekend's paper there's an ad for a psychiatrist too. I'm sure psychiatry is not the only specialty struggling this way.

Across Ontario, health care users are likely to experience more and more service transfers under LHINs. The LHINs are not a one-time restructuring, but rather a process for continual amalgamations, transfers and even the winding-up of certain services. This is a permanent instability within our system. While there are some limited protections for the workers under the Public Sector Labour Relations Transition Act, which Bill 36 proposes to amend, it is cold comfort to those who will be forced to choose between their community and their job. Workers are not always as portable as the government would like us to believe.

In mental health, we've been down this road. I've lived it, and I can tell you, it was not pleasant. Kingston Psychiatric Hospital was divested in 2001, and there are still outstanding issues around that. Yes, we did have a choice: We could not accept employment with the receiving hospital, and we could be unemployed. Some real choice we had there.

With the recent media attention on the divestment of ACTT teams in southwestern Ontario—from St. Joseph's Regional Mental Health, the former London Psychiatric Hospital and St. Thomas Psychiatric Hospital to community agencies in the Windsor area—my members are scared. They are asking if they have to face this again: accept job offers from employers they never really wanted to work for or face unemployment.

I do have many ideas on what we need to do with this legislation. I would like to say that human resources need to be addressed. We need to rebuild our health care system. We need to include front-line workers and the unions in it. Our health care system needs to be portable and equitable across the province. There should be no competitive bidding in health care.

We need to ensure that the Minister of Health is accountable and responsible for our system.

Employment stability will ensure the best patient care: Successor rights need to be restored to the OPS members; front-line staff, their bargaining agents and collective agreement must follow the work in any restructurings, transfers or sale of business; employment stability, no layoffs and a mandatory comparable job offer, seniority recognized and voluntary exit options are all necessary; and a human resources plan for all of the affected workers must be negotiated with health care unions.

**The Chair:** Thank you very much for your presentation. There is no time for questions.

## HEART AND STROKE FOUNDATION OF ONTARIO

**The Chair:** The next presentation is from the Heart and Stroke Foundation of Ontario. Rocco Rossi, please.

**Mr. Rocco Rossi:** Thank you very much, Mr. Chair. I want to begin by expressing my appreciation and that of the Heart and Stroke Foundation of Ontario for the

opportunity to provide input on this important legislation. We are always pleased to offer our advice and input to the Ontario government, particularly when we see the government moving in the right direction to improve our health care system and address prevention.

However, before offering our positive comments, mixed with some cautions and constructive criticism, let me introduce our foundation. The Heart and Stroke Foundation of Ontario is a community-based, volunteer organization. Our mission is to reduce the risk of premature death and disability from heart disease and stroke through research, advocacy and public education. Every year, our organization funds some $47 million in research in Canada, over $30 million in Ontario itself, and awards another $8 million to support young Canadian heart and stroke researchers. We are the largest nongovernmental source of research funds in this country. Here in Ontario, we work to educate the public and professionals, encourage healthier lifestyles and improve patient care and rehabilitation. With the perspective of our provincial scope, our foundation appreciates the need for the health care system to respond to the different realities in various parts of the province, including the need to take community needs and concerns into account in planning and setting priorities at the local level. Finally, the Heart and Stroke Foundation of Ontario recognizes that continuity of care is very important to patients and their families.

For all of these reasons, we believe that Bill 36 holds the promise of important and significant improvements in health care for the people of Ontario. This government deserves acclaim for developing the LHINs concept into sensible legislation.

We strongly support the goal of the legislation: ensuring that all Ontarians have access to the best possible quality of health care. Accomplishing this goal will save lives and improve lives across our province. However, if we are to accomplish those very laudable goals, some aspects of Bill 36 must be improved, both on paper and in implementation. The advice the foundation wants to share with you is not mere opinion; it is based on our many years of real-world experience and research across Ontario.

For example, we've been working with the Cardiac Care Network of Ontario on cardiac care issues, holding focus groups or soundings with a cross-section of stakeholders in every proposed LHIN area of our province. I know that you heard from Dr. Kevin Glasgow this morning regarding this important work towards an improved cardiac strategy in Ontario. We will be providing reports to the LHINs and preparing a composite report on the province-wide results.

For our purposes here today, you should know that the preliminary findings of this study underline a vital aspect of care that must be better integrated and supported in our system: that is, prevention. A shortage of family physicians and limited access to primary care in Ontario results in little time to devote to preventive measures. There is also insufficient emphasis on primary prevention of heart disease and inadequate public awareness of measures to prevent cardiac disease. Our foundation sees the LHINs as key future partners in addressing these challenges, and we look forward to working with them.

Another relevant finding from this study to date is a common thread we are seeing across all LHIN areas and all services: the need for common and consistent protocols and standards. This and other issues exist across boundaries. No matter how sensibly you draw the lines, not everything is going to fit neatly within them.

Another useful lesson from these focus groups is that wait times need to be thought of in a comprehensive way. Cardiac care provides a perfect example of this. While the wait list after seeing a cardiologist appears to be under control, cardiac patients actually experience significant delays long before they are referred to a specialist. The lack of primary care providers and shortage of cardiologists means that there are real, significant barriers to access, regardless of what the wait list would suggest.

**1600**

Another source of lessons learned—our experience with the Ontario stroke strategy—underlines those conclusions. It also demonstrates the value of a regional planning approach and integration across the continuum of care.

The Ontario stroke audit of 2002-03 found an enormous disparity in the type of care and investigation offered to patients across Ontario. For example, 14% of ischemic stroke patients in LHIN area 11 received TPA while not a single patient in five other LHIN areas received that treatment. Province-wide, some 19% of stroke survivors have access to in-patient stroke rehab beds, but that number varies from 31% in one region to only 6% in another region. One is reminded of the wisdom of an old folk saying: Never try to walk across a river with an average depth of five feet. Averages and means do not tell the whole tale. We have geographic areas that need extra support and resources. I would be extremely surprised if this was not true for many, if not most, medical services.

So regional strategies and province-wide strategies, standards and protocols must be in place to ensure consistency of care. Just look at the establishment of secondary prevention clinics, which we supported as part of the stroke strategy: They have ensured that individuals with the symptoms of a TIA or mini-stroke are seen within days instead of months and they have made full diagnostic workups, together with lifestyle counselling, available to those patients. These clinics have reduced the admissions to hospital by 18.5% over a six-year period. We need to ensure that improvements like this are equally available in every LHIN area.

I want to return to rehabilitation for a moment because, to quote another folk saying, a chain is only as strong as its weakest link. Rehabilitation is certainly the weakest link in the continuum of care even though it is one of the most important. Pilot projects have demonstrated the tremendous potential of providing more in-

tensive rehabilitation in the community. We found that patients who received intense rehab had half the number of hospital readmissions in the first three months following hospital discharge. The usual care group was admitted for fractures and falls.

There's an interesting sidebar to this story. When we present this experience at conferences across Ontario, some participants comment that the enhanced care provided in their area is very similar to the usual care. It's just more evidence of the need for province-wide standards.

Any large, complex, cross-Ontario program needs guidelines. In fact, having a policy framework was one of the key success factors of the Ontario stroke strategy, and this committee would probably benefit from looking at the best practices guidelines and how framework development has been embraced as an ongoing process.

The other success factors we identified for the stroke strategy also provide a useful template for implementing integration through LHINs. Along with providing a policy framework, the key points were:

—the participation of clinical leaders, who played an essential role in the strategy's success;

—identifying change agents at the regional level who help make new thinking and new methodologies a priority;

—making a significant investment in professional education;

—providing a role for organizations such as our foundation, which has been very successful in bringing people together, engaging communities and identifying common issues; and the final point,

—engaging the public.

Let me just note that our public awareness campaign on the warning signs of stroke has increased awareness by 20%. That translates directly into more patients coming to hospital within the crucial two-and-a-half-hour window for initial treatment, which both saves lives and reduces the subsequent readmission, rehabilitation and disability costs to the system. The government's implementation of the ideas in Bill 36 could only benefit from a careful study of those success factors and the patterns and paradigms discovered in the stroke strategy experience.

Frankly, one of our concerns about the establishment of LHINs is that there will not be clear accountability at the provincial level to ensure continuing progress with implementation of the stroke strategy. This strategy must be continued for the sake of today's patients and those at risk of becoming patients in the future. It must continue to be the object of improvements, such as increased powers for the provincial and regional steering committees to hold health care providers accountable for integration. And, as I think members of this committee now understand, it stands as a highly useful and inspiring example of how to implement the kind of province-wide, systemic improvements the government hopes to create with LHINs.

Finally, I would like to mention two areas that the foundation feels are not adequately addressed in the legislation. The first is research. I don't believe that Bill 36 even mentions the word once. True integration must include strong links to research so that we minimize the gap between what we know and what is practical. Good research has been the bedrock of our foundation's success and the wellspring of innovation and improvement. Please don't forget that you are not just building a system for now but a mechanism for distributing the fruits of progress in the future.

Our last point concerns accountability. I mentioned at the beginning our common goal of providing quality care to all Ontarians. This will only happen when information flows freely both up and down the chain, from Queen's Park to the front lines and back again; when those who have an intimate understanding of patient needs and critical issues are heard; and when those who make the final decisions are fully accountable for the choices and outcomes. The creation of LHINs and the introduction of Bill 36 are far more than first steps, but they are also not the end of the journey toward an integrated health care system.

This government has built on the efforts of previous administrations and the labour of many individuals and organizations to move Ontario closer than ever to our goal. With the leadership of government and through our continued mutual effort, I am confident of our ongoing progress and success.

Once again, I thank you on behalf of our foundation for the introduction of this important bill and for the opportunity to speak to you today.

**The Chair:** Thank you, Mr. Rossi. There are two minutes each, and I'll start with Mrs. Witmer.

**Mrs. Witmer:** Thank you very much for your presentation. I would agree with you that rehabilitation is absolutely essential; in fact, I'm dealing with someone right now who has been funded to provide rehab services and has just discovered they're going to be losing the government funding come March. I know what a difference it has made in the lives of those people. So I think it is important that we continue to focus on what is needed and also that people throughout the whole province have the same access to the same services. I think you've pointed out that right now there is inequity and there doesn't seem to be any mechanism within the LHINs to ensure that everyone would have that service.

I want to thank you, and we hope that the government will be responsive to your concerns.

**Mr. Rossi:** I would be remiss in not taking this opportunity to thank you for the role you played, in your prior role, in making the Ontario stroke strategy happen.

**The Chair:** Madame Martel.

**Ms. Martel:** Thank you very much for being here today. Because you referenced the presentation we had first thing this morning from the Cardiac Care Network of Ontario, I was just curious as to whether you had seen the proposed amendments they've tabled with the committee.

**Mr. Rossi:** Yes, we have.

**Ms. Martel:** I'm going to assume, because of your reference to them and because they are pretty generic, that your recommendation for change would be the same with respect to legislative amendments.

**Mr. Rossi:** We're very supportive, and have discussed these issues on a combined basis. In fact, CCN is part of our cardiac soundings process across the province.

**The Chair:** Mr. Fonseca.

**Mr. Fonseca:** Rocco, thank you very much for your presentation, and it was great how you brought up some examples of the regional disparity that exists. Previous governments did not take care of that regional disparity. This government really has looked at the facts and at fixing the health care system, a system the Minister of Health did not see when he came into this role. What we're doing is building a stronger system for its sustainability.

Throughout your presentation, you addressed a lot of the regional disparities. Do you feel that with the local health integration network we will be able to better address those disparities than ever before, because it is based on CIHI information and fact?

**Mr. Rossi:** We certainly are hopeful, and we certainly see how the mechanisms for integration within a LHIN will lead to minimizing disparities within the LHIN. What we'd like better understanding on from the legislation and from the government—because you're devolving some significant powers into the LHINs—is how you still maintain and move toward addressing these disparities across LHINs. As you pointed out, they are not things that just appeared this year or last year but are systemic and have been long-standing.

**Mr. Fonseca:** Like CCN, you'd like to see that mechanism where province-wide—

**Mr. Rossi:** There are guidelines and protocols that can be used as a basis within the strategic plans of all LHINs to ensure that Ontarians, no mater what LHIN they happen to live within, will receive quality health care.

**The Chair:** Thank you, Mr. Rossi.

**1610**

## ALZHEIMER SOCIETY OF ONTARIO

**The Chair:** We will have the next presentation from the Alzheimer Society of Ontario. Nancy MacArthur and Linda Stebbins, please. Good afternoon. You can start any time you are ready. You have 15 minutes in total.

**Ms. Nancy MacArthur:** Mr. Chairman, my name is Nancy MacArthur. I'm the vice-president of the Alzheimer Society of Ontario. With me is Linda Stebbins, our executive director.

I wish to thank the committee members for allowing us to present today. We will address five major issues. I have copies of our position paper for each of you, which contains the details on the changes we propose to address and our concerns.

Before Linda outlines the issues and proposals, I want to introduce you to our organization and our mission. The vision of the Alzheimer Society is a world without Alzheimer disease and related disorders. One hundred years ago this month, Dr. Alois Alzheimer first described the disease we now associate with his name. Each year, we move closer to a cure for a disease that robs us of our memories and our loved ones. Along this path, our volunteers and staff have responded with compassion to the pressing needs of persons with the disease and their caregivers. It is our hope that our next centenary celebrates a world long rid of dementia.

But there is a shorter-term reality that we must face with eyes wide open. The national council on aging paper published in 2004 states:

"By 2031, Canada's biggest demographic group—the so-called 'baby boomers'—will move into the age of highest risk for developing AD. It is estimated that by that time, the number of Canadians who will have AD or a related dementia will have more than doubled from the 2001 figure of 364,000 to 750,000! .., these costs will rise exponentially if prevalence projections remain unchanged. Some analysts believe that over the next 25 years, AD—together with other forms of cognitive impairment—will prove to have the highest economic, social and health cost burden of all diseases in Canada."

Our 39 Alzheimer Society chapters in Ontario and the provincial association have raised significant funds over our 25-year history. In the past three years, we have contributed more than $37.5 million towards research and service to Ontarians. These funds have benefited research at the national and provincial levels in both the biomedical and psychosocial spheres. Dollars raised also underwrite support for people with dementia, families and caregivers, information and referral to community services, public education and Safely Home, the Alzheimer wandering registry. We also acknowledge the ever-increasing support from the province for our diverse range of in-demand services.

People with dementia require services across the health care continuum, from disease onset to end of life. We have an interest and a presence at every point on the continuum of care, partnering with family physicians to achieve better diagnosis and advocating for better pain management at the end of a person's life. We take a broad perspective on the health system and health care.

**Ms. Linda Stebbins:** As a result of this broad perspective, the Alzheimer Society is keenly interested in the evolution of Bill 36 and hopes to offer you a distinctive point of view on the current draft. We will identify five major issues for your consideration.

Issue (1) The primacy of quality of care: We have two parts to this issue.

Part A: The Alzheimer Society in Ontario believes the legislation should commit local health integration networks to high-quality care. A major concern of Ontarians is quality of care. The concepts of person-centred care provided in the right place and at the right time define key components of quality. Since LHINs will have responsibility for overseeing direct service agencies that have a duty to provide high-quality care, the LHINs themselves should share this duty.

Part B: The Alzheimer Society in Ontario believes that bills of rights in both the Long-Term Care Act, 1994, and the various acts governing long-term-care homes need to be reaffirmed.

Since powers in these acts may be delegated to LHINs, LHINs should also be bound by the bills of rights in these acts so that clients can expect consistency. The legislation before you has been criticized for not being client-centred enough. Reaffirming the rights of clients addresses this shortcoming.

(2) Caregiver recognition: The Alzheimer Society of Ontario believes that the role of informal caregiving merits recognition in Bill 36. While we benefit from a comprehensive and reasonably well-run health care system, it must be acknowledged that Ontarians, through kinship, friendship and community affiliations, provide most of the care to persons who need it. This is especially so in the care of the dying, the elderly and persons who are severely disabled by chronic diseases.

Most caregivers are women. Many face economic hardship that, in turn, creates new and unexpected social costs. Our system often fails to support caregivers. Caregiver respite was the first service typically jettisoned in cutbacks. For example, this was true when community care access centre budgets were scaled back a few years ago. It is also true now, given the pressures to meet the needs of acute care clients.

(3) Engaging clients and caregivers: The Alzheimer Society of Ontario believes that Bill 36 should specify that LHINs consult with clients and caregivers. Ontarians welcome the opportunity to engage with LHINs on key issues, but the current Bill 36 wording is vague on this score. Historically, district health councils drew a third of their members from the client, caregiver and consumer community, and the original community care access centre boards also provided for client membership. While we acknowledge the government's focus on skill mix for LHIN boards, Bill 36 needs to be more explicit about meaningful client and caregiver consultation and involvement. After all, the act provides a structure for service providers and health care professionals. The people they serve, as well as the persons providing the most service, deserve no less.

(4) Unreasonable encroachment: The Alzheimer Society of Ontario believes that Bill 36 unnecessarily extends the reach of government into the affairs of health charities. Our 25-year history is one of uncovering unmet needs and developing innovative services with funds raised from our communities. In time, some services have been funded by government and extended across Ontario. Our clients are appreciative, and we are as well. After the public sector assumes some of these costs, we continue to explore how, through charitable funds raised, we can deepen our supports to persons with Alzheimer disease and related disorders and their caregivers. An innovation currently underway in some parts of Ontario is the concept of respite bungalows, where persons with Alzheimer disease can go for a short time while their caregiver is relieved of their commitment. Other health charities have done the same thing: hospices for the dying; services for the addicted; coffee houses for the mentally ill. These now are all a part of our range of services for Ontarians, all introduced by health charities in our communities.

The public sector needs to manage its resources, and we support LHINs having jurisdiction over funding from government. It is a principle of our parliamentary democracy that governments should only take on the powers required in order to achieve the goals for which they were elected. Section 28 gives the minister powers beyond what is required and which strike at the core of our civil society. We resist strongly the provision that the minister would have jurisdiction over the entirety of an organization with which a LHIN has a funding relationship. This, in our view, is unnecessary, unreasonable, counterproductive and, we believe, undemocratic.

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Some of our member chapters receive only a small percentage of their overall budget from government. For example, the Alzheimer Society of Toronto receives only 8% of its $1.3-million operating budget from government. On the other hand, the Alzheimer Society of Elgin-St. Thomas receives 50% of its $200,000 operating budget from the province. In neither case, however, should the minister have authority to interfere with our mission-related services that are not funded by government. Section 28 gives powers to the minister to issue directives on all of the Alzheimer Society activities. These powers need to be restricted to services funded by government, as per subsections 26(2)(b) or 27(3). Our accountability for charitable dollars should remain to our donors for purpose, and to the government for tax status.

(5) Diffusion of accountability: The Alzheimer Society of Ontario believes that Bill 36 can undermine the accountability relationship for both LHINs and health service providers. Section 25 enables a LHIN to integrate "persons or entities" with a "person or entity that is not a health service provider." Given that LHIN jurisdiction is restricted to health service providers, the subsequent accountability relationship of a non-health service provider is unclear. To whom is the non-health service provider entity accountable? Is it to the original health service provider? If so, what are the mechanisms for accountability? Are the contractual rights of the service provider compromised by the third-party interests of the LHIN? These questions demand clear answers. This section has the capacity to undermine the not-for-profit sector by transferring services, as defined in section 23, to the for-profit sector, blurring accountability and narrowing the LHIN and the minister's reach since it does not extend in an effective manner to the private sector.

In summary, the Alzheimer Society of Ontario appreciates this opportunity to raise these important issues, and we are confident that you will recommend amendments that (1) extend the rights of clients already found in other legislation; (2) recognize informal caregiving; (3) assure clients and informal caregivers of engagement; (4) cir-

cumscribe LHIN and ministerial powers so that charities are not jeopardized; and (5) clarify accountability relationships.

The thousands of Ontarians with Alzheimer's disease and related disorders and the thousands more who will contract it benefit greatly from our partnership with government. We have outlined how Bill 36 threatens this collaboration, and our proposed amendments show how Bill 36 can be improved. Ontario and Ontario's health system was built upon such partnerships, and this is where our future lies. We ask for your support for our amendments.

**The Chair:** Thank you for the presentation. There's no time for questions.

## YWCA OF PETERBOROUGH, VICTORIA AND HALIBURTON

**The Chair:** The next presentation is the YWCA of Peterborough, Victoria and Haliburton. Lynn Zimmer, please. Good afternoon. You can start any time you're ready.

**Ms. Lynn Zimmer:** Members of the committee, my name is Lynn Zimmer—kind of ironic. I am the executive director of the YWCA of Peterborough, Victoria and Haliburton. Our YWCA is a 115-year-old women's equality-seeking organization which promotes the leadership of women and supports the right of all women and their families to live free from violence, poverty and oppression. We bring four issues to this consultation. I can't critique your specific plans because I don't know what they are, so I'm going to share some thoughts and concerns.

Transportation is my first topic. Transportation is a big factor in our health care challenge, but it is not yet adequately included in the health care system. In our region, travel for medical services is already a huge burden, particularly for single individuals, single parents, people with low incomes, elderly people and people with disabilities. Women are a large part of all of these groups. Please note that when health care is the issue, disability may be lifelong, recent or temporary. Disability can be the reason that health care intervention is needed. It could be a symptom of a new or old problem. It could be caused by medications, by anxiety or by the treatment itself.

People in our region already face huge travel burdens when seeking cancer treatments, for instance, or when seeing specialists in Toronto or Kingston. Rural people are the most disadvantaged. The trip from the village of Haliburton to Peterborough in midwinter can be harrowing, but there is no public or private transportation, except perhaps from Peterborough. So you can call a taxi from Peterborough and, for a mere $143 one way, you can get yourself down to the hospital.

For people already marginalized by poverty, mental health problems, isolation or lack of social connection, and for those who are elderly, alone and poor, lack of transportation means no access to health care. No one wants to travel when they are ill, and many just can't. There's a lot of talk about shortening wait times for hip and knee replacement surgery. The idea is to preserve people's mobility and thus their ability to live independently. No one ever talks about how they get home after their surgery.

A friend of mine lives in a community north of Peterborough. It's called Buckhorn. It's about a 20- to 25-minute drive. Her parents, who live nearby, are both in their 80s and both are battling cancer. Her mother has had to travel back and forth to Peterborough and Kingston for her breast cancer treatments. Her father has to travel to Peterborough and Toronto for treatment for prostate and bladder cancer. When her dad was hospitalized in Peterborough, her mother cancelled her remaining treatments so she could be with her husband for his, and she has had to travel back and forth every day to visit him. The entire family is exhausted from the combination of treatments, travel and worry. These people are lucky: They have immediate family members to do the driving. Most are not so lucky. Many take to the roads when their health status makes them marginal drivers at best. Many give up. They're too independent to ask for help, and they don't know who to ask. Taxi fare one way from Buckhorn to Peterborough is $55.

It is our recommendation that the new system should determine a maximum travel distance for treatment—which should be shorter than the one we have now—and implement a system of transportation supports suitable for people coping with pre- and post-treatment pain, fear, anaesthetics and disability. I understand that changes would actually be needed to the Highway Traffic Act to add extra busing to help people get back and forth, for instance, because our current arrangement allows for only one transportation provider per route. So local organizations that want to organize not-for-profit busing are precluded from doing so.

The next issue is the lack of democratic process and community input. We've heard a lot about that today, and I think that some of the very concrete advice you've had from some other presenters may be even more to the point than mine.

Communities and equity-seeking groups have had no input into the LHIN's design and we have no assurance that the LHIN planners will create a system that responds to the needs of the most vulnerable and unprotected people. If our health care system is to be truly responsive, how do we access the decision-makers? To whom do we present the stories of good service or tragic lack of service? How can we compare the barriers faced by a family in Buckhorn or Haliburton to those of someone who lives near the subway station in Scarborough?

The members of this committee may end up feeling that many of the presenters are afraid of change, that we see only the worst possibilities. Maybe we seem paranoid. Partly that's because we have no solid information and no assurance about the core values that are really driving this process.

I'm generally considered to be a fairly positive sort of person, but I have a nightmare image that haunts me. I

am a very old lady and I wake up in a hospital-like setting, alone and frightened. I don't know how I got there. The worst part is that my husband is in another institution, also alone. We don't know where each other is and we both feel abandoned. No one helps us find each other or communicate. Each of us is seen and treated as lone patients with no connections. We have no children to act as our advocates. When I've presented this picture to people in the health care sector, no one has ever been able to assure me that it couldn't happen.

**1630**

It is images like these that haunt health care advocates. We see the human care in the health system disappearing. It becomes less and less likely that we will be treated by a doctor who knew us when we were well. The bits and pieces of our bodies and minds are analyzed, poked and treated, often in different facilities and different cities, as if they were all separate from who we are and how we live in the world.

The health care needs of women: Peterborough's Women's Health Care Centre is a unique and valuable feature of health services in our region. We will fight very hard to retain it. In fact, its services should be expanded and given greater financial support. If our health care system is truly to become preventive, then women need access to community-based resources that help them educate themselves, make informed choices about their health and that of their families, and access services that support their right to make their own decisions about their reproductive and general health. More communities should have a women's health care centre, not fewer.

Now that most procedures are done on an outpatient basis, women pick up a huge proportion of the downloaded impact of patient care. This includes transportation, aftercare, monitoring of medication and post-op care for close family members. Yet even the simplest tools, like a written description of the homely details of recovery and aftercare, are often simply not provided.

A little thing like parking fees can break people. In Peterborough, a state-of-the-art long-term-care facility has been built on the outskirts of the city. Bus service is available, but anyone who must drive because they come from outside the city must pay a $2-parking fee each visit. That's $60 a month, if you're making daily visits. For a low-income woman, that can mean not enough money for food. Yet those daily visitors are a critical part of the health care system.

Finally, human beings are capable of generating powerful healing energy from within themselves. Research has shown the power of guided imagery, the power of positive emotions, the power of hope and love to influence a positive health outcome, even for people who are critically ill. As we continue to slice and dice and centralize care, what is being done to harness this energy and power, to work with it instead of against it?

Treating the whole person and keeping their lives intact in the midst of all their support systems is important. Bring treatment closer to the people. Don't add unnecessary trauma and delay. Don't ignore all the barriers we have to overcome to access the system.

In summary, we want a system that understands that we human beings are the real source of healing. The professionals and caregivers bring their healing skills. They bring experience and compassion, not just their organization skills and their ability to operate machines and their cost-effectiveness. The patients bring their hope, their resiliency and their power to help themselves.

Women are the unacknowledged aftercare providers. They need to be included in your thinking, and they need more information and community supports to help themselves and their families.

Access to transportation to and from consultations and treatment must be considered in any health care planning. Thank you.

**The Chair:** Thank you. There is about a minute and a half each. We'll start with Ms. Martel, please.

**Ms. Martel:** Thank you for being here today. I just wanted to focus on transportation from the perspective of the concerns that are being raised with me from my part of the world, which is northeastern Ontario. I live outside of Sudbury, but not that far outside of Sudbury. But there are many from northeastern Ontario who would drive from Timmins, three hours away; the Soo, four hours away; North Bay, an hour and a half away, to access care at the regional centre. The concern they see with this bill is that the move will be afoot, essentially, to rationalize services from those hospitals into the regional centre, which would be ours, to our benefit, but to the extreme detriment of those who would then be on the road for even more services.

I have a concern from that perspective. Now people who don't have to travel or who travel very little, because they can access that service at the Soo and area hospital or at the North Bay General, are going to end up losing that and then having to drive, with all of those complications when you are unwell, or having someone drive them into Sudbury for some of those services.

I don't know if you want to comment on that. You've commented on how difficult it already is for existing services, if they don't move anywhere. I'm cognizant of that, and I'm also very concerned about what's going to happen if some of those start to move from smaller centres to larger, from smaller hospitals to larger hospitals.

**Ms. Zimmer:** I think there are many, many services that really do need to continue to be available at many places, and as close to people's living communities as possible. The issue of what things get centralized and require long-distance travelling is a critical issue, and there should be as few of those as possible. I don't know how that is rationalized with cost-effectiveness, but people can actually be made more ill by the stress of getting to their treatment than the treatment itself.

**The Chair:** Thank you. Mr. Fonseca.

**Mr. Fonseca:** Lynn, thank you very much for your presentation. I'd like to bring up that when the minister developed this and the ministry looked at LHINs and at

driving care into the community—I'll give you an example: Cardiac care post-op and rehab programs were taking place in hospitals. I was at one recently where it cost $12 a day to park and people were coming in a few times a week. That's $30 or $40 a week. Today what we're doing in terms of driving that care into the community and that best practice is moving it into things like the YMCA—there's a program set up with the YMCA—or the community centre, where a nurse can also be there. Rather than having those people come into the hospital and pay that $12 a day, it's closer to their house. They have gotten their operation at the hospital and now they've moved into their community. They can almost walk across the street, many of them, and do that rehab in a place they find more appealing than going to the hospital a few times week. Those are the innovative ways and best practices to better the system and make it more patient-centred. Do you agree that would be a good practice to follow forward with?

**Ms. Zimmer:** Yes.

**The Chair:** One more quick question for the government.

**Ms. Wynne:** Very quickly: You talked about transportation and that those guidelines should be in the plan. Do you see that as part of a provincial strategy? Do you see those guidelines at the provincial level?

**Ms. Zimmer:** I think so, because it's really an equity issue, so there has to be some kind of principle about what people should have to go through to get to their health care.

**The Chair:** Thank you. Ms. Witmer, please.

**Mrs. Witmer:** Contrary to what Mr. Fonseca has just said, we want to talk about cardiac rehabilitation. Our government actually did set up cardiac rehabilitation programs outside of the hospital settings. In fact, I have one right here: the Ontario Aerobics Centre in Breslau. We provided funding because we thought people should be getting the opportunities outside of the hospital. I have to inform you that they have now been advised by the ministry that perhaps as of the end of March, their funding may be discontinued. So all those patients who thought this innovation was a wonderful thing will lose the opportunity for cardiac rehabilitation in a setting outside of the hospital. I just wanted to let Mr. Fonseca know that we did introduce this type of innovation. Obviously, we're very concerned for the patients who are going to suffer the consequences as a result when this is no longer funded.

Thank you for your presentation.

**The Chair:** Thank you very much for your presentation.

**1640**

## CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 1909

**The Chair:** The last presentation of the evening is from the Canadian Union of Public Employees, local 1909, Lindsay/Kawartha Lakes, in the Peterborough area, I believe; Melissa Lotton and friends.

**Ms. Melissa Lotton:** Friends, yes. These are my supports.

**The Chair:** Welcome, and you can start any time.

**Ms. Lotton:** I am brand new to this—I've never done this before—and I ask you to keep that in mind. I'd like to introduce my colleague Doug Allan, from CUPE, and my colleague and co-worker Maggie Jewell, who has worked as an RPN for 23 years at Ross Memorial Hospital and is also president of local 1909.

I am Melissa Lotton, a registered practical nurse, mother of two and a taxpayer. I live in what is to be LHIN number 9. I have worked at Ross Memorial Hospital for the past 15 years and I am just now allowed to use my nursing education to full scope. I am also vice-president of CUPE local 1909 and I am considered part of support services, which is threatened to be removed from the hospital by Bill 36. I was born and raised within this community and find I am very concerned about where this LHIN legislation is heading. I feel that the public has been directly eliminated from any input on this legislation.

With regard to centralization, I feel LHINs are local in name only. Local communities and providers will lose the ability to make decisions. LHINs will have the power to turn delivery over to for-profit corporations. More bureaucracy will be created, which in turn will be unaccountable to the local communities, will undermine health care and social services and remove the accountability from the government.

LHINs will not be able to increase revenue, so to me, it seems that smaller communities may be the first to see their services joined with other communities.

LHINs are not local; rather, they are far too extensive, as our local area services from Algonquin Park to east Toronto to Cobourg and Campbellford. Where is the "local" in that? Our population doubles in the summer as we are cottage country, and our hospital has recently undergone renovations to help accommodate the increasing patient volume and the modernization of health-care delivery.

Public, tax-paying people should have their input into the geographical areas of the LHINs, as well as a voice if and when proposals, amalgamations or divisions of LHINs may occur, as we are the people living in those areas.

Patients and their families requiring the use of health care will have to travel further distances for routine procedures, which need to remain in their communities. Travelling will create two-tier care for those who can afford to travel and pay and those who will not be able to pay. In our community, the next-largest city to us is Peterborough, which is 45 minutes away, and there is no public transport. Are we to assume that the government is going to use ambulance service to transport patients, as they are not at this time included in the LHINs? Our hospital, along with many others, is currently using private transport systems for our public.

Ontarians deserve the right to know when, where and what is happening to their health care. Health care must

stay public and must stay in our communities. This is what we call local health care. Privatization will bring disintegration with the multiple providers that will be in competition to win contracts. Competitive bidding should not exist in health care legislation, but we need consultations to develop appropriate funding formulas for the LHINs and service providers.

Privatization creates unstable job security such as that faced by CCACs, with home care workers needing to leave their chosen professions due to poor wages and unstable working conditions, such as contract renewals. If our CCACs are reduced by numbers from 42 to 14 to match the number of LHINs, how will they ever cope with the overwhelming workload, not to mention the geographical demands they will have to service? Privatization will create specialized services spread out over many different health care providers, which in turn will create more problems for those with multiple health issues, of poor social standing, the elderly and their families.

Although hospitals provide many diagnostics, surgical clinics and laboratory services, privatization will remove these services and therefore turn them into private clinics that increase their cost. Profitable private services will become priorities at the expense of other services. Once again, those who can afford to pay will receive and those who cannot will do without.

LHINs, Bill 36 and the privatization of our health care services will join us with other countries, countries that have envied Ontario for having one of the best health care services in the world. As a member of CUPE, I ask that we be included to participate in the talks to aid in the redevelopment of a health care system that everyone can be proud of.

Privatization will create an end to one-stop hospitals. With access to services being at the forefront, it is imperative that Bill 36 not give the government and the LHINs the ability to restructure public health care. Integration decisions force not-for-profit health care providers to cease providing services or to transfer such services, but for-profit providers are exempted from this. Bill 36 gives the authority to contract out services despite the needs dictated by the hospital.

With the threat of reduced community control and LHINs being given power to fund and manage health care and social services, is this to mean that services will vary from LHIN to LHIN? This will not unite service providers but will increase competition between providers. What purpose will be served if integration creates new and higher costs? Bill 36, the minister and LHINs must include public input, push for not-for-profit services and refrain from ordering direct integration.

Legislation should not in any way override the terms and conditions of freely negotiated or arbitrated collective agreements to protect their health care and social service workers. Front-line workers such as support services are a priority in the health care field, such as the workers who dealt directly with SARS. They deserve reasonable employment, security and protected working conditions. Bargaining unit rights and collective agreements must be adhered to. Health care and social service workers have been through many rounds of restructuring, and their collective agreements cannot be overridden by this legislation.

In conclusion, I feel the government's attempt to change health care as we know it is going about it the wrong way. The community, health care workers and the public need to be included in health care reform. I believe in the democratic process and had no idea this would be the direction the government decided upon in restructuring our health care. As a front-line worker and a registered practical nurse, I ask that section 33 of Bill 36, where the cabinet can order the transfer of non-clinical services out of the hospital, be removed from the legislation. Privatization of these services will decrease the high standards that are now in our hospitals.

I thank the committee for listening to my concerns and hope for a positive outcome. I will be attending the health coalition meeting in Peterborough on February 8 to offer my support and hope that others who hear me will join me at the Evinrude Centre.

**The Chair:** Thank you, Ms. Lotton. There are about six minutes left, so I'll start with the government; two minutes.

**Mr. Leal:** Melissa, thanks very much for your presentation. The Central East LHIN is under the chairmanship of Foster Loucks, who is a former chief administrative officer for Haliburton Health Services and who formerly served on the St. Joseph's Hospital board in Peterborough. There's no question that in Haliburton or the city of Kawartha Lakes, in summertime there is increased pressure. Don't you think that with Mr. Loucks representing your area, he can bring his experience to the table to establish priorities and get funding for that particular area of the LHIN that has increased pressures, particularly during the summer months? Have you met with Mr. Loucks?

**Ms. Lotton:** No, I have not.

**Mr. Leal:** Do you know of him?

**Ms. Lotton:** I've heard his name a few times, but that's about all I know of him.

**Mr. Leal:** Could you just respond in terms of setting priorities because of the increased pressures you have, particularly during the summer months? You're on the front line there. I'm interested in getting your response.

**Mr. Doug Allan:** The problem is that there really is a dramatic lack of democratic control within the structure that is envisaged to date. While there may be good people, in some cases, who have been appointed to the board, what we would actually want is genuine community control that would see the process unfold better, a more democratic process and not a government-controlled process. That's what we need.

**Ms. Wynne:** A quick comment. I just want to know whether you understood that section 33 is a transition clause that is there to facilitate some processes that are already under way in terms of amalgamating hospital business services. I didn't know if you were aware of that.

The second point I wanted to make was that you talked about the reduction of CCACs. The offices will remain—the administration will be integrated, but the offices will remain—so that interface with the community will still be there in the offices that are already in place.

**The Chair:** Thank you. Mrs. Witmer or Mr. Arnott.

**1650**

**Mrs. Witmer:** My question to you would be, what is your biggest priority in terms of what the government should do with Bill 36? What is most offensive, or what is the biggest change needed?

**Ms. Lotton:** I just want to focus on keeping our general hospital for ourselves there in that community. I'm not looking forward to services being cut, services being moved from here to there, everywhere. Support services are very important in a hospital when it comes to infection. If we could have more public involvement so that, say, my grandmother could understand what's going on with this bill—because in all reality, other than us, the immediate people talking about it, I don't believe that anybody has a clue about what's going on with their health care. I think what's going on with our health care needs to be brought more to the forefront.

**Ms. Martel:** I want to return to section 33 and read it into the record. It says, "The Lieutenant Governor in Council"—that's cabinet—"may, by regulation"—that's behind closed doors, not through legislation—"order one or more persons or entities that operate a public hospital ... to cease performing any prescribed non-clinical service and to integrate the service by transferring it to the prescribed person or entity on the prescribed date." I don't know what the reference to "transition" is. I know the legal opinion from Sack Goldblatt on this particular provision is that it allows government to order any hospital to transfer its non-clinical service to any entity and there's no limitation on the nature or the structure of the service or to whom it may be transferred. So when you talk about contracting out a service, that's where the reference comes from. The particular legal opinion that looked at that also said that's where you're going to see dietary, cleaning and housekeeping services, for example—many of whom are CUPE members, though I appreciate it might not be you folks—see their services privatized regardless of what the will of the local hospital board might be. That's the power we're talking about there. I don't know what the reference is to "transition." I look at that and say, why are we giving the minister authority over a hospital board to order privatization of those kinds of services? I don't think that should happen in anybody's community. I certainly don't see what the appeal is here, because there isn't an appeal mechanism, if the minister decides to do that. What do you think about that?

**Mr. Allan:** I think that's an excellent point. Ms. Wynne raises this idea of transition. What we've been informed is transitional—you may be referring to the hospital business services which are being established over the 14 GTA hospitals. That will see 1,000 people transferred out of employment with the hospitals to the HBS, with 20% to 25% of those people then severed and services then contracted out. That's the information they provided to us. I'm not sure what the government is telling you, but it is not just the first or the only example of support service regionalization that they're looking at. We know this is happening in many, many different locations. If there is some sort of transitional nature to this, not only should that power be capped and ceased but it should be explicitly put in the legislation that the sort of contracting out this legislation contemplates should not be permitted and should be stopped. If we wish to preserve integrated hospital systems—not fragmented, multiple employers—with decent conditions for the employees at the facilities themselves, that's what's at stake here, and that's what I think you people inside the government have to stand up for if you're going to maintain credibility.

**The Chair:** Thank you for your answer and for your presentation.

This is the end of the presentations, but there is a motion before us that was introduced at the beginning that we should potentially vote on.

Are there any comments on the motion? We all have it in writing. There are two things: We are asking that we deal with Bill 210 clause-by-clause on February 15, and that the deadline for amendments be noon on Friday the 10th. We need permission for that. Yes, Ms. Martel?

**Ms. Martel:** I asked about this earlier because I wanted to be able to check with our folks to see who actually sits on the committee to make sure they were aware of this and that it was fine. I thought we were getting this much earlier in the day so I could actually talk to someone about it; I haven't. I'm happy to try and deal with it tomorrow morning now that I have the motion in front of me, just to see who sits on the committee for this particular bill and make sure that the other committee members—because I wasn't party to this conversation—are aware of it and are okay. Can we do that?

**Ms. Wynne:** That's fine. I thought you had the information, but that's fine; we can do it by tomorrow morning.

**The Chair:** To prepare for tomorrow, can I ask both of you to please consult so we—

**Ms. Martel:** Now that we have it, yes.

**The Chair:** Mr. Arnott?

**Mr. Arnott:** I have another question. Maybe I'm missing something, but a standing committee of the Legislature needs the authority of the House to sit when the House is not sitting. As I understand it, the House comes back on February 13, so why do we need the approval of the House leaders to sit on February 15?

**The Chair:** Normally we sit Monday and Tuesday on this committee, and this is for a Wednesday. It's out of the norm.

**Mr. Arnott:** But it would still require a motion of the House, right? So it's not really in our hands anyway, other than that we can ask for it.

**The Chair:** I guess it's important for us to know—

**Ms. Wynne:** If they agree.

**The Chair:** So again, we'll deal with this tomorrow. Is that the agreement? Thank you. That is all for the evening.

The other issue that we may want to discuss is that we can leave any time, but I understand there has been a request to leave at 6. Can we all agree that we meet at 6 at the main entrance, the south entrance? There will be a bus to take us to the airport at 6. Does anyone have a problem with that time? Okay.

*The committee adjourned at 1655.*

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